

109TH CONGRESS  
1ST SESSION

# S. 1356

To amend title XVIII of the Social Security Act to provide incentives for the provision of high quality care under the medicare program.

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IN THE SENATE OF THE UNITED STATES

JUNE 30, 2005

Mr. GRASSLEY (for himself, Mr. BAUCUS, Mr. ENZI, and Mr. KENNEDY) introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

To amend title XVIII of the Social Security Act to provide incentives for the provision of high quality care under the medicare program.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECU-**  
4 **RITY ACT; REFERENCE TO SECRETARY;**  
5 **TABLE OF CONTENTS.**

6 (a) SHORT TITLE.—This Act may be cited as the  
7 “Medicare Value Purchasing Act of 2005”.

8 (b) AMENDMENTS TO SOCIAL SECURITY ACT.—Ex-  
9 cept as otherwise specifically provided, whenever in this

1 Act an amendment is expressed in terms of an amendment  
 2 to or repeal of a section or other provision, the reference  
 3 shall be considered to be made to that section or other  
 4 provision of the Social Security Act.

5 (c) REFERENCE TO SECRETARY.—In this Act, the  
 6 term “Secretary” means the Secretary of Health and  
 7 Human Services.

8 (d) TABLE OF CONTENTS.—The table of contents of  
 9 this Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; reference to Secretary;  
 table of contents.

Sec. 2. Findings; purpose.

#### TITLE I—MEASURING QUALITY AND EFFICIENCY OF CARE

Sec. 101. Establishment of quality measurement systems for medicare value-  
 based purchasing programs.

Sec. 102. MedPAC study and reports on the impact of medicare value-based  
 purchasing programs.

#### TITLE II—VALUE-BASED PURCHASING FOR HOSPITALS

##### Subtitle A—PPS Hospitals

Sec. 201. PPS hospital value-based purchasing program.

##### Subtitle B—Critical Access Hospitals

Sec. 211. MedPAC study and report regarding a value-based purchasing pro-  
 gram for critical access hospitals.

Sec. 212. Value-based purchasing demonstration program for critical access  
 hospitals.

#### TITLE III—VALUE-BASED PURCHASING FOR PHYSICIANS AND CERTAIN PRACTITIONERS

Sec. 301. Physician and practitioner value-based purchasing program.

Sec. 302. Demonstration project on data coordination through the use of health  
 information technology.

Sec. 303. Sense of the Senate regarding payments under medicare physician fee  
 schedule.

#### TITLE IV—VALUE-BASED PURCHASING FOR PLANS

##### Subtitle A—Medicare Advantage Plans

Sec. 401. Plan value-based purchasing program.

Subtitle B—Plans Offering Part D Prescription Drug Coverage

Sec. 411. MedPAC study and report regarding a value-based purchasing program for plans offering part D prescription drug coverage.

TITLE V—VALUE-BASED PURCHASING FOR PROVIDERS AND FACILITIES THAT PROVIDE SERVICES TO MEDICARE BENEFICIARIES WITH END STAGE RENAL DISEASE

Sec. 501. End stage renal disease provider and facility value-based purchasing program.

Sec. 502. Value-based purchasing under the demonstration of bundled case-mix adjusted payment system for ESRD services.

Sec. 503. Chronic kidney disease demonstration projects.

Sec. 504. MedPAC study and report regarding a value-based purchasing program for pediatric renal dialysis facilities.

Sec. 505. MedPAC report on ESRD provider and facility value-based purchasing program.

Sec. 506. Sense of the Senate regarding an update to the composite rate payment for dialysis services.

TITLE VI—VALUE-BASED PURCHASING FOR HOME HEALTH AGENCIES

Sec. 601. Home health agency value-based purchasing program.

TITLE VII—VALUE-BASED PURCHASING FOR SKILLED NURSING FACILITIES

Sec. 701. Requirement for skilled nursing facilities to report functional capacity of medicare residents upon admission and discharge.

Sec. 702. HHS study on measures of quality for skilled nursing facilities; voluntary reporting of skilled nursing facility quality data.

Sec. 703. MedPAC study and report regarding a value-based purchasing program for skilled nursing facilities.

TITLE VIII—ADDITIONAL PROVISIONS

Sec. 801. Exception to Federal anti-kickback and physician self referral laws for the provision of permitted support.

Sec. 802. National health information pilot project.

Sec. 803. Health care value project.

Sec. 804. Demonstration project on data aggregation across all payors of health care.

Sec. 805. GAO studies and reports on the accuracy and completeness of quality data.

Sec. 806. HHS study and report regarding telehealth and telemedicine.

**1 SEC. 2. FINDINGS; PURPOSE.**

**2 (a) FINDINGS.—**Congress makes the following find-  
**3 ings:**

1           (1) The United States pays more per capita for  
2 health care than any other developed nation, yet—

3           (A) we rank 37th in health care quality ac-  
4 cording to the World Health Organization; and

5           (B) as many as 100,000 patients die each  
6 year in the United States as a result of medical  
7 errors.

8           (2) The Institute of Medicine of the National  
9 Academy of Sciences has highlighted problems with  
10 our health care system in the areas of quality and  
11 patient safety, and has concluded that the United  
12 States should commit to building an information in-  
13 frastructure to support health care delivery, quality  
14 measurement and improvement, consumer health,  
15 public accountability, research, education, and evi-  
16 dence-based medicine.

17           (3) The New England Journal of Medicine has  
18 published research in an article entitled “The Qual-  
19 ity of Health Care Delivered to Adults in the United  
20 States” showing that adults in the United States re-  
21 ceive recommended health care only about half of  
22 the time.

23           (4) Health Affairs has published an article enti-  
24 tled “Medicare Spending, the Physician Workforce,

1 and Beneficiaries' Quality of Care'' showing that  
2 more care is not necessarily better care.

3 (5) Duke University has published a survey  
4 showing that 65 percent of United States business  
5 leaders, unlike their European and Asian counter-  
6 parts, feel that it is very important for Congress to  
7 address the cost of health care.

8 (6) The Midwest Business Group on Health has  
9 found that inefficient resource use in health care  
10 represents more than 30 percent of health care  
11 spending in the United States.

12 (7) Payment policies under the medicare pro-  
13 gram under title XVIII of the Social Security Act do  
14 not include mechanisms designed to improve the  
15 quality of care.

16 (8) The medicare program should reward health  
17 care providers who show that they are delivering  
18 high quality health care and that they are achieving  
19 improvements in the quality of care delivered to  
20 their patients.

21 (9) The medicare program should promote the  
22 adoption of health information technology, which can  
23 enhance the quality of health care services, prevent  
24 medical errors, and enable greater efficiency of  
25 health care delivery with improved outcomes.

1           (10) Reimbursement for items and services fur-  
 2           nished under the medicare program should be based  
 3           on a value-based purchasing system.

4           (b) PURPOSE.—The purpose of this Act is to require  
 5 the Secretary of Health and Human Services to develop  
 6 and implement value-based purchasing programs under  
 7 the medicare program in order to improve the quality and  
 8 efficiency of health care.

9           **TITLE I—MEASURING QUALITY**  
 10           **AND EFFICIENCY OF CARE**

11 **SEC. 101. ESTABLISHMENT OF QUALITY MEASUREMENT**  
 12           **SYSTEMS FOR MEDICARE VALUE-BASED PUR-**  
 13           **CHASING PROGRAMS.**

14           (a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et  
 15 seq.) is amended—

16           (1) by redesignating part E as part F; and

17           (2) by inserting after part D the following new  
 18 part:

19           “PART E—VALUE-BASED PURCHASING  
 20 “QUALITY MEASUREMENT SYSTEMS FOR VALUE-BASED  
 21 PURCHASING PROGRAMS

22           “SEC. 1860E–1. (a) ESTABLISHMENT.—

23           “(1) IN GENERAL.—The Secretary shall develop  
 24 quality measurement systems for purposes of pro-  
 25 viding value-based payments to—

1           “(A) hospitals pursuant to section 1860E–  
2           2;

3           “(B) physicians and practitioners pursuant  
4           to section 1860E–3;

5           “(C) plans pursuant to section 1860E–4;

6           “(D) end stage renal disease providers and  
7           facilities pursuant to section 1860E–5; and

8           “(E) home health agencies pursuant to  
9           section 1860E–6.

10          “(2) QUALITY.—The systems developed under  
11          paragraph (1) shall measure the quality of the care  
12          furnished by the provider involved.

13          “(3) HIGH QUALITY HEALTH CARE DEFINED.—  
14          In this part, the term ‘high quality health care’  
15          means health care that is safe, effective, patient-cen-  
16          tered, timely, equitable, efficient, necessary, and ap-  
17          propriate.

18          “(b) REQUIREMENTS FOR SYSTEMS.—Under each  
19          quality measurement system described in subsection  
20          (a)(1), the Secretary shall do the following:

21                 “(1) MEASURES.—

22                         “(A) IN GENERAL.—Subject to subpara-  
23                         graph (B), the Secretary shall select measures  
24                         of quality to be used by the Secretary under  
25                         each system.

1           “(B) REQUIREMENTS.—In selecting the  
2 measures to be used under each system pursu-  
3 ant to subparagraph (A), the Secretary shall, to  
4 the extent feasible, ensure that—

5           “(i) such measures are evidence-  
6 based, reliable and valid, and feasible to  
7 collect and report;

8           “(ii) measures of process, structure,  
9 outcomes, beneficiary experience, effi-  
10 ciency, and equity are included;

11           “(iii) measures of overuse and  
12 underuse of health care items and services  
13 are included;

14           “(iv)(I) at least 1 measure of health  
15 information technology infrastructure that  
16 enables the provision of high quality health  
17 care and facilitates the exchange of health  
18 information, such as the use of one or  
19 more elements of a qualified health infor-  
20 mation system (as defined in subparagraph  
21 (E)), is included during the first year each  
22 system is implemented; and

23           “(II) additional measures of health in-  
24 formation technology infrastructure are in-  
25 cluded in subsequent years;

1 “(v) in the case of the system that is  
2 used to provide value-based payments to  
3 hospitals under section 1860E–2, by not  
4 later than January 1, 2008, at least 5  
5 measures that take into account the unique  
6 characteristics of small hospitals located in  
7 rural areas and frontier areas are included;  
8 and

9 “(vi) measures that assess the quality  
10 of care furnished to frail individuals over  
11 the age of 75 and to individuals with mul-  
12 tiple complex chronic conditions are in-  
13 cluded.

14 “(C) REQUIREMENT FOR COLLECTION OF  
15 DATA ON A MEASURE FOR 1 YEAR PRIOR TO  
16 USE UNDER THE SYSTEMS.—Data on any  
17 measure selected by the Secretary under sub-  
18 paragraph (A) must be collected by the Sec-  
19 retary for at least a 12-month period before  
20 such measure may be used to determine wheth-  
21 er a provider receives a value-based payment  
22 under a program described in subsection (a)(1).

23 “(D) AUTHORITY TO VARY MEASURES.—

24 “(i) UNDER SYSTEM APPLICABLE TO  
25 HOSPITALS.—In the case of the system ap-

1 plicable to hospitals under section 1860E–  
2 2, the Secretary may vary the measures se-  
3 lected under subparagraph (A) by hospital  
4 depending on the size of, and the scope of  
5 services provided by, the hospital.

6 “(ii) UNDER SYSTEM APPLICABLE TO  
7 PHYSICIANS AND PRACTITIONERS.—In the  
8 case of the system applicable to physicians  
9 and practitioners under section 1860E–3,  
10 the Secretary may vary the measures se-  
11 lected under subparagraph (A) by physi-  
12 cian or practitioner depending on the spe-  
13 cialty of the physician, the type of practi-  
14 tioner, or the volume of services furnished  
15 to beneficiaries by the physician or practi-  
16 tioner.

17 “(iii) UNDER SYSTEM APPLICABLE TO  
18 ESRD PROVIDERS AND FACILITIES.—In the  
19 case of the system applicable to providers  
20 of services and renal dialysis facilities  
21 under section 1860E–5, the Secretary may  
22 vary the measures selected under subpara-  
23 graph (A) by provider or facility depending  
24 on the type of, the size of, and the scope

1 of services provided by, the provider or fa-  
2 cility.

3 “(iv) UNDER SYSTEM APPLICABLE TO  
4 HOME HEALTH AGENCIES.—In the case of  
5 the system applicable to home health agen-  
6 cies under section 1860E–6, the Secretary  
7 may vary the measures selected under sub-  
8 paragraph (A) by agency depending on the  
9 size of, and the scope of services provided  
10 by, the agency.

11 “(E) QUALIFIED HEALTH INFORMATION  
12 SYSTEM DEFINED.—For purposes of subpara-  
13 graph (B)(iv)(I), the term ‘qualified health in-  
14 formation system’ means a computerized sys-  
15 tem (including hardware, software, and train-  
16 ing) that—

17 “(i) protects the privacy and security  
18 of health information and properly  
19 encrypts such health information;

20 “(ii) maintains and provides access to  
21 patients’ health records in an electronic  
22 format;

23 “(iii) incorporates decision support  
24 software to reduce medical errors and en-  
25 hance health care quality;

1           “(iv) is consistent with data standards  
2           and certification processes recommended  
3           by the Secretary;

4           “(v) allows for the reporting of quality  
5           measures; and

6           “(vi) includes other features deter-  
7           mined appropriate by the Secretary.

8           “(2) WEIGHTS OF MEASURES.—

9           “(A) IN GENERAL.—The Secretary shall  
10          assign weights to the measures used by the Sec-  
11          retary under each system.

12          “(B) CONSIDERATION.—If the Secretary  
13          determines appropriate, in assigning the  
14          weights under subparagraph (A)—

15               “(i) measures of clinical effectiveness  
16               shall be weighted more heavily than meas-  
17               ures of beneficiary experience; and

18               “(ii) measures of risk adjusted out-  
19               comes shall be weighted more heavily than  
20               measures of process; and

21          “(3) RISK ADJUSTMENT.—The Secretary shall  
22          establish procedures, as appropriate, to control for  
23          differences in beneficiary health status and bene-  
24          ficiary characteristics. To the extent feasible, such

1 procedures may be based on existing models for con-  
2 trolling for such differences.

3 “(4) MAINTENANCE.—

4 “(A) IN GENERAL.—The Secretary shall,  
5 as determined appropriate, but not more often  
6 than once each 12-month period, update each  
7 system, including through—

8 “(i) the addition of more accurate and  
9 precise measures under the systems and  
10 the retirement of existing outdated meas-  
11 ures under the system;

12 “(ii) the refinement of the weights as-  
13 signed to measures under the system; and

14 “(iii) the refinement of the risk ad-  
15 justment procedures established pursuant  
16 to paragraph (3) under the system.

17 “(B) UPDATE SHALL ALLOW FOR COM-  
18 PARISON OF DATA.—Each update under sub-  
19 paragraph (A) of a quality measurement system  
20 shall allow for the comparison of data from one  
21 year to the next for purposes of providing  
22 value-based payments under the programs de-  
23 scribed in subsection (a)(1).

24 “(5) USE OF MOST RECENT QUALITY DATA.—

1           “(A) IN GENERAL.—Except as provided in  
2           subparagraph (B), the Secretary shall use the  
3           most recent quality data with respect to the  
4           provider involved that is available to the Sec-  
5           retary.

6           “(B) INSUFFICIENT DATA DUE TO LOW  
7           VOLUME.—If the Secretary determines that  
8           there is insufficient data with respect to a  
9           measure or measures because of a low number  
10          of services provided, the Secretary may aggre-  
11          gate data across more than 1 fiscal or calendar  
12          year, as the case may be.

