

108TH CONGRESS  
2D SESSION

# S. 2562

To amend title XVIII of the Social Security Act to provide incentives for the furnishing of quality care under Medicare Advantage plans and by end stage renal disease providers and facilities, and for other purposes.

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## IN THE SENATE OF THE UNITED STATES

JUNE 23 (legislative day, JUNE 22), 2004

Mr. BAUCUS 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 furnishing of quality care under Medicare Advantage plans and by end stage renal disease providers and facilities, and for other purposes.

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; TABLE OF CONTENTS.**

4 (a) IN GENERAL.—This Act may be cited as the  
5 “Medicare Quality Improvement Act of 2004”.

6 (b) TABLE OF CONTENTS.—The table of contents of  
7 this Act is as follows:

Sec. 1. Short title; table of contents.  
Sec. 2. Findings.

- Sec. 3. Medicare Advantage and reasonable cost reimbursement contract quality performance incentive payment program.
- Sec. 4. Quality performance incentive payment program for providers and facilities that provide services to medicare beneficiaries with ESRD.
- Sec. 5. Medicare innovative quality practice award program.
- Sec. 6. Quality improvement demonstration program for pediatric renal dialysis facilities providing care to medicare beneficiaries with end stage renal disease.
- Sec. 7. Medicare Quality Advisory Board.
- Sec. 8. Studies and reports on financial incentives for quality items and services under the medicare program.
- Sec. 9. MedPAC study and report on use of adjuster mechanisms under medicare quality performance incentive payment programs.
- Sec. 10. Demonstration program on measuring the quality of health care furnished to pediatric patients under the medicaid and SCHIP programs.
- Sec. 11. Provisions relating to medicaid quality improvements.
- Sec. 12. Demonstration program for Medical Smart Cards.

## 1 **SEC. 2. FINDINGS.**

2 The Senate makes the following findings:

3 (1) The Institute of Medicine has highlighted  
 4 problems with our health care system in the areas  
 5 of quality and patient safety.

6 (2) The New England Journal of Medicine has  
 7 published research in an article entitled “The Qual-  
 8 ity of Health Care Delivered to Adults in the United  
 9 States” showing that adults in the United States re-  
 10 ceive recommended health care only about ½ of the  
 11 time.

12 (3) Payment policies under the medicare pro-  
 13 gram do not include mechanisms designed to im-  
 14 prove the quality of care.

15 (4) The medicare program should reward health  
 16 care providers who show, through measurement and  
 17 reporting of quality indicators and through the prac-

1       tice of innovations, that they are working to deliver  
2       high quality health care to their patients.

3           (5) Reimbursement for services provided under  
4       the original medicare fee-for-service program under  
5       parts A and B of title XVIII of the Social Security  
6       Act should be based on a pay-for-performance sys-  
7       tem.

8           (6) A more aggressive research agenda on the  
9       development of appropriate quality measurement  
10      and payment methodologies under the medicare pro-  
11      gram is necessary.

12 **SEC. 3. MEDICARE ADVANTAGE AND REASONABLE COST**  
13 **REIMBURSEMENT CONTRACT QUALITY PER-**  
14 **FORMANCE INCENTIVE PAYMENT PROGRAM.**

15       (a) PROGRAM.—Part C of title XVIII of the Social  
16      Security Act, as amended by section 241 of the Medicare  
17      Prescription Drug, Improvement, and Modernization Act  
18      of 2003 (Public Law 108–173; 117 Stat. 2214), is amend-  
19      ed by adding at the end the following new section:

20      “QUALITY PERFORMANCE INCENTIVE PAYMENT PROGRAM  
21      “SEC. 1860C–2. (a) PROGRAM.—

22           “(1) IN GENERAL.—The Secretary shall estab-  
23      lish a program under which financial incentive pay-  
24      ments are provided each year to Medicare Advantage  
25      organizations offering Medicare Advantage plans  
26      and organizations that are providing benefits under

1 a reasonable cost reimbursement contract under sec-  
 2 tion 1876(h) that demonstrate the provision of supe-  
 3 rior quality health care to enrollees under the plan  
 4 or contract.

5 “(2) PROGRAM TO BEGIN IN 2007.—The Sec-  
 6 retary shall establish the program so that National  
 7 Performance Quality Payments (described in sub-  
 8 section (c)) and National Quality Improvement Pay-  
 9 ments (described in subsection (d)) are made with  
 10 respect to 2007 and each subsequent year.

11 “(3) REQUIREMENT.—In order for an organiza-  
 12 tion to be eligible for a financial incentive payment  
 13 under this section with respect to a Medicare Advan-  
 14 tage plan or a reasonable cost reimbursement con-  
 15 tract under section 1876(h), the organization shall—

16 “(A) provide for the collection, analysis,  
 17 and reporting of data pursuant to sections  
 18 1852(e)(3) and 1876(h)(8), respectively, with  
 19 respect to the plan or contract; and

20 “(B) not later than a date specified by the  
 21 Secretary during each baseline year (as defined  
 22 in subsection (d)(4)), submit such data on the  
 23 quality measures described in subsection (e)(2)  
 24 as the Secretary determines appropriate for the

1           purpose of establishing a baseline with respect  
2           to the plan or contract.

3           “(4) USE OF MOST RECENT DATA.—Financial  
4           incentive payments under this section shall be based  
5           upon the most recent available quality data.

6           “(5) TIMING OF QUALITY INCENTIVE PAY-  
7           MENTS.—The Secretary shall ensure that financial  
8           incentive payments under this section with respect to  
9           a year are made by March 1 of the subsequent year.

10          “(6) APPLICABILITY OF PROGRAM TO MA  
11          PLANS.—For purposes of this section, the term  
12          ‘Medicare Advantage plan’ shall—

13                 “(A) include both MA regional plans and  
14                 MA local plans; and

15                 “(B) not include an MA plan described in  
16                 subparagraph (A)(ii) or (B) of section  
17                 1851(a)(2).

18          “(b) QUALITY INCENTIVE PAYMENTS.—

19                 “(1) IN GENERAL.—Beginning with 2007, the  
20                 Secretary shall allocate the total amount available  
21                 for financial incentive payments in the year under  
22                 subsection (f) as follows:

23                         “(A) The per beneficiary payment amount  
24                         for National Performance Quality Payments es-  
25                         tablished under paragraph (2) shall be greater

1           than the per beneficiary payment amount for  
 2           National Quality Improvement Payments estab-  
 3           lished under such paragraph.

4           “(B) With respect to National Perform-  
 5           ance Quality Payments, the per beneficiary pay-  
 6           ment amount established under paragraph (2)  
 7           shall be greatest for the organizations offering  
 8           the highest performing plans or contracts.

9           “(C) With respect to National Quality Im-  
 10          provement Payments, the per beneficiary pay-  
 11          ment amount established under paragraph (2)  
 12          shall be greatest for the organizations offering  
 13          plans or contracts with the highest degree of  
 14          improvement.

15          “(2) AMOUNT OF QUALITY INCENTIVE PAY-  
 16          MENT.—

17          “(A) IN GENERAL.—The amount of a fi-  
 18          nancial incentive payment under subsection (c)  
 19          or (d) to a Medicare Advantage organization  
 20          with respect to a Medicare Advantage plan or  
 21          to an organization with respect to a reasonable  
 22          cost reimbursement contract under section  
 23          1876(h) shall be determined by multiplying the  
 24          number of beneficiaries enrolled under the plan  
 25          or contract on the first day of the year for

1           which the payment is provided by a dollar  
 2           amount established by the Secretary (in this  
 3           section referred to as the ‘per beneficiary pay-  
 4           ment amount’) that is the same for all bene-  
 5           ficiaries enrolled under the plan or contract.

6           “(B) LIMITATION ON TOTAL AMOUNT OF  
 7           QUALITY INCENTIVE PAYMENTS.—The total  
 8           amount of all the financial incentive payments  
 9           given with respect to a year shall be equal to  
 10          the amount available for such payments in the  
 11          year under subsection (f).

12          “(3) USE OF QUALITY INCENTIVE PAYMENTS.—  
 13          Financial incentive payments received under this  
 14          section may only be used for the following purposes:

15               “(A) To reduce any beneficiary cost-shar-  
 16               ing applicable under the plan or contract.

17               “(B) To reduce any beneficiary premiums  
 18               applicable under the plan or contract.

19               “(C) To initiate, continue, or enhance  
 20               health care quality programs for enrollees under  
 21               the plan or contract.

22               “(D) To improve the benefit package  
 23               under the plan or contract.

24          “(4) REPORTING ON USE OF QUALITY INCEN-  
 25          TIVE PAYMENTS.—Beginning in 2008, each MA or-

1 organization that receives a financial incentive pay-  
 2 ment under this section shall report to the Secretary  
 3 pursuant to section 1854(a)(7) on how the organiza-  
 4 tion will use such payment.

5 “(5) LIMITATIONS ON QUALITY INCENTIVE PAY-  
 6 MENTS.—

7 “(A) PLAN ONLY ELIGIBLE FOR 1 PAY-  
 8 MENT IN A YEAR.—A Medicare Advantage or-  
 9 ganization offering a Medicare Advantage plan  
 10 or an organization that is providing benefits  
 11 under a reasonable cost reimbursement contract  
 12 under section 1876(h) may not receive more  
 13 than 1 financial incentive payment under this  
 14 section in a year with respect to such plan or  
 15 contract. If an organization with respect to the  
 16 plan or contract is eligible for a National Per-  
 17 formance Quality Payment and a National  
 18 Quality Improvement Payment, the organiza-  
 19 tion shall be given the National Performance  
 20 Quality Payment.

21 “(B) PLAN MUST BE AVAILABLE FOR EN-  
 22 TIRE YEAR.—A Medicare Advantage organiza-  
 23 tion offering a Medicare Advantage plan or an  
 24 organization that is providing benefits under a  
 25 reasonable cost reimbursement contract under



1           section 1876(h) is not eligible for a financial in-  
2           centive payment under this section with respect  
3           to such plan or contract unless the plan or con-  
4           tract offers benefits throughout the year in  
5           which the payment is provided.

6           “(c) NATIONAL PERFORMANCE QUALITY PAY-  
7   MENTS.—The Secretary shall make National Performance  
8   Quality Payments to the Medicare Advantage organiza-  
9   tions and organizations offering reasonable cost reim-  
10   bursement contracts under section 1876(h) with respect  
11   to each Medicare Advantage plan or reasonable cost con-  
12   tract offered by the organization that receives ratings for  
13   the year in the top applicable percent of all plans and con-  
14   tracts rated by the Secretary pursuant to subsection (e)  
15   for the year. For purposes of the preceding sentence, the  
16   term ‘applicable percent’ means a percent determined ap-  
17   propriate by the Secretary in consultation with the Quality  
18   Advisory Board, but in no case less than 20 percent.

19           “(d) NATIONAL QUALITY IMPROVEMENT PAY-  
20   MENTS.—

21           “(1) IN GENERAL.—Subject to paragraph (2),  
22           the Secretary shall make National Quality Improve-  
23           ment Payments to Medicare Advantage organiza-  
24           tions and organizations offering reasonable cost re-  
25           imbursement contracts under section 1876(h) with

1       respect to each Medicare Advantage plan or reason-  
2       able cost reimbursement contract offered by the or-  
3       ganization that receives a rating under subsection  
4       (e) for the payment year that exceeds the rating re-  
5       ceived under such subsection for the plan or contract  
6       for the baseline year.

7               “(2) NATIONAL IMPROVEMENT STANDARD.—  
8       Beginning with 2009, the Secretary may implement  
9       a national improvement standard that Medicare Ad-  
10      vantage plans and reasonable cost reimbursement  
11      contracts must meet in order to receive a National  
12      Quality Improvement Payment.

13              “(3) APPLICATION OF THRESHOLDS.—In deter-  
14      mining whether a rating received under subsection  
15      (e) for the payment year exceeds the rating received  
16      under such subsection for the baseline year, the Sec-  
17      retary shall hold any applicable thresholds constant.  
18      For purposes of the preceding sentence, the term  
19      ‘threshold’ means norms used to assess performance.

20              “(4) BASELINE YEAR DEFINED.—In this sub-  
21      section, the term ‘baseline year’ means the year  
22      prior to the payment year.

23              “(e) RATING METHODOLOGY.—

24              “(1) SCORING AND RANKING SYSTEMS.—

1           “(A) IN GENERAL.—The Secretary shall  
2       develop separate scoring and ranking systems  
3       for purposes of determining which organizations  
4       offering Medicare Advantage plans and reason-  
5       able cost reimbursement contracts under section  
6       1876(h) qualify for—

7           “(i) National Performance Quality  
8       Payments; and

9           “(ii) National Quality Improvement  
10       Payments.