13          “(c) REQUIREMENTS FOR DEVELOPING AND UPDAT-  
14          ING THE SYSTEMS.—In developing and updating each  
15          quality measurement system under this section, the Sec-  
16          retary shall—

17                 “(1) take into account the quality measures de-  
18                 veloped by nationally recognized quality measure-  
19                 ment organizations, researchers, health care provider  
20                 organizations, and other appropriate groups;

21                 “(2) consult with, and take into account the  
22                 recommendations of, the entity that the Secretary  
23                 has an arrangement with under subsection (e);

24                 “(3) consult with provider-based groups and  
25                 clinical specialty societies;

1           “(4) take into account existing quality measure-  
2           ment systems that have been developed through a  
3           rigorous process of validation and with the involve-  
4           ment of entities and persons described in subsection  
5           (e)(2)(B); and

6           “(5) take into account—

7           “(A) each of the reports by the Medicare  
8           Payment Advisory Commission that are re-  
9           quired under the Medicare Value Purchasing  
10          Act of 2005;

11          “(B) the results of—

12           “(i) the demonstrations required  
13           under such Act;

14           “(ii) the demonstration program  
15           under section 1866A;

16           “(iii) the demonstration program  
17           under section 1866C; and

18           “(iv) any other demonstration or pilot  
19           program conducted by the Secretary relat-  
20           ing to measuring and rewarding quality  
21           and efficiency of care; and

22          “(C) the report by the Institute of Medi-  
23          cine of the National Academy of Sciences under  
24          section 238(b) of the Medicare Prescription

1 Drug, Improvement, and Modernization Act of  
2 2003 (Public Law 108–173).

3 “(d) REQUIREMENTS FOR IMPLEMENTING THE SYS-  
4 TEMS.—In implementing each quality measurement sys-  
5 tem under this section, the Secretary shall consult with  
6 entities—

7 “(1) that have joined together to develop strate-  
8 gies for quality measurement and reporting, includ-  
9 ing the feasibility of collecting and reporting mean-  
10 ingful data on quality measures; and

11 “(2) that involve representatives of health care  
12 providers, health plans, consumers, employers, pur-  
13 chasers, quality experts, government agencies, and  
14 other individuals and groups that are interested in  
15 quality of care.

16 “(e) ARRANGEMENT WITH AN ENTITY TO PROVIDE  
17 ADVICE AND RECOMMENDATIONS.—

18 “(1) ARRANGEMENT.—On and after July 1,  
19 2006, the Secretary shall have in place an arrange-  
20 ment with an entity that meets the requirements de-  
21 scribed in paragraph (2) under which such entity  
22 provides the Secretary with advice on, and rec-  
23 ommendations with respect to, the development and  
24 updating of the quality measurement systems under

1 this section, including the assigning of weights to  
2 the measures under subsection (b)(2).

3 “(2) REQUIREMENTS DESCRIBED.—The re-  
4 quirements described in this paragraph are the fol-  
5 lowing:

6 “(A) The entity is a private nonprofit enti-  
7 ty governed by an executive director and a  
8 board.

9 “(B) The members of the entity include  
10 representatives of—

11 “(i)(I) health plans and providers re-  
12 ceiving reimbursement under this title for  
13 the provision of items and services, includ-  
14 ing health plans and providers with experi-  
15 ence in the care of the frail elderly and in-  
16 dividuals with multiple complex chronic  
17 conditions; or

18 “(II) groups representing such health  
19 plans and providers;

20 “(ii) groups representing individuals  
21 receiving benefits under this title;

22 “(iii) purchasers and employers or  
23 groups representing purchasers or employ-  
24 ers;

1           “(iv) organizations that focus on qual-  
2           ity improvement as well as the measure-  
3           ment and reporting of quality measures;

4           “(v) State government health pro-  
5           grams;

6           “(vi) persons skilled in the conduct  
7           and interpretation of biomedical, health  
8           services, and health economics research  
9           and with expertise in outcomes and effec-  
10          tiveness research and technology assess-  
11          ment; and

12          “(vii) persons or entities involved in  
13          the development and establishment of  
14          standards and certification for health in-  
15          formation technology systems and clinical  
16          data.

17          “(C) The membership of the entity is rep-  
18          resentative of individuals with experience  
19          with—

20                  “(i) urban health care issues;

21                  “(ii) safety net health care issues; and

22                  “(iii) rural and frontier health care  
23          issues.

24          “(D) The entity does not charge a fee for  
25          membership for participation in the work of the

1 entity related to the arrangement with the Sec-  
2 retary under paragraph (1). If the entity does  
3 require a fee for membership for participation  
4 in other functions of the entity, there shall be  
5 no linkage between such fee and participation  
6 in the work of the entity related to such ar-  
7 rangement with the Secretary.

8 “(E) The entity—

9 “(i) permits any member described in  
10 subparagraph (B) to vote on matters of  
11 the entity related to the arrangement with  
12 the Secretary under paragraph (1); and

13 “(ii) ensures that such members have  
14 an equal vote on such matters .

15 “(F) With respect to matters related to the  
16 arrangement with the Secretary under para-  
17 graph (1), the entity conducts its business in an  
18 open and transparent manner and provides the  
19 opportunity for public comment.

20 “(G) The entity operates as a voluntary  
21 consensus standards setting organization as de-  
22 fined for purposes of section 12(d) of the Na-  
23 tional Technology Transfer and Advancement  
24 Act of 1995 (Public Law 104–113) and Office  
25 of Management and Budget Revised Circular

1           A-119 (published in the Federal Register on  
2           February 10, 1998).

3           “(3) AUTHORIZATION OF APPROPRIATIONS.—  
4           For the purpose of carrying out the provisions of  
5           this subsection, there are authorized to be appro-  
6           priated—

7                   “(A) for each of the fiscal years 2006 and  
8                   2007, \$3,000,000; and

9                   “(B) for fiscal year 2008 and each subse-  
10                  quent fiscal year, an amount equal to the sum  
11                  of—

12                           “(i) \$3,000,000; and

13                           “(ii) such amount multiplied by the  
14                           percentage (if any) by which the average of  
15                           the Consumer Price Index for all urban  
16                           consumers (United States city average) for  
17                           the 12-month period ending with June of  
18                           the calendar year in which such fiscal year  
19                           begins exceeds such average for the 12-  
20                           month period ending with June 2006.”.

21           (b) CONFORMING REFERENCES TO PREVIOUS PART  
22           E.—Any reference in law (in effect before the date of the  
23           enactment of this Act) to part E of title XVIII of the So-  
24           cial Security Act is deemed a reference to part F of such  
25           title (as in effect after such date).

1 **SEC. 102. MEDPAC STUDY AND REPORTS ON THE IMPACT**  
2 **OF MEDICARE VALUE-BASED PURCHASING**  
3 **PROGRAMS.**

4 (a) STUDY.—The Medicare Payment Advisory Com-  
5 mission shall conduct a study on how the medicare value-  
6 based purchasing programs under part E of title XVIII  
7 of the Social Security Act, as added by this Act, will im-  
8 pact medicare beneficiaries, medicare providers, and the  
9 Federal Hospital Insurance Trust Fund and the Federal  
10 Supplementary Medical Insurance Trust Fund under sec-  
11 tions 1817 and 1841, respectively, of the Social Security  
12 Act (42 U.S.C. 1395i; 1395t), including how such pro-  
13 grams will impact the access of such beneficiaries to items  
14 and services under the medicare program and the volume  
15 and utilization of such items and services.

16 (b) REPORTS.—

17 (1) INITIAL REPORT.—

18 (A) IN GENERAL.—Not later than March  
19 1, 2008, the Commission shall submit a report  
20 to Congress and the Secretary on the study  
21 conducted under subsection (a).

22 (B) CONTENTS.—The report submitted  
23 under subparagraph (A) shall include—

24 (i) an analysis of the impact of the  
25 data collection and submission and report-  
26 ing requirements under the amendments

1 made by this Act on the quality of care  
2 under the medicare program, including the  
3 impact of such requirements on—

4 (I) subsection (d) hospitals (as  
5 defined in section 1886(d)(1)(B) of  
6 the Social Security Act (42 U.S.C.  
7 1395w(d)(1)(B)) with a low number  
8 of inpatient beds or a low volume of  
9 discharges in a year; and

10 (II) physicians with a low num-  
11 ber of patient encounters in a year;

12 (ii) a detailed description of issues for  
13 the Secretary to consider in implementing  
14 and updating the medicare value-based  
15 purchasing programs under part E of title  
16 XVIII of such Act and recommendations  
17 on such issues; and

18 (iii) recommendations for such legisla-  
19 tion and administrative actions as the  
20 Commission considers appropriate.

21 (2) INTERIM AND FINAL REPORT.—

22 (A) IN GENERAL.—Not later than March  
23 1, 2011, and June 1, 2012, the Commission  
24 shall submit a report to Congress and the Sec-

1           retary on the study conducted under subsection  
2           (a).

3                   (B) CONTENTS.—The reports submitted  
4           under subparagraph (A) shall include—

5                           (i) an update on the items described  
6                           in clauses (i) and (ii) of paragraph (1)(B);

7                           (ii) an analysis of the impact of the  
8                           payment changes on providers under the  
9                           medicare program by reason of the amend-  
10                          ments made by this Act; and

11                           (iii) recommendations for such legisla-  
12                          tion and administrative actions as the  
13                          Commission considers appropriate.

14                           **TITLE II—VALUE-BASED**  
15                           **PURCHASING FOR HOSPITALS**  
16                           **Subtitle A—PPS Hospitals**

17                           **SEC. 201. PPS HOSPITAL VALUE-BASED PURCHASING PRO-**  
18                           **GRAM.**

19                           (a) VOLUNTARY SUBMISSION OF HOSPITAL QUALITY  
20           DATA.—

21                           (1) UPDATE FOR HOSPITALS THAT SUBMIT  
22           QUALITY DATA.—Section 1886(b)(3)(B) (42 U.S.C.  
23           1395ww(b)(3)(B)) is amended—

24                           (A) in clause (vii)—

1 (i) in subclause (I), by striking “for  
2 each of fiscal years 2005 through 2007”  
3 and inserting “for fiscal years 2005 and  
4 2006”; and

5 (ii) in subclause (II), by striking  
6 “Each” and inserting “For fiscal years  
7 2005 and 2006, each”; and

8 (B) by adding at the end the following new  
9 clause:

10 “(viii)(I) For purposes of clause (i)(XX), for fiscal  
11 year 2007 and each subsequent fiscal year, in the case  
12 of a subsection (d) hospital that does not submit data in  
13 accordance with subclause (II) with respect to such a fis-  
14 cal year, the applicable percentage increase under such  
15 clause for such fiscal year shall be reduced by 2 percentage  
16 points. Such reduction shall apply only with respect to the  
17 fiscal year involved, and the Secretary shall not take into  
18 account such reduction in computing the applicable per-  
19 centage increase under clause (i)(XX) for a subsequent  
20 fiscal year.

21 “(II) For fiscal year 2007 and each subsequent fiscal  
22 year, each subsection (d) hospital shall submit to the Sec-  
23 retary such data that the Secretary determines is appro-  
24 priate for the measurement of health care quality, includ-  
25 ing data necessary for the operation of the PPS hospital

1 value-based purchasing program under section 1860E–2.  
 2 Such data shall be submitted in a form and manner, and  
 3 at a time, specified by the Secretary for purposes of this  
 4 clause.

5 “(III) The Secretary shall establish procedures for  
 6 making data submitted under subclause (II) available to  
 7 the public in a clear and understandable form. Such proce-  
 8 dures shall ensure that a subsection (d) hospital has the  
 9 opportunity to review the data that is to be made public  
 10 with respect to the hospital prior to such data being made  
 11 public.”.

12 (2) CONFORMING AMENDMENTS.—Section  
 13 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is  
 14 amended—

15 (A) in subclause (XIX), by striking  
 16 “2007” and inserting “2006”; and

17 (B) in subclause (XX)—

18 (i) by striking “2008” and inserting  
 19 “2007”; and

20 (ii) by inserting “subject to clause  
 21 (viii),” after “fiscal year,”.

22 (b) PROGRAM.—Title XVIII (42 U.S.C. 1395 et seq.)  
 23 is amended by inserting after section 1860E–1, as added  
 24 by section 101(a), the following new section:

25 “PPS HOSPITAL VALUE-BASED PURCHASING PROGRAM

26 “SEC. 1860E–2. (a) PROGRAM.—

1           “(1) IN GENERAL.—The Secretary shall estab-  
2           lish a program under which value-based payments  
3           are provided each fiscal year to hospitals that dem-  
4           onstrate the provision of high quality health care to  
5           individuals who are entitled to benefits under part A  
6           and are inpatients of the hospital.

7           “(2) PROGRAM TO BEGIN IN FISCAL YEAR  
8           2007.—The Secretary shall establish the program  
9           under this section so that value-based payments de-  
10          scribed in subsection (b) are made with respect to  
11          fiscal year 2007 and each subsequent fiscal year.

12          “(3) APPLICABILITY OF PROGRAM TO HOS-  
13          PITALS.—For purposes of this section, the term  
14          ‘hospital’ means a subsection (d) hospital (as defined  
15          in section 1886(d)(1)(B)).

16          “(b) VALUE-BASED PAYMENTS.—

17                 “(1) IN GENERAL.—Subject to paragraph (4),  
18                 the Secretary shall make a value-based payment to  
19                 a hospital with respect to a fiscal year if the Sec-  
20                 retary determines that the quality of the care pro-  
21                 vided in that year to individuals who are entitled to  
22                 benefits under part A and are inpatients of the hos-  
23                 pital—

24                         “(A) has substantially improved (as deter-  
25                         mined by the Secretary) over the prior year; or

1           “(B) exceeds a threshold established by the  
2           Secretary.

3           “(2) USE OF SYSTEM.—In determining which  
4           hospitals qualify for a value-based payment under  
5           paragraph (1), the Secretary shall use the quality  
6           measurement system developed for this section pur-  
7           suant to section 1860E–1(a).

8           “(3) DETERMINATION OF AMOUNT OF AWARD  
9           AND ALLOCATION OF AWARDS.—

10           “(A) IN GENERAL.—The Secretary shall  
11           determine—

12                   “(i) the amount of a value-based pay-  
13                   ment under paragraph (1) provided to a  
14                   hospital; and

15                   “(ii) subject to subparagraph (B), the  
16                   allocation of the total amount available  
17                   under subsection (d) for value-based pay-  
18                   ments for any fiscal year between pay-  
19                   ments with respect to hospitals that meet  
20                   the requirement under subparagraph (A)  
21                   of paragraph (1) and hospitals that meet  
22                   the requirement under subparagraph (B)  
23                   of such paragraph.

24           “(B) REQUIREMENTS REGARDING THE  
25           AMOUNT OF FUNDING AVAILABLE FOR VALUE-

1           BASED PAYMENTS FOR HOSPITALS EXCEEDING  
2           A THRESHOLD.—The Secretary shall ensure  
3           that—

4                   “(i) a majority of the total amount  
5                   available under subsection (d) for value-  
6                   based payments for any fiscal year is pro-  
7                   vided to hospitals that are receiving such  
8                   payments because they meet the require-  
9                   ment under paragraph (1)(B); and

10                   “(ii) with respect to fiscal year 2008  
11                   and each subsequent fiscal year, the per-  
12                   centage of the total amount available  
13                   under subsection (d) for value-based pay-  
14                   ments for any fiscal year that is used to  
15                   make payments to hospitals that meet such  
16                   requirement is greater than such percent-  
17                   age in the previous fiscal year.

18           “(4) REQUIREMENTS.—

19                   “(A) REQUIRED SUBMISSION OF DATA.—  
20                   In order for a hospital to be eligible for a value-  
21                   based payment for a fiscal year, the hospital  
22                   must have complied with the requirements  
23                   under section 1886(b)(3)(B)(viii)(II) with re-  
24                   spect to that fiscal year.

1           “(B) ATTESTATION REGARDING DATA.—In  
2           order for a hospital to be eligible for a value-  
3           based payment for a fiscal year, the hospital  
4           must have provided the Secretary (under proce-  
5           dures established by the Secretary) with an at-  
6           testation that the data submitted under section  
7           1886(b)(3)(B)(viii)(II) for the fiscal year is  
8           complete and accurate.