11          “(B) REQUIREMENTS.—In developing, im-  
12       plementing, and updating the scoring and rank-  
13       ing systems, the Secretary shall—

14          “(i) consult with the Quality Advisory  
15       Board established under section 1898;

16          “(ii) take into account the report on  
17       health care performance measures sub-  
18       mitted by the Institute of Medicine of the  
19       National Academy of Sciences under sec-  
20       tion 238 of the Medicare Prescription  
21       Drug, Improvement, and Modernization  
22       Act of 2003; and

23          “(iii) take into account the Managed  
24       Care Organization (MCO) standards and  
25       guideline methodology of the National

Committee for Quality Assurance for  
 awarding total Health Plan Employer  
 Data and Information Set (HEDIS) points  
 (based on HEDIS and Consumer Assess-  
 ment of Health Plans Survey (CAHPS)  
 measures).

“(2) MEASURES.—

“(A) IN GENERAL.—Subject to subpara-  
 graph (B), in developing the scoring and rank-  
 ing systems under paragraph (1), the Secretary  
 shall use all measures determined appropriate  
 by the Secretary. Such measures may include—

“(i) outcome measures for highly  
 prevalent chronic conditions;

“(ii) audited HEDIS outcomes and  
 process measures, CAHPS data, and other  
 data reported to the Department of Health  
 and Human Services; and

“(iii) the Joint Commission on Ac-  
 creditation of Healthcare Organizations  
 core measures.

“(B) SCORING AND RANKING SYSTEM FOR  
 NATIONAL PERFORMANCE QUALITY PAYMENTS  
 ONLY BASED ON MEASURES OF CLINICAL EF-  
 FECTIVENESS.—The scoring and ranking sys-

1           tem for National Performance Quality Pay-  
2           ments shall only include measures of clinical ef-  
3           fectiveness.

4           “(3) WEIGHTS OF MEASURES.—In developing  
5           the scoring and ranking systems under paragraph  
6           (1), the Secretary shall assign weights to the meas-  
7           ures used by the Secretary under such system pur-  
8           suant to paragraph (2). In assigning such weights,  
9           the Secretary shall provide greater weight to the  
10          measures that measure clinical effectiveness.

11          “(4) RISK ADJUSTMENT.—In developing the  
12          scoring and ranking systems under paragraph (1),  
13          the Secretary shall establish procedures for adjust-  
14          ing the data used under the system to take into ac-  
15          count differences in the health status of individuals  
16          enrolled under Medicare Advantage plans and rea-  
17          sonable cost contracts.

18          “(5) UPDATE.—

19                 “(A) IN GENERAL.—The Secretary shall as  
20                 determined appropriate, but in no case more  
21                 often than once each 12-month period, update  
22                 the scoring and ranking systems developed  
23                 under paragraph (1), including the measures  
24                 used by the Secretary under such system pursu-  
25                 ant to paragraph (2), the weights established

1           pursuant to paragraph (3), and the risk adjust-  
2           ment procedures established pursuant to para-  
3           graph (4).

4           “(B) COMPARISON FOR NATIONAL QUAL-  
5           ITY IMPROVEMENT PAYMENTS.—Each update  
6           under subparagraph (A) of the scoring and  
7           ranking system for National Quality Improve-  
8           ment Payments shall allow for the comparison  
9           of data from one year to the next for purposes  
10          of identifying which plans or contracts will re-  
11          ceive such Payments.

12          “(C) CONSULTATION.—In determining  
13          when and how to update the scoring and rank-  
14          ing systems under subparagraph (A), the Sec-  
15          retary shall consult with the Quality Advisory  
16          Board.

17          “(f) FUNDING OF PAYMENTS.—The amount available  
18          for financial incentive payments under this section with  
19          respect to a year shall be equal to the amount of the reduc-  
20          tion in expenditures under the Federal Hospital Insurance  
21          Trust Fund and the Federal Supplementary Medical In-  
22          surance Trust Fund in the year as a result of the amend-  
23          ments made by section 3(b) of the Medicare Quality Im-  
24          provement Act of 2004.”.

1 (b) REDUCTION IN PAYMENTS TO ORGANIZATIONS IN  
2 ORDER TO FUND PROGRAM.—

3 (1) MA PAYMENTS.—

4 (A) IN GENERAL.—Section 1853(j) of the  
5 Social Security Act (42 U.S.C. 1395w–23(j)),  
6 as added by section 222(d) of the Medicare  
7 Prescription Drug, Improvement, and Mod-  
8 ernization Act of 2003 (Public Law 108–173;  
9 117 Stat. 2200), is amended—

10 (i) in subparagraphs (A) and (B) of  
11 paragraph (1), by inserting “and, begin-  
12 ning in 2007, reduced by 2 percent in the  
13 case of an MA plan described in subpara-  
14 graph (A)(i) or (C) of section 1851(a)(2)”  
15 before the semicolon at the end; and

16 (ii) in paragraph (2), by inserting  
17 “and, beginning in 2007, reduced by 2 per-  
18 cent in the case of an MA plan described  
19 in subparagraph (A)(i) or (C) of section  
20 1851(a)(2)” before the period at the end.

21 (B) REDUCTIONS IN PAYMENTS DO NOT  
22 EFFECT THE GOVERNMENT SAVINGS FOR BIDS  
23 BELOW THE BENCHMARK.—Section  
24 1854(b)(1)(C)(i) of the Social Security Act (42  
25 U.S.C. 1395w–24(b)(1)(C)(i)), as added by sec-

tion 222(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2196), is amended—

(i) by striking “75 percent” and inserting “100 percent”; and

(ii) by inserting the following before the period at the end: “, reduced by 25 percent of such average per capita savings (if any), as applicable to the plan and year involved, that would be computed if sections 1853(j) and 1860C–1(e)(1) was applied by substituting ‘zero percent’ for ‘2 percent’ each place it appears”.

(2) REASONABLE COST CONTRACT PAYMENTS.—Section 1876(h) of the Social Security Act (42 U.S.C. 1395mm(h)) is amended by adding at the end the following new paragraph:

“(6) Notwithstanding the preceding provisions of this subsection, the Secretary shall reduce each payment to an eligible organization under this subsection with respect to benefits provided on or after January 1, 2007, by an amount equal to 2 percent of the payment amount. The preceding sentence shall have no effect on payments to



1 eligible organizations for the provision of qualified pre-  
 2 scription drug coverage under part D.”.

3 (3) CCA PAYMENTS.—The first sentence of sec-  
 4 tion 1860C–1(e)(1) of the Social Security Act, as  
 5 added by section 241 of the Medicare Prescription  
 6 Drug, Improvement, and Modernization Act of 2003  
 7 (Public Law 108–173; 117 Stat. 2214) is amended  
 8 by inserting “, reduced by 2 percent in the case of  
 9 an MA plan described in subparagraph (A)(i) or (C)  
 10 of section 1851(a)(2)” before the period at the end.

11 (c) REQUIREMENT FOR REPORTING ON USE OF FI-  
 12 NANCIAL INCENTIVE PAYMENTS.—

13 (1) MA PLANS.—Section 1854(a) of the Social  
 14 Security Act (42 U.S.C. 1395w–24(a)), as amended  
 15 by section 222(a) of the Medicare Prescription  
 16 Drug, Improvement, and Modernization Act of 2003  
 17 (Public Law 108–173; 117 Stat. 2193), is amend-  
 18 ed—

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

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

22 “(7) SUBMISSION OF INFORMATION OF HOW FI-  
 23 NANCIAL INCENTIVE PAYMENTS WILL BE USED BE-  
 24 GINNING IN 2008.—For an MA plan described in  
 25 subparagraph (A)(i) or (C) of section 1851(a)(2) for

1 a plan year beginning on or after January 1, 2008,  
 2 the information described in this paragraph is a de-  
 3 scription of how the organization offering the plan  
 4 will use any financial incentive payment that the or-  
 5 ganization received under section 1860C–2 with re-  
 6 spect to the plan.”.

7 (2) ELIGIBLE ENTITIES WITH REASONABLE  
 8 COST CONTRACTS.—Section 1876(h) of the Social  
 9 Security Act (42 U.S.C. 1395mm(h)), as amended  
 10 by subsection (b)(2), is amended by adding at the  
 11 end the following new paragraph:

12 “(7)(A) Not later than July 1 of each year (beginning  
 13 in 2008), any eligible entity with a reasonable cost reim-  
 14 bursement contract under this subsection that receives a  
 15 financial incentive payment under section 1860C–2 with  
 16 respect to each plan year shall submit to the Secretary  
 17 a report containing the information described in subpara-  
 18 graph (B).

19 “(B) The information described in this subparagraph  
 20 is a description of how the organization offering the plan  
 21 will use any financial incentive payment that the organiza-  
 22 tion received under section 1860C–2 with respect to the  
 23 plan.”.

24 (d) SUBMISSION OF QUALITY DATA.—

(1) MA ORGANIZATIONS.—Section 1852(e) of the Social Security Act (42 U.S.C. 1395w-22(e)), as amended by section 722 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173; 117 Stat. 2347), is amended—

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

(B) by striking paragraph (3) and inserting the following new paragraph:

“(3) COLLECTION, ANALYSIS, AND REPORTING.—

“(i) IN GENERAL.—As part of the quality improvement program under paragraph (1), each MA organization shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality.

“(ii) COORDINATION WITH COMMERCIAL ENROLLEE REPORTING REQUIREMENTS.—The Secretary shall establish procedures to ensure the coordination of the reporting requirement under clause (i) with reporting requirements for the organization under this part relating to individuals enrolled with the organization but not

1           under this part. Although such reporting re-  
2           quirements shall be coordinated pursuant to the  
3           preceding sentence, the use of the data reported  
4           may vary.”.

5           (2) ELIGIBLE ENTITIES WITH REASONABLE  
6           COST CONTRACTS.—Section 1876(h) of the Social  
7           Security Act (42 U.S.C. 1395mm(h)), as amended  
8           by subsection (c)(2), is amended by adding at the  
9           end the following new paragraph:

10          “(8)(A) With respect to plan years beginning on or  
11       after January 1, 2006, an eligible entity with a reasonable  
12       cost reimbursement contract under this subsection shall  
13       provide for the collection, analysis, and reporting of data  
14       that permits the measurement of health outcomes and  
15       other indices of quality.

16          “(B) The Secretary shall establish procedures to en-  
17       sure the coordination of the reporting requirement under  
18       subparagraph (A) with reporting requirements for the en-  
19       tity under this title relating to individuals enrolled with  
20       the entity but not receiving benefits under this title.”.

1 **SEC. 4. QUALITY PERFORMANCE INCENTIVE PAYMENT**  
 2 **PROGRAM FOR PROVIDERS AND FACILITIES**  
 3 **THAT PROVIDE SERVICES TO MEDICARE**  
 4 **BENEFICIARIES WITH ESRD.**

5 Section 1881(b) of the Social Security Act (42 U.S.C.  
 6 1395rr(b)), as amended by section 623(d)(1) of the Medi-  
 7 care Prescription Drug, Improvement, and Modernization  
 8 Act of 2003 (Public Law 108–173; 117 Stat. 2313), is  
 9 amended—

10 (1) in paragraph (11)(B), by striking “para-  
 11 graphs (12) and (13)” and inserting “paragraphs  
 12 (12), (13), and (14)”;

13 (2) in paragraph (12), by striking “In lieu of”  
 14 and inserting “Subject to paragraph (14), in lieu  
 15 of”;

16 (3) in paragraph (13)(A), in the matter pre-  
 17 ceding clause (i), by striking “The payment  
 18 amounts” and inserting “Subject to paragraph (14),  
 19 the payment amounts”; and

20 (4) by adding at the end the following new  
 21 paragraph:

22 “(14) RENAL DIALYSIS PERFORMANCE INCEN-  
 23 TIVE PAYMENT PROGRAM.—

24 “(A) ESTABLISHMENT OF PROGRAM.—

25 “(i) IN GENERAL.—The Secretary  
 26 shall establish a program under which fi-

1           nancial incentive payments are provided  
2           each year to providers of services and renal  
3           dialysis facilities that receive payments  
4           under paragraph (12) or (13) and dem-  
5           onstrate the provision of superior quality  
6           health care to individuals with end stage  
7           renal disease.

8           “(ii) PROGRAM TO BEGIN IN 2007.—  
9           The Secretary shall establish the program  
10          so that National Performance Quality Pay-  
11          ments (described in subparagraph (C)) and  
12          National Quality Improvement Payments  
13          (described in subparagraph (D)) are made  
14          with respect to 2007 and each subsequent  
15          year.

16          “(iii) REQUIREMENT.—In order for a  
17          provider of services or a renal dialysis fa-  
18          cility to be eligible for a financial incentive  
19          payment under this section, the provider or  
20          facility shall, not later than a date speci-  
21          fied by the Secretary during the baseline  
22          year (as defined in subparagraph (D)(iv)),  
23          submit such data on the quality measures  
24          as the Secretary determines appropriate

1 for the purpose of establishing a baseline  
2 with respect to the provider or facility.

3 “(iv) USE OF MOST RECENT DATA.—  
4 Financial incentive payments under this  
5 paragraph shall be based upon the most  
6 recent available quality data as provided by  
7 the Consolidated Renal Operations in a  
8 Web-enabled Network (CROWN) system.