9           “(5) TOTAL AMOUNT OF VALUE-BASED PAY-  
10          MENTS EQUAL TO TOTAL AMOUNT OF AVAILABLE  
11          FUNDING.—The Secretary shall establish payment  
12          amounts under paragraph (3)(A) so that, as esti-  
13          mated by the Secretary, the total amount of value-  
14          based payments made in a fiscal year under para-  
15          graph (1) is equal to the total amount available  
16          under subsection (d) for such payments for the year.

17          “(6) PAYMENT METHODS AND TIMING OF PAY-  
18          MENTS.—

19                 “(A) IN GENERAL.—Subject to subpara-  
20                 graph (B), the payment of value-based pay-  
21                 ments under paragraph (1) shall be based on  
22                 such a method as the Secretary determines ap-  
23                 propriate.

24                 “(B) TIMING.—The Secretary shall ensure  
25                 that value-based payments under paragraph (1)

1 with respect to a fiscal year are made by not  
2 later than the close of the following fiscal year.

3 “(c) DESCRIPTION OF HOW HOSPITALS WOULD  
4 HAVE FARED UNDER PROGRAM IF PROGRAM HAD AP-  
5 PLIED TO FISCAL YEAR 2006.—Not later than January  
6 1, 2007, the Secretary shall provide each hospital with a  
7 description of the Secretary’s estimate of how payments  
8 to the hospital under this title would have been affected  
9 with respect to items and services furnished in fiscal year  
10 2006 if the program under this section (and the amend-  
11 ments made by subsections (a) and (c) of section 201 of  
12 the Medicare Value Purchasing Act of 2005) had been in  
13 effect with respect to fiscal year 2006.

14 “(d) FUNDING.—

15 “(1) AMOUNT.—The amount available for  
16 value-based payments under this section with respect  
17 to a fiscal year shall be equal to the amount of the  
18 reduction in expenditures under the Federal Hos-  
19 pital Insurance Trust Fund under section 1817 in  
20 the year as a result of the amendments made by sec-  
21 tion 201(c) of the Medicare Value Purchasing Act of  
22 2005, as estimated by the Secretary.

23 “(2) PAYMENTS FROM TRUST FUND.—Pay-  
24 ments to hospitals under this section shall be made  
25 from the Federal Hospital Insurance Trust Fund.”.

1 (c) REDUCTION OF AVERAGE STANDARDIZED  
2 AMOUNT FOR HOSPITALS THAT SUBMIT QUALITY DATA  
3 IN ORDER TO FUND PROGRAM.—

4 (1) IN GENERAL.—Section 1886(d)(3)(B) (42  
5 U.S.C. 1395ww(d)(3)(B)) is amended to read as fol-  
6 lows:

7 “(B) REDUCTION OF AVERAGE STANDARDIZED  
8 AMOUNT FOR VALUE OF OUTLIER PAYMENTS AND  
9 TO FUND VALUE-BASED PURCHASING PROGRAM.—

10 “(i) OUTLIER PAYMENTS.—The Secretary  
11 shall reduce each of the average standardized  
12 amounts determined under subparagraph (A)  
13 (and determined without regard to any reduc-  
14 tion under clause (ii)) by a factor equal to the  
15 proportion of payments under this subsection  
16 (as estimated by the Secretary as if the applica-  
17 ble percent in clause (ii) were zero) based on  
18 DRG prospective payment amounts which are  
19 additional payments described in paragraph  
20 (5)(A) (relating to outlier payments).

21 “(ii) VALUE-BASED PURCHASING PRO-  
22 GRAM.—In the case of a subsection (d) hospital  
23 that complies with the submission requirements  
24 under subsection (b)(3)(B)(viii)(II) for a fiscal  
25 year, in addition to the reduction under clause

1 (i), the Secretary shall reduce each of the aver-  
2 age standardized amounts determined under  
3 subparagraph (A) for that fiscal year (and de-  
4 termined without regard to any reduction under  
5 clause (i)) by the applicable percent (as defined  
6 in clause (iii)) for that fiscal year.

7 “(iii) APPLICABLE PERCENT.—For pur-  
8 poses of clause (ii), the term ‘applicable per-  
9 cent’ means—

10 “(I) for fiscal year 2007, 1.0 percent;

11 “(II) for fiscal year 2008, 1.25 per-  
12 cent;

13 “(III) for fiscal year 2009, 1.5 per-  
14 cent;

15 “(IV) for fiscal year 2010, 1.75 per-  
16 cent; and

17 “(V) for fiscal year 2011 and each  
18 subsequent year, 2.0 percent.”.

19 (2) CONFORMING AMENDMENT.—Section  
20 1886(d)(5)(A)(iv) (42 U.S.C. 1395ww(d)(5)(A)(iv))  
21 is amended by adding at the end the following new  
22 sentence: “Such projection or estimate shall be made  
23 as if the applicable percent under paragraph  
24 (3)(B)(ii) were zero.”.

1           **Subtitle B—Critical Access**  
2                           **Hospitals**

3   **SEC. 211. MEDPAC STUDY AND REPORT REGARDING A**  
4                           **VALUE-BASED PURCHASING PROGRAM FOR**  
5                           **CRITICAL ACCESS HOSPITALS.**

6           (a) STUDY.—The Medicare Payment Advisory Com-  
7 mission shall conduct a study on the advisability and feasi-  
8 bility of establishing a value-based purchasing program  
9 under the medicare program under title XVIII of the So-  
10 cial Security Act for critical access hospitals (as defined  
11 in section 1861(mm)(1) of such Act (42 U.S.C.  
12 1395x(mm)(1)).

13           (b) REPORT.—Not later than March 1, 2007, the  
14 Commission shall submit a report to Congress and the  
15 Secretary on the study conducted under subsection (a) to-  
16 gether with recommendations for such legislation and ad-  
17 ministrative actions as the Commission considers appro-  
18 priate.

19   **SEC. 212. VALUE-BASED PURCHASING DEMONSTRATION**  
20                           **PROGRAM FOR CRITICAL ACCESS HOS-**  
21                           **PITALS.**

22           (a) ESTABLISHMENT.—

23                   (1) IN GENERAL.—Not later than 6 months  
24 after the date of enactment of this Act, the Sec-  
25 retary shall establish a demonstration program

1 under which the Secretary establishes a value-based  
2 purchasing program under the medicare program  
3 under title XVIII of the Social Security Act for crit-  
4 ical access hospitals (as defined in section  
5 1861(mm)(1) of such Act (42 U.S.C.  
6 1395x(mm)(1)) in order to test innovative methods  
7 of measuring and rewarding quality health care fur-  
8 nished by such hospitals.

9 (2) DURATION.—The demonstration program  
10 under this section shall be conducted for a 2-year  
11 period.

12 (3) SITES.—The Secretary shall conduct the  
13 demonstration program under this section at 6 crit-  
14 ical access hospitals. The Secretary shall ensure that  
15 such hospitals are representative of the spectrum of  
16 such hospitals that participate in the medicare pro-  
17 gram.

18 (b) WAIVER AUTHORITY.—The Secretary may waive  
19 such requirements of titles XI and XVIII of the Social  
20 Security Act as may be necessary to carry out the dem-  
21 onstration program under this section.

22 (c) FUNDING.—The Secretary shall provide for the  
23 transfer from the Federal Hospital Insurance Trust Fund  
24 under section 1817 of the Social Security Act (42 U.S.C.

1 1395i) of such funds as are necessary for the costs of car-  
 2 rying out the demonstration program under this section.

3 (d) REPORT.—Not later than 6 months after the  
 4 demonstration program under this section is completed,  
 5 the Secretary shall submit to Congress a report on the  
 6 demonstration program together with—

7 (1) recommendations on the establishment of a  
 8 permanent value-based purchasing program under  
 9 the medicare program for critical access hospitals;  
 10 and

11 (2) recommendations for such other legislation  
 12 or administrative action as the Secretary determines  
 13 appropriate.

14 **TITLE III—VALUE-BASED PUR-**  
 15 **CHASING FOR PHYSICIANS**  
 16 **AND CERTAIN PRACTI-**  
 17 **TIONERS**

18 **SEC. 301. PHYSICIAN AND PRACTITIONER VALUE-BASED**  
 19 **PURCHASING PROGRAM.**

20 (a) VOLUNTARY SUBMISSION OF PHYSICIAN AND  
 21 PRACTITIONER QUALITY DATA.—

22 (1) UPDATE FOR PHYSICIANS AND PRACTI-  
 23 TIONERS THAT SUBMIT QUALITY DATA.—Section  
 24 1848(d)(4) (42 U.S.C. 1395w-4(d)(4)) is amended

1 by adding at the end the following new subpara-  
2 graph:

3 “(G) ADJUSTMENT IF QUALITY DATA NOT  
4 SUBMITTED.—

5 “(i) ADJUSTMENT.—For 2007 and  
6 each subsequent year, in the case of serv-  
7 ices furnished by a physician or a practi-  
8 tioner (as defined in section 1860E-  
9 3(a)(3)) that does not submit data in ac-  
10 cordance with clause (ii) with respect to  
11 such a year, the update under subpara-  
12 graph (A) shall be reduced by 2 percentage  
13 points. Such reduction shall apply only  
14 with respect to the year involved, and the  
15 Secretary shall not take into account such  
16 reduction in computing the conversion fac-  
17 tor for a subsequent year.

18 “(ii) SUBMISSION OF QUALITY  
19 DATA.—For 2007 and each subsequent  
20 year, each physician and practitioner (as  
21 defined in section 1860E-3(a)(3)) shall  
22 submit to the Secretary such data that the  
23 Secretary determines is appropriate for the  
24 measurement of health outcomes and other  
25 indices of quality, including data necessary

1 for the operation of the physician and  
2 practitioner value-based purchasing pro-  
3 gram under section 1860E-3. Such data  
4 shall be submitted in a form and manner,  
5 and at a time, specified by the Secretary  
6 for purposes of this subparagraph.

7 “(iii) AVAILABLE TO THE PUBLIC.—

8 “(I) IN GENERAL.—Subject to  
9 subclause (II), the Secretary shall es-  
10 tablish procedures for making data  
11 submitted under clause (ii), with re-  
12 spect to items and services furnished  
13 on or after January 1, 2008, available  
14 to the public in a clear and under-  
15 standable form. Such procedures shall  
16 ensure that a physician or practitioner  
17 has the opportunity to review the data  
18 that is to be made public with respect  
19 to the physician or practitioner prior  
20 to such data being made public.

21 “(II) EXCEPTIONS.—The Sec-  
22 retary shall establish exceptions to the  
23 requirement for making data available  
24 to the public under the first sentence  
25 of subclause (I). In providing for such

1 exceptions, the Secretary shall take  
2 into account the size and specialty  
3 representation of the practice in-  
4 volved.”.

5 (2) CONFORMING AMENDMENT.—Section  
6 1848(d)(4)(A) (42 U.S.C. 1395w-4(d)(4)(A)) is  
7 amended, in the matter preceding clause (i), by  
8 striking “subparagraph (F)” and inserting “sub-  
9 paragraphs (F) and (G)”.

10 (b) PROGRAM.—Title XVIII (42 U.S.C. 1395 et seq.)  
11 is amended by inserting after section 1860E-2, as added  
12 by section 201(b), the following new section:

13 “PHYSICIAN AND PRACTITIONER VALUE-BASED  
14 PURCHASING PROGRAM

15 “SEC. 1860E-3. (a) PROGRAM.—

16 “(1) IN GENERAL.—The Secretary shall estab-  
17 lish a program under which value-based payments  
18 are provided each year to physicians and practi-  
19 tioners that demonstrate the provision of high qual-  
20 ity health care to individuals enrolled under part B.

21 “(2) PROGRAM TO BEGIN IN 2008.—The Sec-  
22 retary shall establish the program under this section  
23 so that value-based payments described in subsection  
24 (b) are made with respect to 2008 and each subse-  
25 quent year.

1           “(3) DEFINITION OF PHYSICIAN AND PRACTI-  
2           TIONER.—In this section:

3                   “(A) PHYSICIAN.—The term ‘physician’  
4           has the meaning given that term in section  
5           1861(r).

6                   “(B) PRACTITIONER.—The term ‘practi-  
7           tioner’ means—

8                           “(i) a practitioner described in section  
9                           1842(b)(18)(C);

10                           “(ii) a physical therapist (as described  
11                           in section 1861(p));

12                           “(iii) an occupational therapist (as so  
13                           described); and

14                           “(iv) a qualified speech-language pa-  
15                           thologist (as defined in section  
16                           1861(ll)(3)(A)).

17           “(4) IDENTIFICATION OF PHYSICIANS AND  
18           PRACTITIONERS.—For purposes of applying this sec-  
19           tion and paragraphs (4)(G) and (6) of section  
20           1848(d), the Secretary shall establish procedures for  
21           the identification of physicians and practitioners,  
22           such as through physician or practitioner billing  
23           units or other units.

24           “(b) VALUE-BASED PAYMENTS.—

1           “(1) IN GENERAL.—Subject to paragraph (4),  
2           the Secretary shall make a value-based payment to  
3           a physician or a practitioner with respect to a year  
4           if the Secretary determines that both the quality of  
5           the care and the efficiency of the care provided in  
6           that year by the physician or practitioner to individ-  
7           uals enrolled under part B—

8                   “(A) has substantially improved (as deter-  
9                   mined by the Secretary) over the prior year; or

10                   “(B) exceeds a threshold established by the  
11                   Secretary.

12           “(2) USE OF SYSTEMS AND DATA.—

13                   “(A) IN GENERAL.—In determining which  
14                   physicians and practitioners qualify for a value-  
15                   based payment under paragraph (1), the Sec-  
16                   retary shall use—

17                           “(i) the quality measurement system  
18                           developed for this section pursuant to sec-  
19                           tion 1860E–1(a) with respect to the qual-  
20                           ity of the care provided by the physician or  
21                           practitioner; and

22                           “(ii) the comparative utilization sys-  
23                           tem developed under subsection (c) with  
24                           respect to the efficiency of such care.

1           “(3) DETERMINATION OF AMOUNT OF AWARD  
2           AND ALLOCATION OF AWARDS.—

3           “(A) IN GENERAL.—The Secretary shall  
4           determine—

5                   “(i) the amount of a value-based pay-  
6                   ment under paragraph (1) provided to a  
7                   physician or a practitioner; and

8                   “(ii) subject to subparagraph (B), the  
9                   allocation of the total amount available  
10                  under subsection (e) for value-based pay-  
11                  ments for any year between payments with  
12                  respect to physicians and practitioners that  
13                  meet the requirement under subparagraph  
14                  (A) of paragraph (1) and physicians and  
15                  practitioners that meet the requirement  
16                  under subparagraph (B) of such para-  
17                  graph.

18           “(B) REQUIREMENTS REGARDING THE  
19           AMOUNT OF FUNDING AVAILABLE FOR VALUE-  
20           BASED PAYMENTS FOR PHYSICIANS AND PRAC-  
21           TITIONERS EXCEEDING A THRESHOLD.—The  
22           Secretary shall ensure that—

23                   “(i) a majority of the total amount  
24                   available under subsection (e) for value-  
25                   based payments for any year is provided to

1 physicians and practitioners that are re-  
2 ceiving such payments because they meet  
3 the requirement under paragraph (1)(B);  
4 and

5 “(ii) with respect to 2009 and each  
6 subsequent year, the percentage of the  
7 total amount available under subsection (e)  
8 for value-based payments for any year that  
9 is used to make payments to physicians  
10 and practitioners that meet such require-  
11 ment is greater than such percentage in  
12 the previous year.

13 “(4) REQUIREMENTS.—

14 “(A) REQUIRED SUBMISSION OF DATA.—

15 In order for a physician or a practitioner to be  
16 eligible for a value-based payment for a year,  
17 the physician or practitioner must have com-  
18 plied with the requirements under section  
19 1848(d)(6)(B)(ii) with respect to that year.

20 “(B) ATTESTATION REGARDING DATA.—In

21 order for a physician or a practitioner to be eli-  
22 gible for a value-based payment for a year, the  
23 physician or practitioner must have provided  
24 the Secretary (under procedures established by  
25 the Secretary) with an attestation that the data

1 submitted under section 1848(d)(6)(B)(ii) with  
2 respect to that year is complete and accurate.

3 “(5) TOTAL AMOUNT OF VALUE-BASED PAY-  
4 MENTS EQUAL TO TOTAL AMOUNT OF AVAILABLE  
5 FUNDING.—The Secretary shall establish payment  
6 amounts under paragraph (3)(A) so that, as esti-  
7 mated by the Secretary, the total amount of value-  
8 based payments made in a year under paragraph (1)  
9 is equal to the total amount available under sub-  
10 section (e) for such payments for the year.

11 “(6) PAYMENT METHODS AND TIMING OF PAY-  
12 MENTS.—

13 “(A) IN GENERAL.—Subject to subpara-  
14 graph (B), the payment of value-based pay-  
15 ments under paragraph (1) shall be based on  
16 such a method as the Secretary determines ap-  
17 propriate.

18 “(B) TIMING.—The Secretary shall ensure  
19 that value-based payments under paragraph (1)  
20 with respect to a year are made by not later  
21 than December 31 of the subsequent year.

22 “(c) COMPARATIVE UTILIZATION SYSTEM.—

23 “(1) DEVELOPMENT.—The Secretary shall de-  
24 velop a comparative utilization system for purposes

1 of providing value-based payments under subsection  
2 (b).

3 “(2) ADDITIONAL MEASURES OF EFFICIENT RE-  
4 SOURCE USE.—The comparative utilization system  
5 developed under paragraph (1) shall measure the ef-  
6 ficiency of the care provided by a physician or prac-  
7 titioner.

8 “(3) REQUIREMENTS FOR SYSTEM.—Under the  
9 comparative utilization system described in para-  
10 graph (1), the Secretary shall do the following:

11 “(A) MEASURES.—The Secretary shall se-  
12 lect measures of efficiency to be used by the  
13 Secretary under the system.

14 “(B) USE OF CLAIMS DATA FOR UTILIZA-  
15 TION PATTERNS AND EFFICIENCY.—

16 “(i) REVIEW OF CLAIMS DATA.—The  
17 Secretary shall review claims data with re-  
18 spect to services furnished or ordered by  
19 physicians and practitioners.

20 “(ii) USE OF MOST RECENT CLAIMS  
21 DATA.—The Secretary shall use the most  
22 recent claims data with respect to the phy-  
23 sician or practitioner that is available to  
24 the Secretary.

1           “(C) RISK ADJUSTMENT.—The Secretary  
2           shall establish procedures, as appropriate, to  
3           control for differences in beneficiary health sta-  
4           tus and beneficiary characteristics.

5           “(4) ANNUAL REPORTS.—Beginning in 2006,  
6           the Secretary shall provide physicians and practi-  
7           tioners with annual reports on the utilization of  
8           items and services under this title based upon the  
9           review of claims data under paragraph (3)(B). With  
10          respect to reports provided in 2006 and 2007, such  
11          reports are confidential and the Secretary shall not  
12          make such reports available to the public.

13          “(d) DESCRIPTION OF HOW PHYSICIANS AND PRAC-  
14          TITIONERS WOULD HAVE FARED UNDER PROGRAM IF  
15          PROGRAM HAD APPLIED TO 2007.—Not later than March  
16          1, 2008, the Secretary shall provide each physician and  
17          practitioner with a description of the Secretary’s estimate  
18          of how payments to the physician or practitioner under  
19          this title would have been affected with respect to items  
20          and services furnished in 2007 if the program under this  
21          section (and the amendments made by subsections (a) and  
22          (c) of section 301 of the Medicare Value Purchasing Act  
23          of 2005) had been in effect with respect to 2007.

24          “(e) FUNDING.—

1           “(1) AMOUNT.—The amount available for  
 2 value-based payments under this section with respect  
 3 to a year shall be equal to the amount of the reduc-  
 4 tion in expenditures under the Federal Supple-  
 5 mentary Medical Insurance Trust Fund under sec-  
 6 tion 1841 in the year as a result of the amendments  
 7 made by section 301(c) of the Medicare Value Pur-  
 8 chasing Act of 2005, as estimated by the Secretary.

9           “(2) PAYMENTS FROM TRUST FUND.—Pay-  
 10 ments to physicians and practitioners under this sec-  
 11 tion shall be made from the Federal Supplementary  
 12 Medical Insurance Trust Fund.”.

13           (c) REDUCTION IN CONVERSION FACTOR FOR PHYSI-  
 14 CIANS AND PRACTITIONERS THAT SUBMIT QUALITY  
 15 DATA IN ORDER TO FUND PROGRAM.—

16           (1) IN GENERAL.—Section 1848(d) (42 U.S.C.  
 17 1395w-4(d)) is amended by adding at the end the  
 18 following new paragraph:

19           “(6) REDUCTION IN CONVERSION FACTOR FOR  
 20 PHYSICIANS AND PRACTITIONERS IN ORDER TO  
 21 FUND VALUE-BASED PURCHASING PROGRAM.—

22           “(A) IN GENERAL.—For 2008 and each  
 23 subsequent year, the single conversion factor  
 24 otherwise applicable under this subsection to  
 25 services furnished in the year by a physician or

1 a practitioner (as defined in section 1860E-  
 2 3(a)(3)) that complies with the requirements  
 3 under paragraph (4)(G)(ii) for the year (deter-  
 4 mined after application of the update under  
 5 paragraph (4)) shall be reduced by the applica-  
 6 ble percent.

7 “(B) APPLICABLE PERCENT.—For pur-  
 8 poses of subparagraph (A), the term ‘applicable  
 9 percent’ means—

10 “(i) for 2008, 1.0 percent;

11 “(ii) for 2009, 1.25 percent;

12 “(iii) for 2010, 1.5 percent;

13 “(iv) for 2011, 1.75 percent; and

14 “(v) for 2012 and each subsequent  
 15 year, 2.0 percent.”.

16 (2) CONFORMING AMENDMENT.—Section  
 17 1848(d)(1)(A) (42 U.S.C. 1395w-4(d)(1)(A)) is  
 18 amended by striking “The conversion factor” and in-  
 19 serting “Subject to paragraph (6), the conversion  
 20 factor”.

21 **SEC. 302. DEMONSTRATION PROJECT ON DATA COORDINA-**  
 22 **TION THROUGH THE USE OF HEALTH INFOR-**  
 23 **MATION TECHNOLOGY.**

24 (a) DEMONSTRATION PROJECT.—

1           (1) ESTABLISHMENT.—Not later than 6  
2 months after the date of enactment of this Act, the  
3 Secretary, in consultation with the National Coordi-  
4 nator for Health Information Technology, shall es-  
5 tablish a demonstration project to determine the  
6 threshold amount of information technology  
7 connectivity that is necessary in order to improve  
8 the ability of physicians and practitioners (as de-  
9 fined in section 1860E–3(a)(3) of the Social Secu-  
10 rity Act, as added by section 301(b)) in rural and  
11 frontier areas to—

12                   (A) collect, report, and maintain data on  
13 quality of care; and

14                   (B) use such data as a resource for im-  
15 proving the quality and efficiency of the care  
16 provided to medicare beneficiaries by such phy-  
17 sicians and practitioners.

18           (2) DURATION.—The demonstration project  
19 under this section shall be conducted for a 3-year  
20 period.

21           (3) SITES.—The Secretary shall conduct the  
22 project under this section at 6 sites.

23           (4) PARTICIPANTS.—Participants in the dem-  
24 onstration project under this section may include re-  
25 gional networks, public-private partnerships includ-

1 ing health care providers, persons or entities in-  
2 volved in the delivery of health care through the use  
3 of telemedicine and telehealth, and other persons or  
4 entities determined appropriate by the Secretary.

5 (5) REQUIREMENT FOR PARTICIPANTS.—Par-  
6 ticipants in the demonstration project under this  
7 section shall comply with any interoperability and  
8 certification standards and processes that have been  
9 developed or adopted by the Secretary or a designee  
10 of the Secretary.

11 (b) REPORT.—

12 (1) IN GENERAL.—Not later than 6 months  
13 after the demonstration project under this section is  
14 completed, the Secretary shall submit to Congress a  
15 report on the demonstration project.

16 (2) CONTENTS.—The report submitted under  
17 paragraph (1) shall include—

18 (A) an analysis of—

19 (i) the types of information accessed,  
20 transferred, and exchanged through dif-  
21 ferent models for information technology  
22 connectivity;

23 (ii) the characteristics of such models  
24 that have been successful in providing im-

1           proved information flow and improved  
2           quality and efficiency in health care; and

3                   (iii) barriers to widespread adoption  
4           of such models; and

5                   (B) recommendations for such legislation  
6           and administrative actions as the Secretary con-  
7           siders appropriate.

8           (c) FUNDING.—There are authorized to be appro-  
9           priated to the Secretary such sums as may be necessary  
10          to carry out this section.

11 **SEC. 303. SENSE OF THE SENATE REGARDING PAYMENTS**

12                   **UNDER MEDICARE PHYSICIAN FEE SCHED-**  
13                   **ULE.**

14          (a) FINDINGS.—The Senate makes the following  
15          findings:

16                  (1) Based on current projections, estimates sug-  
17                  gest that, absent any action, payment amounts  
18                  under the physician fee schedule under section 1848  
19                  of the Social Security Act (42 U.S.C. 1395w-4) will  
20                  be reduced by 4.3 percent in 2006 and further re-  
21                  duced each year thereafter until 2011.

22                  (2) Future increases in medicare beneficiary  
23                  cost-sharing raise concerns about the affordability of  
24                  the medicare program for such beneficiaries: The  
25                  medicare part B premium will be increased due to

1 any update of the physician fee schedule and such  
2 beneficiaries will also begin paying a premium for  
3 the prescription drug benefit under part D of the  
4 medicare program in January 2006.

5 (3) The current formula under the physician fee  
6 schedule that is used to reimburse physicians under  
7 the medicare program—

8 (A) has not been successful in appro-  
9 priately controlling the volume of services pro-  
10 vided by physicians; and

11 (B) is not a sustainable model for deter-  
12 mining physician payments under the medicare  
13 program in the future.

14 (4) The Centers for Medicare & Medicaid Serv-  
15 ices should use its administrative authority to ex-  
16 clude medicare-covered drugs and biologicals from  
17 the formula used under the physician fee schedule  
18 and accurately reflect in the formula the direct and  
19 indirect cost of increases due to coverage decisions,  
20 administrative actions, and rules and regulations.

21 (b) SENSE OF THE SENATE.—It is the sense of the  
22 Senate that, while the provisions of, and amendments  
23 made by, this Act develop a value-based purchasing pro-  
24 gram for physicians and other practitioners under the  
25 medicare program, further action by Congress is needed

1 to address the negative physician payment updates under  
2 such program in order to ensure—

3 (1) the long-term stability of the medicare pay-  
4 ment system for items and services furnished by  
5 physicians and other health care professionals;

6 (2) appropriate reimbursement under the medi-  
7 care program for such items and services that is  
8 consistent with high quality and efficient delivery of  
9 such items and services; and

10 (3) future access to, and the affordability of,  
11 such items and services for medicare beneficiaries.

12 **TITLE IV—VALUE-BASED**  
13 **PURCHASING FOR PLANS**  
14 **Subtitle A—Medicare Advantage**  
15 **Plans**

16 **SEC. 401. PLAN VALUE-BASED PURCHASING PROGRAM.**

17 (a) SUBMISSION OF QUALITY DATA.—

18 (1) MEDICARE ADVANTAGE ORGANIZATIONS.—  
19 Section 1852(e) (42 U.S.C. 1395w–22(e)), as  
20 amended by section 722 of the Medicare Prescrip-  
21 tion Drug, Improvement, and Modernization Act of  
22 2003 (Public Law 108–173; 117 Stat. 2347), is  
23 amended—

24 (A) in paragraph (1), by striking “an MA  
25 private fee-for-service plan or”; and

1 (B) in paragraph (3)—

2 (i) in subparagraph (A)—

3 (I) in clause (i), by adding at the  
4 end the following new sentence: “Such  
5 data shall include data necessary for  
6 the operation of the plan value-based  
7 purchasing program under section  
8 1860E-4.”;

9 (II) by redesignating clause (iv)  
10 as clause (vi); and

11 (III) by inserting after clause  
12 (iii) the following new clauses:

13 “(iv) APPLICATION TO MA PRIVATE  
14 FEE-FOR-SERVICE PLANS.—The Secretary  
15 shall establish as appropriate by regulation  
16 requirements for the collection, analysis,  
17 and reporting of data that permits the  
18 measurement of health outcomes and other  
19 indices of quality for MA organizations  
20 with respect to MA private fee-for-service  
21 plans.”.

22 “(v) AVAILABILITY TO THE PUBLIC.—  
23 The Secretary shall establish procedures  
24 for making data reported under this sub-  
25 paragraph available to the public in a clear

1 and understandable form. Such procedures  
2 shall ensure that an MA organization has  
3 the opportunity to review the data that is  
4 to be made public with respect to the plan  
5 offered by the organization prior to such  
6 data being made public.”; and

7 (ii) in subparagraph (B)—

8 (I) in clause (i), by striking  
9 “The” and inserting “Subject to  
10 clause (ii), the”; and

11 (II) by striking clause (ii) and in-  
12 serting the following new clause:

13 “(ii) CHANGES IN TYPES OF DATA.—  
14 Subject to clause (iii), the Secretary may  
15 only change the types of data that are re-  
16 quired to be submitted under subpara-  
17 graph (A) after submitting to Congress a  
18 report on the reasons for such changes  
19 that was prepared—

20 “(I) in the case of data necessary  
21 for the operation of the plan value-  
22 based purchasing program under sec-  
23 tion 1860E-4, after the requirements  
24 under subsections (c) and (d) of sec-

1                   tion 1860E–1 have been complied  
2                   with; and

3                   “(II) in the case of any other  
4                   data, in consultation with MA organi-  
5                   zations and private accrediting bod-  
6                   ies.”.

7                   (2) ELIGIBLE ENTITIES WITH REASONABLE  
8                   COST CONTRACTS.—Section 1876(h) (42 U.S.C.  
9                   1395mm(h)) is amended by adding at the end the  
10                  following new paragraph:

11                 “(6)(A) With respect to plan years beginning on or  
12                 after January 1, 2006, an eligible entity with a reasonable  
13                 cost reimbursement contract under this subsection shall  
14                 submit to the Secretary such data that the Secretary de-  
15                 termines is appropriate for the measurement of health out-  
16                 comes and other indices of quality, including data nec-  
17                 essary for the operation of the plan value-based pur-  
18                 chasing program under section 1860E–4. Such data shall  
19                 be submitted in a form and manner, and at a time, speci-  
20                 fied by the Secretary for purposes of this subparagraph.

21                 “(B) The Secretary shall establish procedures for  
22                 making data reported under subparagraph (A) available  
23                 to the public in a clear and understandable form. Such  
24                 procedures shall ensure that an eligible entity has the op-  
25                 portunity to review the data that is to be made public with

1 respect to the contract prior to such data being made pub-  
2 lic.”.

3 (3) EFFECTIVE DATE.—The amendments made  
4 by this subsection shall apply to plan years begin-  
5 ning on or after January 1, 2006.

6 (4) SENSE OF THE SENATE.—It is the sense of  
7 the Senate that, in establishing the timeframes for  
8 Medicare Advantage organizations and entities with  
9 a reasonable cost reimbursement contract under sec-  
10 tion 1876(h) of the Social Security Act (42 U.S.C.  
11 1395mm(h)) to report quality data under sections  
12 1852(e)(3) and 1876(h)(6), respectively, of such  
13 Act, as added by this section, the Secretary should  
14 take into account other timeframes for reporting  
15 quality data that such organizations and entities are  
16 subject to under other Federal and State programs  
17 and in the commercial market.