9 “(v) PEDIATRIC FACILITIES NOT IN-  
10 CLUDED IN PROGRAM.—For purposes of  
11 this paragraph, including subparagraph  
12 (F)(i), the terms ‘renal dialysis facility’  
13 and ‘facility’ do not include a renal dialysis  
14 facility at least 50 percent of whose pa-  
15 tients are individuals under 18 years of  
16 age.

17 “(B) PAYMENTS.—

18 “(i) IN GENERAL.—Beginning with  
19 2007, the Secretary shall allocate the total  
20 amount available for financial incentive  
21 payments in the year under subparagraph  
22 (F)(ii) as follows:

23 “(I) The amount allocated for  
24 National Performance Quality Pay-  
25 ments shall be greater than the

1 amount allocated for National Quality  
2 Improvement Payments.

3 “(II) With respect to National  
4 Performance Quality Payments, the  
5 per capita amount of the payments  
6 shall be greatest for the organizations  
7 offering the highest performing plans  
8 or contracts.

9 “(III) With respect to National  
10 Quality Improvement Payments, the  
11 per capita amount of the payments  
12 shall be greatest for the organizations  
13 offering plans or contracts with the  
14 highest degree of improvement.

15 “(ii) AMOUNT OF QUALITY INCENTIVE  
16 PAYMENT.—

17 “(I) IN GENERAL.—The amount  
18 of a financial incentive payment under  
19 subparagraph (C) or (D) to a provider  
20 of services or renal dialysis facility  
21 shall be determined by multiplying the  
22 number of beneficiaries who received  
23 dialysis services from the provider or  
24 facility during the year for which the  
25 payment is provided by a dollar



1 amount established by the Secretary  
2 that is the same with respect to each  
3 beneficiary receiving dialysis services  
4 from the provider or facility.

5 “(II) LIMITATION ON TOTAL  
6 AMOUNT OF QUALITY INCENTIVE PAY-  
7 MENTS.—The total amount of all the  
8 financial incentive payments given  
9 with respect to a year shall be equal  
10 to the amount available for such pay-  
11 ments in the year under subparagraph  
12 (F)(ii).

13 “(iii) USE OF QUALITY INCENTIVE  
14 PAYMENTS.—Financial incentive payments  
15 received under this paragraph may be used  
16 for the following purposes:

17 “(I) To invest in information  
18 technology systems that will improve  
19 the quality of care provided to individ-  
20 uals with end stage renal disease.

21 “(II) To initiate, continue, or en-  
22 hance health care quality programs  
23 for individuals with end stage renal  
24 disease.

1                   “(III) Any other purpose deter-  
2                   mined appropriate by the Secretary.

3                   “(iv) LIMITATIONS ON QUALITY IN-  
4                   CENTIVE PAYMENTS.—

5                   “(I) ONLY ELIGIBLE FOR 1 PAY-  
6                   MENT IN A YEAR.—A provider of serv-  
7                   ices or a renal dialysis facility may  
8                   not receive more than 1 financial in-  
9                   centive payment under this paragraph  
10                  in a year. If a provider of services or  
11                  a renal dialysis facility is eligible for a  
12                  National Performance Quality Pay-  
13                  ment and a National Quality Improve-  
14                  ment Payment, the organization shall  
15                  be given the National Performance  
16                  Quality Payment.

17                  “(II) SERVICES MUST BE AVAIL-  
18                  ABLE FOR ENTIRE YEAR.—A provider  
19                  of services or renal dialysis facility is  
20                  not eligible for a financial incentive  
21                  payment under this paragraph unless  
22                  the provider or facility is in operation  
23                  and providing dialysis services for the  
24                  entire year for which the payment is  
25                  provided.

“(C) NATIONAL PERFORMANCE QUALITY PAYMENTS.—The Secretary shall make National Performance Quality Payments to the providers of services and renal dialysis facilities that receive ratings for the year in the top applicable percent of all providers and facilities rated by the Secretary pursuant to subparagraph (E) for the year. For purposes of the preceding sentence, the term ‘applicable percent’ means a percent determined appropriate by the Secretary in consultation with the Quality Advisory Board, but in no case less than 20 percent.

“(D) NATIONAL QUALITY IMPROVEMENT PAYMENTS.—

“(i) IN GENERAL.—National Quality Improvement Payments shall be paid to each provider of services and renal dialysis facility that receives ratings under subparagraph (E) for the payment year that exceed the ratings received under such subparagraph for the provider or facility for the baseline year.

“(ii) NATIONAL IMPROVEMENT STANDARD.—Beginning with 2009, the

1 Secretary shall have the authority to imple-  
 2 ment a national improvement standard  
 3 that providers of services and renal dialysis  
 4 facilities must meet in order to receive a  
 5 National Quality Improvement Payment.

6 “(iii) APPLICATION OF THRESH-  
 7 OLDS.—In determining whether a rating  
 8 received under subparagraph (E) for the  
 9 payment year exceeds the rating received  
 10 under such subsection for the baseline  
 11 year, the Secretary shall hold any applica-  
 12 ble thresholds constant.

13 “(iv) BASELINE YEAR DEFINED.—In  
 14 this subparagraph, the term ‘baseline year’  
 15 means the year prior to the payment year.

16 “(E) RATING METHODOLOGY.—

17 “(i) SCORING AND RANKING SYS-  
 18 TEMS.—

19 “(I) IN GENERAL.—The Sec-  
 20 retary shall develop separate scoring  
 21 and ranking systems for purposes of  
 22 determining which providers of serv-  
 23 ices and renal dialysis facilities qualify  
 24 for—

1 “(aa) National Performance  
2 Quality Payments; and

3 “(bb) National Quality Im-  
4 provement Payments.

5 “(II) REQUIREMENTS.—In devel-  
6 oping, implementing, and updating  
7 the scoring and ranking systems, the  
8 Secretary shall—

9 “(aa) consult with the Qual-  
10 ity Advisory Board established  
11 under section 1898 and the net-  
12 work administrative organiza-  
13 tions designated under subsection  
14 (c)(1)(A)(i)(II); and

15 “(bb) take into account the  
16 report on health care perform-  
17 ance measures submitted by the  
18 Institute of Medicine of the Na-  
19 tional Academy of Sciences under  
20 section 238 of the Medicare Pre-  
21 scription Drug, Improvement,  
22 and Modernization Act of 2003.

23 “(ii) MEASURES.—

24 “(I) IN GENERAL.—Subject to  
25 subclause (II), in developing the scor-

1 ing and ranking system under clause  
2 (i), the Secretary shall use all meas-  
3 ures determined appropriate by the  
4 Secretary. Such measures may include  
5 the following:

6 “(aa) The measures profiled  
7 in the ESRD Clinical Perform-  
8 ance Measures (CPM) project of  
9 the Centers for Medicare & Med-  
10 icaid Services.