18 (b) PROGRAM.—Title XVIII (42 U.S.C. 1395 et seq.)  
19 is amended by inserting after section 1860E–3, as added  
20 by section 301(b), the following new section:

21 “PLAN VALUE-BASED PURCHASING PROGRAM

22 “SEC. 1860E–4. (a) PROGRAM.—

23 “(1) IN GENERAL.—The Secretary shall estab-  
24 lish a program under which value-based payments  
25 are provided each year to Medicare Advantage orga-  
26 nizations offering Medicare Advantage plans under

1 part C that demonstrate the provision of high qual-  
2 ity health care to enrollees under the plan.

3 “(2) PROGRAM TO BEGIN IN 2009.—The Sec-  
4 retary shall establish the program under this section  
5 so that value-based payments under subsection (b)  
6 are made with respect to 2009 and each subsequent  
7 year.

8 “(3) DEFINITIONS OF MEDICARE ADVANTAGE  
9 ORGANIZATION AND PLAN.—

10 “(A) IN GENERAL.—In this section:

11 “(i) MEDICARE ADVANTAGE ORGANI-  
12 ZATION.—The term ‘Medicare Advantage  
13 organization’ has the meaning given such  
14 term in section 1859(a)(1).

15 “(ii) MEDICARE ADVANTAGE PLAN.—  
16 The term ‘Medicare Advantage plan’ has  
17 the meaning given such term in section  
18 1859(b)(1).

19 “(B) APPLICABILITY OF PROGRAM TO  
20 MEDICARE ADVANTAGE REGIONAL AND LOCAL  
21 PLANS.—For purposes of this section, the term  
22 ‘Medicare Advantage plan’ shall include both  
23 Medicare Advantage regional plans (as defined  
24 in section 1859(b)(4)) and Medicare Advantage  
25 local plans (as defined in section 1859(b)(5)).

1           “(C) APPLICABILITY OF PROGRAM TO REA-  
2           SONABLE COST CONTRACTS.—Except for para-  
3           graphs (5) and (6) of subsection (b), for pur-  
4           poses of this section, the terms—

5                   “(i) ‘Medicare Advantage organiza-  
6                   tion’ and ‘organization’ include an organi-  
7                   zation that is providing benefits under a  
8                   reasonable cost reimbursement contract  
9                   under section 1876(h); and

10                   “(ii) ‘Medicare Advantage plan’ and  
11                   ‘plan’ include such a contract.

12           “(b) VALUE-BASED PAYMENTS.—

13                   “(1) IN GENERAL.—Subject to paragraph (4),  
14                   the Secretary shall make value-based payments to  
15                   Medicare Advantage organizations with respect to  
16                   each Medicare Advantage plan offered by the organi-  
17                   zation during a year if the Secretary determines that  
18                   the quality of the care provided under the plan—

19                           “(A) has substantially improved (as deter-  
20                           mined by the Secretary) over the prior year; or

21                           “(B) exceeds a threshold established by the  
22                           Secretary.

23                   “(2) USE OF SYSTEM.—In determining which  
24                   organizations offering Medicare Advantage plans

1 qualify for a value-based payment under paragraph  
2 (1), the Secretary shall—

3 “(A) use the quality measurement system  
4 developed for this section pursuant to section  
5 1860E–1(a); and

6 “(B) ensure that awards are based on data  
7 from a full 12-month period (or 24-month pe-  
8 riod in the case of an award described in para-  
9 graph (1)(A)), such periods determined without  
10 regard to calendar year periods.

11 “(3) DETERMINATION OF AMOUNT OF AWARD  
12 AND ALLOCATION OF AWARDS.—

13 “(A) IN GENERAL.—The Secretary shall  
14 determine—

15 “(i) the amount of a value-based pay-  
16 ment under paragraph (1) provided to an  
17 organization with respect to a plan; and

18 “(ii) subject to subparagraph (B), the  
19 allocation of the total amount available  
20 under subsection (d) for value-based pay-  
21 ments for any year between payments with  
22 respect to plans that meet the requirement  
23 under subparagraph (A) of paragraph (1)  
24 and plans that meet the requirement under  
25 subparagraph (B) of such paragraph.

1           “(B) REQUIREMENT REGARDING THE  
2 AMOUNT OF FUNDING AVAILABLE FOR VALUE-  
3 BASED PAYMENTS FOR PLANS EXCEEDING A  
4 THRESHOLD.—The Secretary shall ensure  
5 that—

6           “(i) a majority of the total amount  
7 available under subsection (d) for value-  
8 based payments for any year is provided to  
9 organizations, with respect to plans offered  
10 by such organizations, that are receiving  
11 such payments because they meet the re-  
12 quirement under paragraph (1)(B); and

13           “(ii) with respect to 2010 and each  
14 subsequent year, the percentage of the  
15 total amount available under subsection (d)  
16 for value-based payments for any year that  
17 is used to make payments to organizations,  
18 with respect to plans offered by such orga-  
19 nizations, that meet such requirement is  
20 greater than such percentage in the pre-  
21 vious year.

22           “(4) USE OF PAYMENTS.—Value-based pay-  
23 ments received under this section may only be used  
24 for the following purposes:

1           “(A) To invest in quality improvement pro-  
2           grams operated by the organization with respect  
3           to the plan.

4           “(B) To enhance beneficiary benefits under  
5           the plan.

6           “(5) REQUIRED SUBMISSION OF DATA.—In  
7           order for an organization to be eligible for a value-  
8           based payment for a year with respect to a Medicare  
9           Advantage plan or a reasonable cost contract, the  
10          organization must have provided for the collection,  
11          analysis, and reporting of data pursuant to sections  
12          1852(e)(3) (or submitted the data under section  
13          1876(h)(6) in the case of a reasonable cost contract)  
14          with respect to the plan or contract for the 2 years  
15          preceding that year.

16          “(6) NO EFFECT ON MEDICARE ADVANTAGE  
17          PLAN BIDS.—In order for a Medicare Advantage or-  
18          ganization to be eligible for a value-based payment  
19          for a year with respect to a Medicare Advantage  
20          plan, the organization must have provided the Sec-  
21          retary with an attestation that the program under  
22          this section, including the payment adjustments  
23          made by reason of the amendments made by section  
24          401(c)(1) of the Medicare Value Purchasing Act of  
25          2005, had no effect on the integrity and actuarial

1 soundness of the bid submitted under section 1854  
2 for the plan for the year.

3 “(7) TOTAL AMOUNT OF VALUE-BASED PAY-  
4 MENTS EQUAL TO TOTAL AMOUNT OF REDUCTION IN  
5 PAYMENTS.—The Secretary shall establish payment  
6 amounts under paragraph (3)(A) so that, as esti-  
7 mated by the Secretary, the total amount of value-  
8 based payments made in a year under paragraph (1)  
9 is equal to the total amount available under sub-  
10 section (d) for such payments for the year.

11 “(8) PAYMENT METHODS AND TIMING OF PAY-  
12 MENTS.—

13 “(A) IN GENERAL.—Subject to subpara-  
14 graph (B), the payment of value-based pay-  
15 ments under paragraph (1) shall be based on  
16 such a method as the Secretary determines ap-  
17 propriate.

18 “(B) TIMING.—The Secretary shall ensure  
19 that value-based payments under paragraph (1)  
20 with respect to a year are made by not later  
21 than March 1 of the subsequent year.

22 “(c) DESCRIPTION OF HOW PLANS WOULD HAVE  
23 FARED UNDER PROGRAM IF PROGRAM HAD APPLIED TO  
24 2008.—Not later than March 1, 2009, the Secretary shall  
25 provide each Medicare Advantage organization offering a

1 Medicare Advantage plan with a description of the Sec-  
2 retary's estimate of how payments under this title to such  
3 organization with respect to the plan for 2008 would have  
4 been affected if the program under this section (and the  
5 amendments made by subsections (a) and (c) of section  
6 401 of the Medicare Value Purchasing Act of 2005) had  
7 been in effect with respect to 2008.

8 “(d) FUNDING.—

9 “(1) AMOUNT.—The amount available for  
10 value-based payments under this section with respect  
11 to a year shall be equal to the amount of the reduc-  
12 tion in expenditures under the Federal Hospital In-  
13 surance Trust Fund under section 1817 and the  
14 Federal Supplementary Medical Insurance Trust  
15 Fund under section 1841 in the year as a result of  
16 the amendments made by section 401(c) of the  
17 Medicare Value Purchasing Act of 2005, as esti-  
18 mated by the Secretary.

19 “(2) PAYMENTS FROM TRUST FUNDS.—Pay-  
20 ments to organizations under this section shall be  
21 made from the Federal Hospital Insurance Trust  
22 Fund and the Federal Supplementary Medical In-  
23 surance Trust Fund in the same proportion as pay-  
24 ments to Medicare Advantage organizations are

1       made from such Trust Funds under the first sen-  
2       tence of section 1853(f).”.

3       (c) REDUCTION IN PAYMENTS TO ORGANIZATIONS IN  
4 ORDER TO FUND PROGRAM.—

5           (1) MEDICARE ADVANTAGE PAYMENTS.—

6           (A) IN GENERAL.—Section 1853(a)(1) (42  
7 U.S.C. 1395w–23(a)(1)), as amended by section  
8 222(e) of the Medicare Prescription Drug, Im-  
9 provement, and Modernization Act of 2003  
10 (Public Law 108–173; 117 Stat. 2200), is  
11 amended—

12           (i) in clauses (i) and (ii) of subpara-  
13 graph (B), by inserting “and, for 2009 and  
14 each subsequent year, except in the case of  
15 an MSA plan or an MA plan for which  
16 there was no contract under section 1857  
17 during either of the preceding 2 years, re-  
18 duced by the applicable percent (as defined  
19 in subparagraph (I))” after “(G)”; and

20           (ii) by adding at the end the following  
21 new subparagraph:

22           “(I) APPLICABLE PERCENT.—For pur-  
23 poses of clauses (i) and (ii) of subparagraph  
24 (B), the term ‘applicable percent’ means—

25           “(i) for 2009, 1.0 percent;

1                   “(ii) for 2010, 1.25 percent;  
 2                   “(iii) for 2011, 1.5 percent;  
 3                   “(iv) for 2012, 1.75 percent; and  
 4                   “(v) for 2013 and each subsequent  
 5                   year, 2.0 percent.”.

6                   (B) REDUCTIONS IN PAYMENTS DO NOT  
 7                   AFFECT THE REBATE FOR BIDS BELOW THE  
 8                   BENCHMARK.—The amendments made by sub-  
 9                   paragraph (A) shall not be construed to have  
 10                   any effect on—

11                   (i) the determination of whether a  
 12                   Medicare Advantage plan has average per  
 13                   capita monthly savings described in para-  
 14                   graph (3)(C) or (4)(C) of section 1854(b)  
 15                   of the Social Security Act (42 U.S.C.  
 16                   1395w–24(b)); or

17                   (ii) the amount of such savings.

18                   (2) REASONABLE COST CONTRACT PAY-  
 19                   MENTS.—Section 1876(h) (42 U.S.C. 1395mm(h)),  
 20                   as amended by subsection (a)(2), is amended by  
 21                   adding at the end the following new paragraph:

22                   “(7) Notwithstanding the preceding provisions of this  
 23                   subsection, the Secretary shall reduce each payment to an  
 24                   eligible organization under this subsection with respect to  
 25                   benefits provided on or after January 1, 2009, by an

1 amount equal to the applicable percent (as defined in sec-  
 2 tion 1853(a)(1)(I)) of the payment amount. The preceding  
 3 sentence shall have no effect on payments to eligible orga-  
 4 nizations for the provision of qualified prescription drug  
 5 coverage under part D.”.

6 (d) REQUIREMENT FOR REPORTING ON USE OF  
 7 VALUE-BASED PAYMENTS.—

8 (1) MA PLANS.—Section 1854(a) (42 U.S.C.  
 9 1395w–24(a)), as amended by section 222(a) of the  
 10 Medicare Prescription Drug, Improvement, and  
 11 Modernization Act of 2003 (Public Law 108–173;  
 12 117 Stat. 2193), is amended—

13 (A) in paragraph (1)(A)(i), by striking “or  
 14 (6)(A)” and inserting “(6)(A), or (7)”; and

15 (B) by adding at the end the following:

16 “(7) SUBMISSION OF INFORMATION OF HOW  
 17 VALUE-BASED PAYMENTS WILL BE USED.—For an  
 18 MA plan for a plan year beginning on or after Janu-  
 19 ary 1, 2011, the information described in this para-  
 20 graph is a description of how the organization offer-  
 21 ing the plan will use any value-based payments that  
 22 the organization received under section 1860E–4  
 23 with respect to the plan for the year preceding the  
 24 year in which such information is submitted.”.



1 under part C of such Act, and under reasonable cost con-  
 2 tracts under section 1876(h) of such Act (42 U.S.C.  
 3 1395mm).

4 (b) REPORT.—Not later than March 1, 2007, the  
 5 Commission shall submit a report to Congress and the  
 6 Secretary on the study conducted under subsection (a) to-  
 7 gether with recommendations for such legislation and ad-  
 8 ministrative actions as the Commission considers appro-  
 9 priate.

10 **TITLE V—VALUE-BASED PUR-**  
 11 **CHASING FOR PROVIDERS**  
 12 **AND FACILITIES THAT PRO-**  
 13 **VIDE SERVICES TO MEDI-**  
 14 **CARE BENEFICIARIES WITH**  
 15 **END STAGE RENAL DISEASE**

16 **SEC. 501. END STAGE RENAL DISEASE PROVIDER AND FA-**  
 17 **CILITY VALUE-BASED PURCHASING PRO-**  
 18 **GRAM.**

19 (a) VOLUNTARY SUBMISSION OF QUALITY DATA.—  
 20 Section 1881(b) (42 U.S.C. 1395rr(b)) is amended by  
 21 adding at the end the following new paragraph:

22 “(14) By not later than July 31, 2006, the Sec-  
 23 retary shall establish procedures under which pro-  
 24 viders of services and renal dialysis facilities that re-  
 25 ceive payments under paragraph (12) or (13) may

1 submit to the Secretary data that permits the meas-  
2 urement of health outcomes and other indices of  
3 quality.”.

4 (b) PROGRAM.—Title XVIII (42 U.S.C. 1395 et seq.)  
5 is amended by inserting after section 1860E–4, as added  
6 by section 401(b), the following new section:

7 “ESRD PROVIDER AND FACILITY VALUE-BASED  
8 PURCHASING PROGRAM

9 “SEC. 1860E–5. (a) PROGRAM.—

10 “(1) IN GENERAL.—The Secretary shall estab-  
11 lish a program under which value-based payments  
12 are provided each year to providers of services and  
13 renal dialysis facilities that—

14 “(A) provide items and services to individ-  
15 uals with end stage renal disease who are en-  
16 rolled under part B; and

17 “(B) demonstrate the provision of high  
18 quality health care to such individuals.

19 “(2) PROGRAM TO BEGIN IN 2007.—The Sec-  
20 retary shall establish the program under this section  
21 so that value-based payments described in subsection  
22 (b) are made with respect to 2007 and each subse-  
23 quent year.

24 “(3) EXCLUSIONS FROM PROGRAM.—

25 “(A) PEDIATRIC FACILITIES.—Any renal  
26 dialysis facility at least 50 percent of whose pa-

1           tients are individuals under 18 years of age  
2           shall not be included in the program under this  
3           section.

4           “(B) PROVIDERS AND FACILITIES CUR-  
5           RENTLY PARTICIPATING IN BUNDLED CASE-MIX  
6           DEMONSTRATION NOT INCLUDED IN PRO-  
7           GRAM.—Any provider of services or renal dialy-  
8           sis facility that is currently participating in the  
9           bundled case-mix adjusted payment system for  
10          ESRD services demonstration project under  
11          section 623(e) of the Medicare Prescription  
12          Drug, Improvement, and Modernization Act of  
13          2003 (Public Law 108–173) shall not be in-  
14          cluded in the program under this section, but  
15          only for so long as the provider or facility is so  
16          participating.

17          “(b) VALUE-BASED PAYMENTS.—

18                 “(1) IN GENERAL.—Subject to paragraph (4),  
19                 the Secretary shall make a value-based payment to  
20                 a provider of services or a renal dialysis facility with  
21                 respect to a year if the Secretary determines that  
22                 the quality of the care provided in that year by the  
23                 provider or facility to individuals with end stage  
24                 renal disease who are enrolled under part B—

1           “(A) has substantially improved (as deter-  
2           mined by the Secretary) over the prior year; or

3           “(B) exceeds a threshold established by the  
4           Secretary.

5           “(2) USE OF SYSTEM.—In determining which  
6           providers of services and renal dialysis facilities  
7           qualify for a value-based payment under paragraph  
8           (1), the Secretary shall use the quality measurement  
9           system developed for this section pursuant to section  
10          1860E–1(a).

11          “(3) DETERMINATION OF AMOUNT OF AWARD  
12          AND ALLOCATION OF AWARDS.—

13                 “(A) IN GENERAL.—The Secretary shall  
14                 determine—

15                         “(i) the amount of a value-based pay-  
16                         ment under paragraph (1) provided to a  
17                         provider of services or a renal dialysis fa-  
18                         cility; and

19                         “(ii) subject to subparagraphs (B)  
20                         and (C), the allocation of the total amount  
21                         available under subsection (c) for value-  
22                         based payments for any year between pay-  
23                         ments with respect to providers and facili-  
24                         ties that meet the requirement under sub-  
25                         paragraph (A) of paragraph (1) and pro-

1           viders and facilities that meet the require-  
2           ment under subparagraph (B) of such  
3           paragraph.

4           “(B) REQUIREMENT REGARDING AMOUNT  
5           OF FUNDING AVAILABLE FOR VALUE-BASED  
6           PAYMENTS FOR PROVIDERS AND FACILITIES  
7           EXCEEDING A THRESHOLD.—The Secretary  
8           shall ensure that—

9                   “(i) a majority of the total amount  
10                  available under subsection (c) for value-  
11                  based payments for any year is provided to  
12                  providers of services and renal dialysis fa-  
13                  cilities that are receiving such payments  
14                  because they meet the requirement under  
15                  paragraph (1)(B); and

16                   “(ii) with respect to 2009 and each  
17                  subsequent year, the percentage of the  
18                  total amount available under subsection (c)  
19                  for value-based payments for any year that  
20                  is used to make payments to providers and  
21                  facilities that meet such requirement is  
22                  greater than such percentage in the pre-  
23                  vious year.

24           “(C) ONLY VALUE-BASED PAYMENTS FOR  
25           PROVIDERS AND FACILITIES EXCEEDING A

1 THRESHOLD IN 2007.—With respect to 2007,  
2 the entire amount available under subsection (c)  
3 for value-based payments for that year shall be  
4 used to make payments to providers of services  
5 and renal dialysis facilities that meet the re-  
6 quirement under paragraph (1)(B).

7 “(4) REQUIREMENTS.—

8 “(A) REQUIRED SUBMISSION OF DATA.—

9 “(i) IN GENERAL.—In order for a pro-  
10 vider of services or a renal dialysis facility  
11 to be eligible for a value-based payment for  
12 a year, the provider or facility must have  
13 provided for the submission of data in ac-  
14 cordance with clause (ii) with respect to  
15 that year.

16 “(ii) SUBMISSION OF DATA.—For  
17 2007 and each subsequent year, each pro-  
18 vider of services and renal dialysis facility  
19 that receives payments under paragraph  
20 (12) shall submit to the Secretary such  
21 data that the Secretary determines is ap-  
22 propriate for the measurement of health  
23 outcomes and other indices of quality, in-  
24 cluding data necessary for the operation of  
25 the program under this section. Such data

1 shall be submitted in a form and manner,  
2 and at a time, specified by the Secretary  
3 for purposes of this clause.

4 “(iii) AVAILABILITY TO THE PUB-  
5 LIC.—The Secretary shall establish proce-  
6 dures for making data submitted under  
7 clause (ii) available to the public in a clear  
8 and understandable form. Such procedures  
9 shall ensure that a provider or facility has  
10 the opportunity to review the data that is  
11 to be made public with respect to the pro-  
12 vider or facility prior to such data being  
13 made public.

14 “(B) ATTESTATION REGARDING DATA.—In  
15 order for a provider of services or a renal dialy-  
16 sis facility to be eligible for a value-based pay-  
17 ment for a year, the provider or facility must  
18 have provided the Secretary (under procedures  
19 established by the Secretary) with an attesta-  
20 tion that the data submitted under subpara-  
21 graph (A)(ii) for the year is complete and accu-  
22 rate.

23 “(5) TOTAL AMOUNT OF VALUE-BASED PAY-  
24 MENTS EQUAL TO TOTAL AMOUNT OF AVAILABLE  
25 FUNDING.—The Secretary shall establish payment

1 amounts under paragraph (3)(A) so that, as esti-  
2 mated by the Secretary, the total amount of value-  
3 based payments made in a year under paragraph (1)  
4 is equal to the total amount available under sub-  
5 section (c) for such payments for the year.

6 “(6) PAYMENT METHODS AND TIMING OF PAY-  
7 MENTS.—

8 “(A) IN GENERAL.—Subject to subpara-  
9 graph (B), the payment of value-based pay-  
10 ments under paragraph (1) shall be based on  
11 such a method as the Secretary determines ap-  
12 propriate.

13 “(B) TIMING.—The Secretary shall ensure  
14 that value-based payments under paragraph (1)  
15 with respect to a year are made by not later  
16 than December 31 of the subsequent year.

17 “(c) FUNDING.—

18 “(1) AMOUNT.—The amount available for  
19 value-based payments under this section with respect  
20 to a year shall be equal to the amount of the reduc-  
21 tion in expenditures under the Federal Supple-  
22 mentary Medical Insurance Trust Fund under sec-  
23 tion 1841 in the year by reason of the application  
24 of section 1881(b)(12)(G), as estimated by the Sec-  
25 retary.

1           “(2) PAYMENTS FROM TRUST FUND.—Pay-  
2           ments to providers of services and renal dialysis fa-  
3           cilities under this section shall be made from the  
4           Federal Supplementary Medical Insurance Trust  
5           Fund.”.

6           (c) REDUCTION IN CASE-MIX ADJUSTED PROSPEC-  
7           TIVE PAYMENT AMOUNT IN ORDER TO FUND PRO-  
8           GRAM.—Section 1881(b)(12) (42 U.S.C. 1395rr(b)(12)) is  
9           amended—

10           (1) by redesignating subparagraph (G) as sub-  
11           paragraph (H); and

12           (2) by inserting after subparagraph (F) the fol-  
13           lowing new subparagraph:

14           “(G)(i) In the case of any payment made under  
15           this paragraph for an item or service furnished on  
16           or after January 1, 2007, such payment shall be re-  
17           duced by the applicable percent. The preceding sen-  
18           tence shall not apply to a payment for an item or  
19           service furnished by a provider of services or a renal  
20           dialysis facility that is excluded from the program  
21           under section 1860E-5 by reason of subsection  
22           (a)(3) of such section at the time the item or service  
23           is furnished.

24           “(ii) For purposes of clause (i), the term ‘appli-  
25           cable percent’ means—

1           “(I) for 2007, 1.0 percent;  
2           “(II) for 2008, 1.25 percent;  
3           “(III) for 2009, 1.5 percent;  
4           “(IV) for 2010, 1.75 percent; and  
5           “(V) for 2011 and each subsequent year,  
6           2.0 percent.”.

7 **SEC. 502. VALUE-BASED PURCHASING UNDER THE DEM-**  
8 **ONSTRATION OF BUNDLED CASE-MIX AD-**  
9 **JUSTED PAYMENT SYSTEM FOR ESRD SERV-**  
10 **ICES.**

11       Section 623(e) of the Medicare Prescription Drug,  
12 Improvement, and Modernization Act of 2003 (42 U.S.C.  
13 1395rr note) is amended by adding at the end the fol-  
14 lowing new paragraph:

15           “(7) VALUE-BASED PURCHASING PROGRAM.—  
16       As part of the demonstration project under this sub-  
17 section, the Secretary shall, beginning January 1,  
18 2007, implement a value-based purchasing program  
19 for providers and facilities participating in the dem-  
20 onstration project. The Secretary shall implement  
21 such value-based purchasing program in a similar  
22 manner as the ESRD provider and facility value-  
23 based purchasing program is implemented under  
24 section 1860E–5 of the Social Security Act, includ-  
25 ing the funding of such program.”.

1 **SEC. 503. CHRONIC KIDNEY DISEASE DEMONSTRATION**  
2 **PROJECTS.**

3 (a) IN GENERAL.—Not later than January 1, 2007,  
4 the Secretary shall establish demonstration projects to—

5 (1) increase public awareness about—

6 (A) the factors that lead to chronic kidney  
7 disease;

8 (B) how to prevent such disease;

9 (C) how to treat such disease; and

10 (D) how to avoid kidney failure;

11 (2) enhance surveillance systems and expand re-  
12 search to better assess the prevalence and incidence  
13 of chronic kidney disease; and

14 (3) evaluate approaches for providing outreach  
15 and education to groups or special populations with  
16 a high prevalence of chronic kidney disease, such as  
17 Native Americans and Alaskan Natives.

18 (b) SCOPE AND DURATION.—

19 (1) SCOPE.—The Secretary shall select at least  
20 3 States in which to conduct demonstration projects  
21 under this section. In selecting the States under this  
22 paragraph, the Secretary shall take into account the  
23 size of the population of medicare beneficiaries with  
24 end-stage renal disease in the State and ensure the  
25 participation of individuals who reside in rural and  
26 urban areas.

1           (2) DURATION.—The demonstration projects  
2           under this section shall be conducted for a period  
3           not to exceed 3 years.

4           (c) WAIVER AUTHORITY.—The Secretary may waive  
5           such requirements of titles XI and XVIII of the Social  
6           Security Act as may be necessary to carry out the dem-  
7           onstration projects under this section.

8           (d) REPORT.—Not later than 6 months after the date  
9           on which the demonstration projects under this section are  
10          completed, the Secretary shall submit to Congress a report  
11          on the demonstration projects together with recommenda-  
12          tions for such legislation and administrative action as the  
13          Secretary determines appropriate.

14          (e) AUTHORIZATION OF APPROPRIATIONS.—There  
15          are authorized to be appropriated such sums as may be  
16          necessary to carry out this section.

17 **SEC. 504. MEDPAC STUDY AND REPORT REGARDING A**  
18                                   **VALUE-BASED PURCHASING PROGRAM FOR**  
19                                   **PEDIATRIC RENAL DIALYSIS FACILITIES.**

20          (a) STUDY.—The Medicare Payment Advisory Com-  
21          mission shall conduct a study on the advisability and feasi-  
22          bility of—

23                (1) including renal dialysis facilities described  
24                in subsection (a)(3)(A) of section 1860E–5 of the  
25                Social Security Act, as added by section 501(b), in

1 the value-based purchasing program under such sec-  
2 tion 1860E–5; or

3 (2) establishing a value-based purchasing pro-  
4 gram under the medicare program under title XVIII  
5 of such Act for such facilities.

6 (b) REPORT.—Not later than June 1, 2007, the Com-  
7 mission shall submit a report to Congress and the Sec-  
8 retary on the study conducted under subsection (a) to-  
9 gether with recommendations for such legislation and ad-  
10 ministrative actions as the Commission considers appro-  
11 priate.

12 **SEC. 505. MEDPAC REPORT ON ESRD PROVIDER AND FA-**  
13 **CILITY VALUE-BASED PURCHASING PRO-**  
14 **GRAM.**

15 (a) REPORT.—Not later than June 1, 2008, the  
16 Medicare Payment Advisory Commission shall submit a  
17 report to Congress and the Secretary on the implementa-  
18 tion of the ESRD provider and facility value-based pur-  
19 chasing program under section 1860E–5 of the Social Se-  
20 curity Act, as added by section 501(b).

21 (b) CONTENTS.—The report submitted under sub-  
22 section (a) shall include—

23 (1) a detailed description of issues for the Sec-  
24 retary to consider in operating the ESRD provider

1 and facility value-based purchasing program and  
2 recommendations on such issues; and

3 (2) recommendations for such legislation and  
4 administrative actions as the Commission considers  
5 appropriate.

6 (c) CONSIDERATION OF DEMONSTRATION  
7 PROJECT.—In preparing the report to be submitted under  
8 subsection (a), the Commission shall take into account the  
9 results to date of the demonstration of bundled case-mix  
10 adjusted payment system for ESRD services under section  
11 623(e) of the Medicare Prescription Drug, Improvement,  
12 and Modernization Act of 2003 (42 U.S.C. 1395rr note).

13 **SEC. 506. SENSE OF THE SENATE REGARDING AN UPDATE**  
14 **TO THE COMPOSITE RATE PAYMENT FOR DI-**  
15 **ALYSIS SERVICES.**

16 It is the sense of the Senate that—

17 (1) while the provisions of, and amendments  
18 made by, this Act develop a value-based purchasing  
19 program for providers of services and renal dialysis  
20 facilities furnishing dialysis services to medicare  
21 beneficiaries, Congress should address the need for  
22 an update to the composite rate payment for dialysis  
23 services under section 1881(b)(12) of the Social Se-  
24 curity Act (42 U.S.C. 1395rr(b)(12)) in order to en-  
25 sure—

1           (A) appropriate reimbursement under the  
2           medicare program for such services that is con-  
3           sistent with high quality and efficient delivery  
4           of such services; and

5           (B) future access to, and the affordability  
6           of, such services for medicare beneficiaries;

7           (2) if Congress determines that an update to  
8           such composite rate payment is appropriate, Con-  
9           gress should ensure that the update takes into ac-  
10          count any change in the costs of furnishing dialysis  
11          services resulting from—

12           (A) the adoption of scientific and techno-  
13           logical innovations used to provide such serv-  
14           ices;

15           (B) changes in the manner or method of  
16           furnishing such services; and

17           (C) productivity improvements in the fur-  
18           nishing of such services.

1 **TITLE VI—VALUE-BASED PUR-**  
2 **CHASING FOR HOME HEALTH**  
3 **AGENCIES**

4 **SEC. 601. HOME HEALTH AGENCY VALUE-BASED PUR-**  
5 **CHASING PROGRAM.**

6 (a) UPDATE FOR HOME HEALTH AGENCIES THAT  
7 SUBMIT QUALITY DATA.—Section 1895(b)(3)(B) (42  
8 U.S.C.fff(b)(3)(B)) is amended—

9 (1) in clause (ii)(IV), by inserting “subject to  
10 clause (v),” after “subsequent year,”; and

11 (2) by adding at the end the following new  
12 clause:

13 “(v) ADJUSTMENT IF QUALITY DATA  
14 NOT SUBMITTED.—

15 “(I) ADJUSTMENT.—For pur-  
16 poses of clause (ii)(IV), for 2007 and  
17 each subsequent year, in the case of a  
18 home health agency that does not sub-  
19 mit data in accordance with subclause  
20 (II) with respect to such a year, the  
21 home health market basket percentage  
22 increase applicable under such clause  
23 for such year shall be reduced by 2  
24 percentage points. Such reduction  
25 shall apply only with respect to the

1 year involved, and the Secretary shall  
2 not take into account such reduction  
3 in computing the prospective payment  
4 amount under this section for a subse-  
5 quent year.

6 “(II) SUBMISSION OF QUALITY  
7 DATA.—For 2007 and each subse-  
8 quent year, each home health agency  
9 shall submit to the Secretary such  
10 data that the Secretary determines is  
11 appropriate for the measurement of  
12 health care quality, including data  
13 necessary for the operation of the  
14 home health agency value-based pur-  
15 chasing program under section  
16 1860E–6. Such data shall be sub-  
17 mitted in a form and manner, and at  
18 a time, specified by the Secretary for  
19 purposes of this clause.