11 “(bb) The measures for bone  
12 disease to be determined by the  
13 K-DOQI project of the National  
14 Kidney Foundation.

15 “(II) Scoring and ranking system  
16 for national performance quality pay-  
17 ments only based on measures of clin-  
18 ical effectiveness.—The scoring and  
19 ranking system for National Perform-  
20 ance Quality Payments shall only in-  
21 clude measures of clinical effective-  
22 ness.

23 “(iii) WEIGHTS OF MEASURES.—In  
24 developing the scoring and ranking sys-  
25 tems under clause (i), the Secretary shall

1 assign weights to the measures used by the  
2 Secretary under such system pursuant to  
3 clause (ii). In assigning such weights, the  
4 Secretary shall provide greater weight to  
5 the measures that measure clinical effec-  
6 tiveness.

7 “(iv) RISK ADJUSTMENT.—In devel-  
8 oping the scoring and ranking systems  
9 under clause (i), the Secretary shall estab-  
10 lish procedures for adjusting the data used  
11 under the system to take into account dif-  
12 ferences in the health status of individuals  
13 receiving dialysis services from providers of  
14 services and renal dialysis facilities.

15 “(v) UPDATE.—

16 “(I) IN GENERAL.—The Sec-  
17 retary shall as determined appro-  
18 priate, but in no case more often than  
19 once each 12-month period, update  
20 the scoring and ranking systems de-  
21 veloped under clause (i), including the  
22 measures used by the Secretary under  
23 such system pursuant to clause (ii),  
24 the weights established pursuant to  
25 clause (iii), and the risk adjustment

1 procedures established pursuant to  
2 clause (iv).

3 “(II) COMPARISON FOR NA-  
4 TIONAL QUALITY IMPROVEMENT PAY-  
5 MENTS.—Each update under sub-  
6 clause (I) of the National Quality Im-  
7 provement Payments shall allow for  
8 the comparison of data from one year  
9 to the next for purposes of identifying  
10 which providers of services and renal  
11 dialysis facilities will receive such Pay-  
12 ments.

13 “(III) CONSULTATION.—In de-  
14 termining when and how to update  
15 the scoring and ranking systems  
16 under subclause (I), the Secretary  
17 shall consult with the Quality Advi-  
18 sory Board.

19 “(F) FUNDING OF PAYMENTS.—

20 “(i) REDUCTION IN PAYMENTS.—In  
21 order to provide the funding for the finan-  
22 cial incentive payments under this para-  
23 graph, for each year (beginning with  
24 2007), the Secretary shall reduce each pay-  
25 ment under paragraphs (12) and (13) to a



1 provider of service and a renal dialysis fa-  
 2 cility by an amount equal to 2 percent of  
 3 the payment.

4 “(ii) AMOUNT AVAILABLE.—The  
 5 amount available for financial incentive  
 6 payments under this section with respect  
 7 to a year shall be equal to the amount of  
 8 the reduction in expenditures under the  
 9 Federal Supplementary Medical Insurance  
 10 Trust Fund in the year as a result of the  
 11 application of clause (i).”.

12 **SEC. 5. MEDICARE INNOVATIVE QUALITY PRACTICE AWARD**  
 13 **PROGRAM.**

14 (a) ESTABLISHMENT.—The Secretary of Health and  
 15 Human Services (in this section referred to as the “Sec-  
 16 retary”) shall establish a program under which the Sec-  
 17 retary shall award bonus payments to entities and individ-  
 18 uals providing items and services under the medicare pro-  
 19 gram under title XVIII of the Social Security Act that  
 20 demonstrate innovative practices, structural improve-  
 21 ments, or capacity enhancements that improve the quality  
 22 of health care provided to medicare beneficiaries by such  
 23 entities and individuals.

24 (b) PERIOD OF PROGRAM.—Awards under the pro-  
 25 gram shall be made during 2006, 2007, and 2008.

1 (c) SELECTION OF RECIPIENTS.—

2 (1) IN GENERAL.—The Secretary shall ensure  
3 that the entities and individuals that receive an  
4 award under this section have demonstrated im-  
5 provements in the quality of health care provided to  
6 medicare beneficiaries by such entities and individ-  
7 uals through comparison with a control group or  
8 baseline evaluation. For purposes of the program,  
9 improvements in the quality of health care provided  
10 to medicare beneficiaries shall be defined as pro-  
11 viding additional services, such as translator services  
12 and health literacy education services, or providing  
13 care to an expanded service area or an expanded  
14 population through telemedicine, increased cultural  
15 competence, or other means, in combination with im-  
16 proved health outcomes or reduced beneficiary costs.

17 (2) ALL ENTITIES AND INDIVIDUALS ELIGI-  
18 BLE.—Any entity, including a plan, or individual  
19 that is providing services under the medicare pro-  
20 gram is eligible for receiving an award under this  
21 section.

22 (3) CONSULTATION.—In selecting the recipients  
23 of the awards under this section, the Secretary shall  
24 consult with the Quality Advisory Board established

1 under section 1898 of the Social Security Act, as  
2 added by section 7.

3 (d) MINIMUM NUMBER OF AWARDS.—The Secretary  
4 shall make at least 10 awards under this section in each  
5 year of the program.

6 (e) APPLICATION.—An entity or individual desiring  
7 an award under this section shall submit an application  
8 to the Secretary at such time, in such manner, and accom-  
9 panied by such information as the Secretary may reason-  
10 ably require.

11 (f) AMOUNT OF AWARD.—

12 (1) IN GENERAL.—Subject to paragraph (2)  
13 and subsection (h), the Secretary shall determine the  
14 amount of awards under this section.

15 (2) REQUIREMENT.—In determining the  
16 amount of awards under this section, the Secretary  
17 shall ensure that—

18 (A) no single award is excessive; and

19 (B) consideration is given to the number of  
20 beneficiaries served by the entity or individual  
21 receiving the award.

22 (g) REPORT.—Not later than 6 months after the date  
23 on which the program established under subsection (a)  
24 ends, the Secretary shall submit to Congress a report on  
25 the program together with such recommendations for leg-

1 islation or administrative action as the Secretary deter-  
 2 mines appropriate.

3 (h) FUNDING.—Out of any funds in the Treasury not  
 4 otherwise appropriated, there are appropriated  
 5 \$10,000,000 for each of 2006, 2007, and 2008 to carry  
 6 out this section.