20 “(III) The Secretary shall estab-  
21 lish procedures for making data sub-  
22 mitted under subclause (II) available  
23 to the public in a clear and under-  
24 standable form.”.

1 (b) PROGRAM.—Title XVIII (42 U.S.C. 1395 et seq.)  
2 is amended by inserting after section 1860E–5, as added  
3 by section 501(b), the following new section:

4 “HOME HEALTH AGENCY VALUE-BASED PURCHASING  
5 PROGRAM

6 “SEC. 1860E–6. (a) PROGRAM.—

7 “(1) IN GENERAL.—The Secretary shall estab-  
8 lish a program under which value-based payments  
9 are provided each year to home health agencies that  
10 demonstrate the provision of high quality health care  
11 to individuals entitled to benefits under part A or  
12 enrolled under part B.

13 “(2) PROGRAM TO BEGIN IN 2008.—The Sec-  
14 retary shall establish the program under this section  
15 so that value-based payments described in subsection  
16 (b) are made with respect to 2008 and each subse-  
17 quent year.

18 “(3) HOME HEALTH AGENCY DEFINED.—In  
19 this section, the term “home health agency” has the  
20 meaning given that term in section 1861(o).

21 “(b) VALUE-BASED PAYMENTS.—

22 “(1) IN GENERAL.—Subject to paragraph (4),  
23 the Secretary shall make a value-based payment to  
24 a home health agency with respect to a year if the  
25 Secretary determines that the quality of the care  
26 provided in that year by the agency to individuals

1 entitled to benefits under part A or enrolled under  
2 part B—

3 “(A) has substantially improved (as deter-  
4 mined by the Secretary) over the prior year; or

5 “(B) exceeds a threshold established by the  
6 Secretary.

7 “(2) USE OF SYSTEM.—In determining which  
8 home health agencies qualify for a value-based pay-  
9 ment under paragraph (1), the Secretary shall use  
10 the quality measurement system developed for this  
11 section pursuant to section 1860E–1(a).

12 “(3) DETERMINATION OF AMOUNT OF AWARD  
13 AND ALLOCATION OF AWARDS.—

14 “(A) IN GENERAL.—The Secretary shall  
15 determine—

16 “(i) the amount of a value-based pay-  
17 ment under paragraph (1) provided to a  
18 home health agency; and

19 “(ii) subject to subparagraph (B), the  
20 allocation of the total amount available  
21 under subsection (d) for value-based pay-  
22 ments for any year between payments with  
23 respect to agencies that meet the require-  
24 ment under subparagraph (A) of para-  
25 graph (1) and agencies that meet the re-

1           requirement under subparagraph (B) of such  
2           paragraph.

3           “(B) REQUIREMENTS REGARDING THE  
4           AMOUNT OF FUNDING AVAILABLE FOR VALUE-  
5           BASED PAYMENTS FOR AGENCIES EXCEEDING A  
6           THRESHOLD.—The Secretary shall ensure  
7           that—

8                   “(i) a majority of the total amount  
9                   available under subsection (d) for value-  
10                  based payments for any year is provided to  
11                  home health agencies that are receiving  
12                  such payments because they meet the re-  
13                  quirement under paragraph (1)(B); and

14                  “(ii) with respect to 2009 and each  
15                  subsequent year, the percentage of the  
16                  total amount available under subsection (d)  
17                  for value-based payments for any year that  
18                  is used to make payments to agencies that  
19                  meet such requirement is greater than  
20                  such percentage in the previous year.

21           “(4) REQUIREMENTS.—

22                   “(A) REQUIRED SUBMISSION OF DATA.—  
23           In order for a home health agency to be eligible  
24           for a value-based payment for a year, the agen-  
25           cy must have complied with the requirements

1 under section 1895(b)(3)(B)(v)(II) with respect  
2 to that year.

3 “(B) ATTESTATION REGARDING DATA.—In  
4 order for a home health agency to be eligible for  
5 a value-based payment for a year, the agency  
6 must have provided the Secretary (under proce-  
7 dures established by the Secretary) with an at-  
8 testation that the data submitted under section  
9 1895(b)(3)(B)(v)(II) with respect to that year  
10 is complete and accurate.

11 “(5) TOTAL AMOUNT OF VALUE-BASED PAY-  
12 MENTS EQUAL TO TOTAL AMOUNT OF AVAILABLE  
13 FUNDING.—The Secretary shall establish payment  
14 amounts under paragraph (3)(A) so that, as esti-  
15 mated by the Secretary, the total amount of value-  
16 based payments made in a year under paragraph (1)  
17 is equal to the total amount available under sub-  
18 section (d) for such payments for the year.

19 “(6) PAYMENT METHODS AND TIMING OF PAY-  
20 MENTS.—

21 “(A) IN GENERAL.—Subject to subpara-  
22 graph (B), the payment of value-based pay-  
23 ments under paragraph (1) shall be based on  
24 such a method as the Secretary determines ap-  
25 propriate.

1           “(B) TIMING.—The Secretary shall ensure  
2           that value-based payments under paragraph (1)  
3           with respect to a year are made by not later  
4           than December 31 of the subsequent year.

5           “(c) DESCRIPTION OF HOW AGENCIES WOULD HAVE  
6 FARED UNDER PROGRAM IF PROGRAM HAD APPLIED TO  
7 2007.—Not later than January 1, 2008, the Secretary  
8 shall provide each home health agency with a description  
9 of the Secretary’s estimate of how payments to the agency  
10 under this title would have been affected with respect to  
11 items and services furnished in 2007 if the program under  
12 this section (and the amendments made by subsections (a)  
13 and (c) of section 601 of the Medicare Value Purchasing  
14 Act of 2005) had been in effect with respect to 2007.

15           “(d) FUNDING.—

16           “(1) AMOUNT.—The amount available for  
17 value-based payments under this section with respect  
18 to a year shall be equal to the amount of the reduc-  
19 tion in expenditures under the the Federal Hospital  
20 Insurance Trust Fund under section 1817 and Fed-  
21 eral Supplementary Medical Insurance Trust Fund  
22 under section 1841 in the year as a result of the ap-  
23 plication of section 1895(b)(3)(D), as estimated by  
24 the Secretary.

1           “(2) PAYMENTS FROM TRUST FUND.—Pay-  
2           ments to home health agencies under this section  
3           shall be made from the the Federal Hospital Insur-  
4           ance Trust Fund and Federal Supplementary Med-  
5           ical Insurance Trust Fund, in the same proportion  
6           as payments for home health services are made from  
7           such trust funds.”.

8           (c) REDUCTION IN STANDARD PROSPECTIVE PAY-  
9           MENT AMOUNT FOR AGENCIES THAT SUBMIT QUALITY  
10          DATA IN ORDER TO FUND PROGRAM.—Section  
11          1895(b)(3) (42 U.S.C. 1395fff(b)(3)) is amended by add-  
12          ing at the end the following new subparagraph:

13                       “(D) REDUCTION IN ORDER TO FUND  
14                       VALUE-BASED PURCHASING PROGRAM.—

15                               “(i) IN GENERAL.—For 2008 and  
16                               each subsequent year, in the case of a  
17                               home health agency that complies with the  
18                               submission requirements under section  
19                               1895(b)(3)(B)(v)(II) for the year, the  
20                               standard prospective payment amount (or  
21                               amounts) otherwise applicable under this  
22                               paragraph for the year shall be reduced by  
23                               the applicable percent.

1                   “(ii) APPLICABLE PERCENT.—For  
2                   purposes of clause (i), the term ‘applicable  
3                   percent’ means—

4                               “(I) for 2008, 1.0 percent;

5                               “(II) for 2009, 1.25 percent;

6                               “(III) for 2010, 1.5 percent;

7                               “(IV) for 2011, 1.75 percent;

8                               and

9                               “(V) for 2012 and each subse-  
10                              quent year, 2.0 percent.”.

11 **TITLE VII—VALUE-BASED PUR-**  
12 **CHASING FOR SKILLED NURS-**  
13 **ING FACILITIES**

14 **SEC. 701. REQUIREMENT FOR SKILLED NURSING FACILI-**  
15 **TIES TO REPORT FUNCTIONAL CAPACITY OF**  
16 **MEDICARE RESIDENTS UPON ADMISSION**  
17 **AND DISCHARGE.**

18           Section 1819(b) (42 U.S.C. 1395i–3(b)) is amended  
19 by adding at the end the following new paragraph:

20                   “(9) REPORTING FUNCTIONAL CAPACITY AT AD-  
21                   MISSION AND DISCHARGE.—

22                               “(A) IN GENERAL.—On and after October  
23                              1, 2006, a skilled nursing facility must submit  
24                              a report to the Secretary on the functional ca-

1           capacity of each resident who is entitled to bene-  
2           fits under this part at the time of—

3                   “(i) the admission of such resident;

4                   and

5                   “(ii) the discharge of such resident.

6                   “(B) TIMEFRAME.—A report required  
7           under subparagraph (A) shall be submitted  
8           within 10 days of the admission or discharge,  
9           as the case may be.”.

10 **SEC. 702. HHS STUDY ON MEASURES OF QUALITY FOR**  
11                   **SKILLED NURSING FACILITIES; VOLUNTARY**  
12                   **REPORTING OF SKILLED NURSING FACILITY**  
13                   **QUALITY DATA.**

14           (a) HHS STUDY AND REPORT ON MEASURES OF  
15 QUALITY FOR SKILLED NURSING FACILITIES.—

16                   (1) STUDY.—The Secretary shall conduct a  
17           study to determine the appropriate measures, includ-  
18           ing process and staffing measures, that should be  
19           used to evaluate the quality of the health care pro-  
20           vided by skilled nursing facilities to individuals who  
21           are entitled to benefits under part A of title XVIII  
22           of the Social Security Act.

23                   (2) REPORT.—Not later than July 1, 2008, the  
24           Secretary shall submit a report to Congress on the  
25           study conducted under paragraph (1) together with

1 recommendations for such legislation and adminis-  
 2 trative actions as the Secretary considers appro-  
 3 priate.

4 (3) CONSULTATION.—In conducting the study  
 5 under paragraph (1) and preparing the report under  
 6 paragraph (2), the Secretary shall consult with the  
 7 entities described in subsections (c)(1), (c)(2), and  
 8 (d) of section 1860E–1 of the Social Security Act,  
 9 as added by section 101.

10 (b) VOLUNTARY SUBMISSION OF SKILLED NURSING  
 11 FACILITY QUALITY DATA.—

12 (1) UPDATE FOR SKILLED NURSING FACILITIES  
 13 THAT SUBMIT QUALITY DATA.—Section  
 14 1888(e)(4)(E) (42 U.S.C. 1395yy(e)(4)(E)) is  
 15 amended—

16 (A) in clause (ii)(IV), by inserting “subject  
 17 to clause (iii),” after “subsequent fiscal year,”;  
 18 and

19 (B) by adding at the end the following new  
 20 clause:

21 “(iii) ADJUSTMENT IF QUALITY DATA  
 22 NOT SUBMITTED.—

23 “(I) ADJUSTMENT.—For pur-  
 24 poses of clause (ii)(IV), for fiscal year  
 25 2009 and each subsequent fiscal year,

1 in the case of a skilled nursing facility  
2 that does not submit data in accord-  
3 ance with subclause (II) with respect  
4 to such a fiscal year, the skilled nurs-  
5 ing facility market basket percentage  
6 change applicable under such clause  
7 for such fiscal year shall be reduced  
8 by 2 percentage points. Such reduc-  
9 tion shall apply only with respect to  
10 the fiscal year involved, and the Sec-  
11 retary shall not take into account  
12 such reduction in computing the Fed-  
13 eral per diem rate under this section  
14 for a subsequent fiscal year.

15 “(II) SUBMISSION OF QUALITY  
16 DATA.—For fiscal year 2009 and each  
17 subsequent fiscal year, each skilled  
18 nursing facility shall submit to the  
19 Secretary such data that the Sec-  
20 retary determines is appropriate for  
21 the measurement of health outcomes  
22 and other indices of quality. Such  
23 data shall be submitted in a form and  
24 manner, and at a time, specified by

1 the Secretary for purposes of this  
2 clause.

3 “(III) The Secretary shall estab-  
4 lish procedures for making data sub-  
5 mitted under subclause (II) available  
6 to the public in a clear and under-  
7 standable form. Such procedures shall  
8 ensure that a facility has the oppor-  
9 tunity to review the data that is to be  
10 made public with respect to the facil-  
11 ity prior to such data being made  
12 public.”.

13 **SEC. 703. MEDPAC STUDY AND REPORT REGARDING A**  
14 **VALUE-BASED PURCHASING PROGRAM FOR**  
15 **SKILLED NURSING FACILITIES.**

16 (a) **STUDY.**—The Medicare Payment Advisory Com-  
17 mission shall conduct a study on the advisability and feasi-  
18 bility of establishing a value-based purchasing program  
19 under the medicare program under title XVIII of the So-  
20 cial Security Act for skilled nursing facilities (as defined  
21 in section 1819(a) of such Act (42 U.S.C. 1395i–3(a)).

22 (b) **REPORT.**—Not later than March 1, 2009, the  
23 Commission shall submit a report to Congress and the  
24 Secretary on the study conducted under subsection (a) to-  
25 gether with recommendations for such legislation and ad-

1 ministrative actions as the Commission considers appro-  
2 priate.

3 **TITLE VIII—ADDITIONAL**  
4 **PROVISIONS**

5 **SEC. 801. EXCEPTION TO FEDERAL ANTI-KICKBACK AND**  
6 **PHYSICIAN SELF REFERRAL LAWS FOR THE**  
7 **PROVISION OF PERMITTED SUPPORT.**

8 (a) ANTI-KICKBACK.—Section 1128B(b) (42 U.S.C.  
9 1320a–7b(b)(3)) is amended—

10 (1) in paragraph (3)—

11 (A) in subparagraph (G), by striking  
12 “and” at the end;

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

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

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

21 (C) by redesignating subparagraph (H), as  
22 added by section 431(a) of the Medicare Pre-  
23 scription Drug, Improvement, and Moderniza-  
24 tion Act of 2003 (Public Law 108–173; 117  
25 Stat. 2287), as subparagraph (I);

1 (D) in subparagraph (I), as so redesign-  
2 nated—

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

5 (ii) by striking the period at the end  
6 and inserting “; and”; and

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

9 “(J) during the 5-year period beginning on  
10 the date the Secretary issues the interim final  
11 rule under section 801(c)(1) of the Medicare  
12 Value Purchasing Act of 2005, the provision,  
13 with or without charge, of any permitted sup-  
14 port (as defined in paragraph (4)).”; and

15 (2) by adding at the end the following new  
16 paragraph:

17 “(4) PERMITTED SUPPORT.—

18 “(A) DEFINITION OF PERMITTED SUP-  
19 PORT.—Subject to subparagraph (B), in this  
20 section, the term ‘permitted support’ means the  
21 provision of any equipment, item, information,  
22 right, license, intellectual property, software,  
23 training, or service used for developing, imple-  
24 menting, operating, or facilitating the use of  
25 systems designed to improve the quality of

1 health care and to promote the electronic ex-  
2 change of health information.

3 “(B) EXCEPTION.—The term ‘permitted  
4 support’ shall not include the provision of—

5 “(i) any support that is determined in  
6 a manner that is related to the volume or  
7 value of any referrals or other business  
8 generated between the parties for which  
9 payment may be made in whole or in part  
10 under a Federal health care program;

11 “(ii) any support that has more than  
12 incidental utility or value to the recipient  
13 beyond the exchange of health care infor-  
14 mation; or

15 “(iii) any health information tech-  
16 nology system, product, or service that is  
17 not capable of exchanging health care in-  
18 formation in compliance with data stand-  
19 ards consistent with interoperability.

20 “(C) DETERMINATION.—In establishing  
21 regulations with respect to the requirement  
22 under subparagraph (B)(iii), the Secretary shall  
23 take in account—

24 “(I) whether the health information  
25 technology system, product, or service is

1 widely accepted within the industry and  
2 whether there is sufficient industry experi-  
3 ence to ensure successful implementation  
4 of the system, product, or service; and

5 “(II) whether the health information  
6 technology system, product, or service im-  
7 proves quality of care, enhances patient  
8 safety, or provides greater administrative  
9 efficiencies.”.

10 (b) PHYSICIAN SELF-REFERRAL.—Section 1877(e)  
11 (42 U.S.C. 1395nn(e)) is amended by adding at the end  
12 the following new paragraph:

13 “(9) PERMITTED SUPPORT.—During the 5-year  
14 period beginning on the date the Secretary issues  
15 the interim final rule under section 801(c)(1) of the  
16 Medicare Value Purchasing Act of 2005, the provi-  
17 sion, with or without charge, of any permitted sup-  
18 port (as defined in section 1128B(b)(4)).”.

19 (c) REGULATIONS.—In order to carry out the amend-  
20 ments made by this section—

21 (1) the Secretary shall issue an interim final  
22 rule with comment period by not later than the date  
23 that is 180 days after the date of enactment of this  
24 Act;

1           (2) the Secretary shall issue a final rule by not  
2 later than the date that is 180 days after the date  
3 that the interim final rule under paragraph (1) is  
4 issued.

5 **SEC. 802. NATIONAL HEALTH INFORMATION NETWORK**  
6 **PILOT PROJECT.**

7 (a) PILOT PROJECT.—

8           (1) ESTABLISHMENT.—For the purpose of im-  
9 proving health care quality, not later than 6 months  
10 after the date of enactment of this Act, the Sec-  
11 retary, in consultation with the National Coordinator  
12 for Health Information Technology, shall establish a  
13 pilot project to facilitate the exchange of—

14           (A) clinical claims and outcomes data with  
15 respect to beneficiaries under the medicare and  
16 medicaid programs, particularly such bene-  
17 ficiaries who are dually eligible under such pro-  
18 grams; and

19           (B) clinical research findings and practice  
20 guidelines.

21           (2) DURATION.—The pilot project under this  
22 section shall be conducted for a 3-year period.

23           (3) SITES.—The Secretary shall conduct the  
24 pilot project in 4 regions that—

1 (A) include at least 3 distinct health care  
2 markets; and

3 (B) are located in a State or multiple  
4 States.

5 (4) PARTICIPANTS.—Participants in the pilot  
6 project under this section—

7 (A) shall include a physician, a physician  
8 group practice, a hospital, a free-standing lab-  
9 oratory, a renal dialysis provider or facility, a  
10 home health agency, a skilled nursing facility, a  
11 safety net provider, and any other entity or per-  
12 son determined appropriate by the Secretary;  
13 and

14 (B) may include regional health informa-  
15 tion networks, health plans, providers under the  
16 medicare program not described in subpara-  
17 graph (A), vendors of health information tech-  
18 nology systems and software, academic entities,  
19 and other entities involved in the exchange of  
20 data related to patient health status, clinical  
21 care guidelines, medical research, billing,  
22 claims, and health care quality.

23 (5) REQUIREMENT FOR PARTICIPANTS.—Par-  
24 ticipants in the pilot project under this section  
25 shall—

1 (A) comply with any interoperability stand-  
2 ards and certification requirements and proc-  
3 esses that have been developed or adopted by  
4 the Secretary or a designee of the Secretary;

5 (B) to the extent feasible, use existing re-  
6 sources, including the Internet; and

7 (C) incorporate data systems and software  
8 from more than one competing vendor.

9 (6) WAIVER AUTHORITY.—The Secretary may  
10 waive such requirements of titles XI and XVIII of  
11 the Social Security Act as may be necessary to carry  
12 out the pilot project under this section.

13 (b) REPORTS.—

14 (1) IN GENERAL.—Not later than the date that  
15 is 6 months prior to the date that the pilot project  
16 under this section is completed, and not later than  
17 the date that is 6 months after the date the project  
18 is completed, the Secretary shall submit to Congress  
19 a report on the pilot project.

20 (2) CONTENTS.—Each report submitted under  
21 paragraph (1) shall include—

22 (A) an analysis of—

23 (i) the methodologies for building a  
24 National Health Information Infrastruc-  
25 ture; and

1                   (ii) the impact of the pilot project on  
2                   medicare beneficiaries, medicare providers,  
3                   and the Medicare Trust Funds;

4                   (B) findings regarding access to, and the  
5                   quality of, care, efficiency of resource use, vol-  
6                   ume and utilization rates, and the projected fu-  
7                   ture impact on the Medicare Trust Funds and  
8                   other health care spending if the pilot project is  
9                   expanded under subsection (c);

10                  (C) a detailed description if issued related  
11                  to the nationwide expansion of the pilot project  
12                  pursuant to subsection (c); and

13                  (D) recommendations for such legislation  
14                  and administrative actions as the Secretary con-  
15                  siders appropriate, including actions related to  
16                  the nationwide expansion of the pilot project  
17                  under subsection (c).

18                  (3) MEDICARE TRUST FUNDS DEFINED.—In  
19                  this title, the term “Medicare Trust Funds” means  
20                  the Federal Hospital Insurance Trust Fund under  
21                  section 1817 of the Social Security Act (42 U.S.C.  
22                  1395i) and the Federal Supplementary Medical In-  
23                  surance Trust Fund under section 1841 of such Act  
24                  (42 U.S.C. 1395t).

1 (c) EXPANSION.—After conducting the pilot project  
2 under this section for not less than 2 years, the Secretary  
3 may transition and implement such project on a national  
4 basis.

5 (d) FUNDING.—There are authorized to be appro-  
6 priated to the Secretary such sums as may be necessary  
7 to carry out this section.

8 **SEC. 803. HEALTH CARE VALUE PROJECT.**

9 (a) PROJECT.—

10 (1) ESTABLISHMENT.—Not later than 6  
11 months after the date of enactment of this Act, the  
12 Secretary shall establish a project to document,  
13 track, and quantify the value created, both in terms  
14 of patient outcomes and reduced expenditures under  
15 the Medicare Trust Funds, by delivering high-quality  
16 health care to individuals under the medicare pro-  
17 gram under title XVIII of the Social Security Act.

18 (2) DURATION.—The project under this section  
19 shall be conducted for a 1-year period.

20 (3) PROJECT REQUIREMENTS.—

21 (A) SITES.—The Secretary shall conduct  
22 the project under this section at 6 sites, of  
23 which—

24 (i) 2 shall include community-based  
25 seatings; and

1 (ii) 2 shall include rural or frontier  
2 health care facilities.

3 (B) TEAMS.—

4 (i) IN GENERAL.—Under the project,  
5 the Secretary shall assign to each site se-  
6 lected under subparagraph (A) a team  
7 made up of—

8 (I) process engineers skilled at  
9 identifying and correcting flaws within  
10 the system of health care delivery;

11 (II) health care providers and  
12 practitioners located at the site; and

13 (III) activity-based cost account-  
14 ants skilled at attaching real costs to  
15 health care outcomes.

16 (ii) REQUIREMENT.—The Secretary  
17 should select members of the team under  
18 clause (i) from within the local community  
19 when possible.

20 (C) DUTIES.—

21 (i) IN GENERAL.—Under the project,  
22 members of the team assigned to a site  
23 shall perform detailed observations on the  
24 process of health care delivery, process  
25 analysis and improvement, and financial

1 analysis using hospital data, clinical data  
2 from the site, and medicare claims data.

3 (ii) MEDICARE CLAIMS DATA.—In  
4 order to provide for a more complete anal-  
5 ysis of the total costs and value of care,  
6 the Secretary shall make all medicare  
7 claims data available to members of the  
8 team so that links can be made to charges  
9 associated with physician visits, skilled  
10 nursing facility stays, and home health vis-  
11 its, inpatient and outpatient rehabilitation,  
12 durable medical equipment, clinical labora-  
13 tory tests and other diagnostic tests, in-  
14 cluding imaging, and other items and serv-  
15 ices furnished to medicare beneficiaries.

16 (4) INCENTIVE PAYMENTS.—If the Secretary  
17 determines that the project under this section will  
18 result in reduced expenditures under the Medicare  
19 Trust Funds, the Secretary may make incentive pay-  
20 ments at a site to encourage entities and persons to  
21 participate in the project. The total amount of such  
22 payments may not exceed the total amount of such  
23 reduced expenditures, as estimated by the Secretary.

24 (5) WAIVER AUTHORITY.—The Secretary may  
25 waive such requirements of titles XI and XVIII of

1 the Social Security Act as may be necessary to carry  
2 out the project under this section.

3 (b) REPORT.—

4 (1) IN GENERAL.—Not later than 18 months  
5 after the date of enactment of this Act, the Sec-  
6 retary shall submit to Congress a report on the  
7 project under this section.

8 (2) CONTENTS.—The report submitted under  
9 paragraph (1) shall include—

10 (A) a detailed description of the findings  
11 from each of the 6 sites at which the project  
12 was conducted; and

13 (B) recommendations for such legislation  
14 and administrative actions as the Secretary con-  
15 siders appropriate.

16 (c) FUNDING.—There are authorized to be appro-  
17 priated to the Secretary such sums as may be necessary  
18 to carry out this section.

19 **SEC. 804. DEMONSTRATION PROJECT ON DATA AGGREGA-**  
20 **TION ACROSS ALL PAYORS OF HEALTH CARE**  
21 **SERVICES.**

22 (a) DEMONSTRATION PROJECT.—

23 (1) ESTABLISHMENT.—Not later than 6  
24 months after the date of enactment of this Act, the  
25 Secretary shall establish a demonstration project to

1 evaluate the process, costs, and benefits of aggregating data on quality of care across all payors of  
2 health care costs within health care delivery mar-  
3 kets.  
4

5 (2) DATA.—In selecting data to be aggregated  
6 under the demonstration project under this section,  
7 the Secretary shall give priority to measures which  
8 have the most potential to inform health care deci-  
9 sions by consumers and patients, to improve quality  
10 and efficiency of care delivered, and to be imple-  
11 mented by providers in a timely manner.

12 (3) DURATION.—The demonstration project  
13 under this section shall be conducted for a 2-year  
14 period.

15 (4) SITES.—The Secretary shall conduct the  
16 demonstration project under this section in 3 health  
17 care delivery markets or geographic areas, at least  
18 1 of which shall be a market or an area where qual-  
19 ity of care data is being aggregated from multiple  
20 sources in the private sector.

21 (5) PARTICIPANTS.—Participants in the dem-  
22 onstration project under this section may include re-  
23 gional health information networks, health plans,  
24 self-insured employers, State health programs, and  
25 other entities responsible for payment of costs asso-

1       ciated with health care coverage and with the ex-  
2       change of data related to patient health status, bill-  
3       ing, claims, and health care quality.

4           (6) REQUIREMENT FOR PARTICIPANTS.—Par-  
5       ticipants in the demonstration project under this  
6       section shall comply with any interoperability and  
7       certification standards and processes that have been  
8       developed or adopted by the Secretary or a designee  
9       of the Secretary.

10          (7) WAIVER AUTHORITY.—The Secretary may  
11       waive such requirements of titles XI and XVIII of  
12       the Social Security Act as may be necessary to carry  
13       out the demonstration project under this section.

14       (b) REPORT.—

15           (1) IN GENERAL.—Not later than 1 year after  
16       the demonstration project under this section is com-  
17       pleted, the Secretary shall submit to Congress a re-  
18       port on the demonstration project.

19           (2) CONTENTS.—The report submitted under  
20       paragraph (1) shall include—

21           (A) an analysis of—

22                   (i) the methodologies for data aggrega-  
23                   tion, including processes for aggregation,  
24                   analysis, attribution, risk adjustment, and  
25                   reporting;

1 (ii) issues related to privacy, security,  
2 and data ownership;

3 (iii) the cost-effectiveness of different  
4 methodologies for data aggregation; and

5 (iv) the effects of aggregation on the  
6 information provided to consumers and pa-  
7 tients; and

8 (B) recommendations for such legislation  
9 and administrative actions as the Secretary con-  
10 siders appropriate.

11 (d) FUNDING.—There are authorized to be appro-  
12 priated to the Secretary such sums as may be necessary  
13 to carry out this section.

14 **SEC. 805. GAO STUDIES AND REPORTS ON THE ACCURACY**  
15 **AND COMPLETENESS OF QUALITY DATA.**

16 (a) STUDIES.—The Comptroller General of the  
17 United States shall conduct a study on the following:

18 (1) The accuracy and completeness of the data  
19 submitted by hospitals pursuant to section  
20 1886(b)(3)(B)(viii)(II) of the Social Security Act, as  
21 added by section 201(a)(1)(B), and the appropriate-  
22 ness of value-based payments made to hospitals  
23 under section 1860E–2 of such Act, as added by  
24 section 201(b), based on such data.

1           (2) The accuracy and completeness of the data  
2 submitted by physicians and practitioners pursuant  
3 to section 1848(d)(4)(G)(ii) of the Social Security  
4 Act, as added by section 301(a)(1), and the appro-  
5 priateness of value-based payments made to physi-  
6 cians and practitioners under section 1860E-3 of  
7 such Act, as added by section 301(b), based on such  
8 data.

9           (3) The accuracy and completeness of the data  
10 submitted by organizations pursuant to sections  
11 1852(e)(3) and 1876(h)(6) of the Social Security  
12 Act, as added by section 401(a), and the appro-  
13 priateness of value-based payments made to organi-  
14 zations under section 1860E-4 of such Act, as  
15 added by section 401(b), based on such data.

16           (4) The accuracy and completeness of the data  
17 submitted by providers of services and renal dialysis  
18 facilities pursuant to subsection (b)(4) of section  
19 1860E-5 of the Social Security Act, as added by  
20 section 501(b), and the appropriateness of value-  
21 based payments made to organizations under such  
22 section 1860E-5 based on such data.

23           (5) The accuracy and completeness of the data  
24 submitted by home health agencies pursuant to sec-  
25 tion 1895(b)(3)(B)(v)(II) of the Social Security Act,

1 as added by section 601(a), and the appropriateness  
2 of value-based payments made to organizations  
3 under such section 1860E-6 of such Act, as added  
4 by section 601(b), based on such data.

5 (b) REPORTS.—Not later than 2 years after the im-  
6 plementation of each of the value-based purchasing pro-  
7 grams under sections 1860E-2, 1860E-3, 1860E-4,  
8 1860E-5, and 1860E-6 of the Social Security Act, as  
9 added by this Act, the Comptroller General of the United  
10 States shall submit to Congress and the Secretary a report  
11 on the study conducted under subsection (a) that relates  
12 to data used under the applicable program, together with  
13 such recommendations for legislative or administrative ac-  
14 tion as the Comptroller General determines to be appro-  
15 priate.

16 **SEC. 806. HHS STUDY AND REPORT REGARDING TELE-**  
17 **HEALTH AND TELEMEDICINE.**

18 (a) STUDY.—The Secretary shall conduct, or contract  
19 with a private entity to conduct, a study that examines  
20 the following:

21 (1) The variation among State laws that relate  
22 to the licensure of physicians and practitioners (as  
23 defined in section 1860E-3(a)(3) of the Social Secu-  
24 rity Act, as added by section 301(b)).

1           (2) How such variation impacts the electronic  
2 exchange of health information for the purposes of  
3 telehealth and telemedicine.

4           (3) How such variation impacts the quality and  
5 safety of care furnished to, the experience of, and  
6 the financial cost incurred by, individuals in under-  
7 served and frontier areas who must travel long dis-  
8 tances for routine visits with out-of-State physicians  
9 and practitioners (as so defined).

10          (4) The potential for interstate coordination be-  
11 tween State licensure boards in regulating the prac-  
12 tices of physician and practitioners (as so defined)  
13 to improve the matters described in paragraph (3),  
14 and the potential costs of such coordination.

15          (b) REPORT.—Not later than 1 year after the date  
16 of enactment of this Act, the Secretary shall submit a re-  
17 port to Congress on the study conducted under subsection  
18 (a) together with recommendations for such legislation  
19 and administrative actions as the Secretary considers ap-  
20 propriate.

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