7 **SEC. 6. QUALITY IMPROVEMENT DEMONSTRATION PRO-**  
 8 **GRAM FOR PEDIATRIC RENAL DIALYSIS FA-**  
 9 **CILITIES PROVIDING CARE TO MEDICARE**  
 10 **BENEFICIARIES WITH END STAGE RENAL DIS-**  
 11 **EASE.**

12 (a) DEMONSTRATION PROJECTS.—

13 (1) ESTABLISHMENT.—The Secretary of Health  
 14 and Human Services (in this section referred to as  
 15 the “Secretary”) shall conduct a 3-year demonstra-  
 16 tion program under which the Secretary establishes  
 17 demonstration projects that encourage pediatric di-  
 18 alysis facilities to provide superior quality health  
 19 care to individuals with end stage renal disease.

20 (2) CONSULTATION IN SELECTING SITES.—In  
 21 selecting the demonstration project sites under this  
 22 section, the Secretary shall consult with the Quality  
 23 Advisory Board established under section 1898 of  
 24 the Social Security Act, as added by section 7.

1           (3) SUBMISSION OF QUALITY DATA.—Under the  
2       demonstration projects, demonstration sites shall se-  
3       lect appropriate measures of quality of care provided  
4       to individuals eligible for benefits under title XVIII  
5       of the Social Security Act who are under 18 years  
6       of age and shall report data on such measures to the  
7       Secretary.

8           (4) ASSESSMENT OF MEASURES.—The Sec-  
9       retary, in consultation with the Quality Advisory  
10      Board, shall assess the validity and reliability of the  
11      measures selected under paragraph (2).

12      (b) WAIVER AUTHORITY.—The Secretary may waive  
13      such requirements of titles XI and XVIII as may be nec-  
14      essary to carry out the purposes of the demonstration pro-  
15      gram established under this section.

16      (c) FUNDING.—

17           (1) IN GENERAL.—Subject to paragraph (2),  
18      the Secretary shall provide for the transfer from the  
19      Federal Supplementary Medical Insurance Trust  
20      Fund under section 1841 of the Social Security Act  
21      (42 U.S.C. 1395t) of such funds as are necessary  
22      for the costs of carrying out the demonstration pro-  
23      gram under this section.

24           (2) BUDGET NEUTRALITY.—In conducting the  
25      demonstration program under this section, the Sec-

1       retary shall ensure that the aggregate expenditures  
 2       made by the Secretary do not exceed the amount  
 3       which the Secretary would have expended if the  
 4       demonstration program under this section was not  
 5       implemented.

6       (d) REPORT.—Not later than 6 months after the date  
 7       on which the demonstration program established under  
 8       this section ends, the Secretary shall prepare and submit  
 9       to Congress a report on the demonstration program to-  
 10      gether with—

11           (1) recommendations on whether pediatric renal  
 12           dialysis facilities should be included in the renal di-  
 13           alysis performance payment program under section  
 14           1881(b)(14) of the Social Security Act (42 U.S.C.  
 15           1395rr(b)(14)), as added by section 4(4); and

16           (2) such recommendations for legislation or ad-  
 17           ministrative action as the Secretary determines ap-  
 18           propriate.

19       (e) PEDIATRIC RENAL DIALYSIS FACILITY DE-  
 20      FINED.—The term “pediatric renal dialysis facility”  
 21      means a renal dialysis facility that receives payments  
 22      under paragraph (12) or (13) of section 1881(b) of the  
 23      Social Security Act (42 U.S.C. 1395rr(b)) and is not eligi-  
 24      ble to participate in the renal dialysis performance pay-  
 25      ment program under paragraph (14) of such section (as

1 added by section 4(4)) because of the application of sub-  
 2 paragraph (A)(iv) of such paragraph.

3 **SEC. 7. MEDICARE QUALITY ADVISORY BOARD.**

4 Title XVIII of the Social Security Act, as amended  
 5 by section 1016 of the Medicare Prescription Drug, Im-  
 6 provement, and Modernization Act of 2003 (Public Law  
 7 108–173; 117 Stat. 2447), is amended by adding at the  
 8 end the following new section:

9 “QUALITY ADVISORY BOARD

10 “SEC. 1898. (a) ESTABLISHMENT.—The Secretary  
 11 shall establish a Medicare Quality Advisory Board (in this  
 12 section referred to as the ‘Board’).

13 “(b) MEMBERSHIP AND TERMS.—

14 “(1) IN GENERAL.—Subject to paragraphs (3),  
 15 (4), and (5), the Board shall be composed of rep-  
 16 resentatives described in paragraph (2) who shall  
 17 serve for such term as the Secretary may specify.

18 “(2) REPRESENTATIVES.—Representatives de-  
 19 scribed in this subparagraph include representatives  
 20 of the following:

21 “(A) Patients or patient advocate organi-  
 22 zations.

23 “(B) Individuals with expertise in the pro-  
 24 vision of quality care, such as medical directors,  
 25 heads of hospital quality improvement commit-

1           tees, health insurance plan representatives, and  
2           academic researchers.

3           “(C) Health care professionals and pro-  
4           viders.

5           “(D) Organizations that focus on the  
6           measurement and reporting of quality indica-  
7           tors.

8           “(E) State government health care pro-  
9           grams.

10          “(3) MAJORITY NONPROVIDERS.—Individuals  
11       who are directly involved in the provision, or man-  
12       agement of the delivery, of items and services cov-  
13       ered under this title shall not constitute a majority  
14       of the membership of the Board.

15          “(4) EXPERIENCE WITH URBAN AND RURAL  
16       HEALTH CARE ISSUES.—The membership of the  
17       Board should be representative of individuals with  
18       experience with urban health care issues and individ-  
19       uals with experience with rural health care issues.

20          “(5) EXPERIENCE ACROSS A SPECTRUM OF AC-  
21       TIVITIES.—The membership of the Board should be  
22       representative of individuals with experience across  
23       the spectrum of activities that the Secretary is re-  
24       sponsible for with respect to this title, including the  
25       coverage of new services and technologies, payment



1 rates and methodologies, beneficiary services, and  
2 claims processing.

3 “(c) DUTIES.—

4 “(1) INCENTIVE PROGRAMS.—

5 “(A) ADVICE.—The Board shall advise the  
6 Secretary regarding—

7 “(i) the development, implementation,  
8 and updating of the scoring and ranking  
9 systems under sections 1860C–2(e) and  
10 1881(b)(14)(E);

11 “(ii) the determination of the applica-  
12 ble percent for national performance qual-  
13 ity payments under sections 1860C–2(c)  
14 and 1881(b)(14)(C);

15 “(iii) the selection of recipients of in-  
16 novative quality practice awards under the  
17 program under section 5 of the Medicare  
18 Quality Improvement Act of 2004;

19 “(iv) the selection of demonstration  
20 project sites and the assessment of meas-  
21 ures of quality of care under the dem-  
22 onstration program under section 6 of the  
23 Medicare Quality Improvement Act of  
24 2004; and

1 “(v) the study and report under sec-  
2 tion 8(b) of the Medicare Quality Improve-  
3 ment Act of 2004.

4 “(B) ANNUAL REPORT ON INCENTIVE PRO-  
5 GRAMS.—The Board shall submit an annual re-  
6 port to the Secretary and Congress on the pro-  
7 grams under sections 1860C–2 and  
8 1881(b)(14).

9 “(C) ADDITIONAL DUTIES.—The Board  
10 shall perform such additional functions to assist  
11 the Secretary in carrying out the programs de-  
12 scribed in clauses (ii) and (iii) of subparagraph  
13 (A) and in subparagraph (B) as the Secretary  
14 may specify.

15 “(2) DEVELOPMENT AND ASSESSMENT OF NA-  
16 TIONAL PRIORITIES AND AGENDA.—The Board shall  
17 develop and assess national priorities and an agenda  
18 for improving the quality of items and services fur-  
19 nished to individuals entitled to benefits under this  
20 title.

21 “(d) WAIVER OF ADMINISTRATIVE LIMITATION.—  
22 The Secretary shall establish the Board notwithstanding  
23 any limitation that may apply to the number of advisory  
24 committees that may be established (within the Depart-  
25 ment of Health and Human Services or otherwise).”.

1 **SEC. 8. STUDIES AND REPORTS ON FINANCIAL INCENTIVES**  
2 **FOR QUALITY ITEMS AND SERVICES UNDER**  
3 **THE MEDICARE PROGRAM.**

4 (a) IOM STUDY AND REPORT ON HOW MEDICARE  
5 PAYMENTS FOR ITEMS AND SERVICES AFFECT THE  
6 QUALITY OF SUCH ITEMS AND SERVICES.—

7 (1) STUDY.—The Secretary of Health and  
8 Human Services (in this section referred to as the  
9 “Secretary”) shall request the Institute of Medicine  
10 of the National Academy of Sciences to conduct a  
11 study on how the payment mechanisms for items  
12 and services under the original medicare fee-for-serv-  
13 ice program under parts A and B of title XVIII of  
14 the Social Security Act effect the quality of such  
15 items and services.

16 (2) REPORT TO CONGRESS.—Not later than  
17 January 1, 2006, the Secretary shall submit to Con-  
18 gress a report on the results of the study described  
19 in paragraph (1) together with such recommenda-  
20 tions for legislation or administrative action as the  
21 Secretary determines appropriate.

22 (b) HHS STUDY AND REPORT ON PROVIDING FI-  
23 NANCIAL INCENTIVES FOR QUALITY SERVICES UNDER  
24 THE ORIGINAL MEDICARE FEE-FOR-SERVICE PRO-  
25 GRAM.—

1           (1) STUDY.—The Secretary of Health and  
2           Human Services shall conduct a study on the actions  
3           necessary to establish a payment system under the  
4           original medicare fee-for-service program under  
5           parts A and B of title XVIII of the Social Security  
6           Act that aligns the quality of services provided under  
7           such program with the reimbursement provided  
8           under such program for such services.

9           (2) REPORT.—

10           (A) IN GENERAL.—Not later than January  
11           1, 2008, the Secretary shall submit a report to  
12           Congress on the study conducted under para-  
13           graph (1).

14           (B) CONTENTS.—The report submitted  
15           under subparagraph (A) shall contain rec-  
16           ommendations with respect to—

17                   (i) the incremental steps necessary to  
18                   develop the payment system described in  
19                   paragraph (1);

20                   (ii) the performance measures to be  
21                   used under such payment system;

22                   (iii) the incentive approaches to be  
23                   used under such payment system;

1 (iv) the geographic and risk adjusters  
 2 to be used under such payment system;  
 3 and

4 (v) a strategy for aligning payment  
 5 with performance across all parts of the  
 6 medicare program.

7 (3) REQUIREMENT.—In conducting the study  
 8 under paragraph (1) and preparing the report under  
 9 paragraph (2), the Secretary shall—

10 (A) consult with the Quality Advisory  
 11 Board established under section 1898 of the  
 12 Social Security Act, as added by section 7; and

13 (B) take into account the report on health  
 14 care performance measures submitted by the  
 15 Institute of Medicine of the National Academy  
 16 of Sciences under section 238 of the Medicare  
 17 Prescription Drug, Improvement, and Mod-  
 18 ernization Act of 2003 (Public Law 108–173;  
 19 117 Stat. 2213).

20 **SEC. 9. MEDPAC STUDY AND REPORT ON USE OF ADJUSTER**  
 21 **MECHANISMS UNDER MEDICARE QUALITY**  
 22 **PERFORMANCE INCENTIVE PAYMENT PRO-**  
 23 **GRAMS.**

24 (a) STUDY.—The Medicare Payment Advisory Com-  
 25 mission shall conduct a study—

1           (1) to determine whether it is appropriate to in-  
2       corporate a geographic adjuster into the quality per-  
3       formance incentive payment programs under sections  
4       1860C–2 and 1881(b)(14) of the Social Security  
5       Act, as added by sections 3 and 4, respectively, to  
6       account for different environments of care, regional  
7       payment variation, regional variation of patient sat-  
8       isfaction, and regional case mix variation; and

9           (2) on the most appropriate methods to risk ad-  
10      just data used under the scoring and ranking system  
11      under such programs pursuant to sections 1860C–  
12      2(e)(4) and 1881(b)(14)(E)(iv) of the Social Secu-  
13      rity Act.

14      (b) REPORT.—Not later than January 1, 2006, the  
15      Commission shall submit a report to Congress and the  
16      Secretary of Health and Human Services on the study  
17      conducted under subsection (a) together with rec-  
18      ommendations for such legislation and administrative ac-  
19      tions as the Commission considers appropriate. If such  
20      study concludes that a geographic adjuster described in  
21      subsection (a)(1) is appropriate, the Commission shall in-  
22      clude in the report recommendations on how such adjuster  
23      could be incorporated into the quality performance incen-  
24      tive payment programs described in such subsection.

1 **SEC. 10. DEMONSTRATION PROGRAM ON MEASURING THE**  
2 **QUALITY OF HEALTH CARE FURNISHED TO**  
3 **PEDIATRIC PATIENTS UNDER THE MEDICAID**  
4 **AND SCHIP PROGRAMS.**

5 (a) ESTABLISHMENT.—

6 (1) IN GENERAL.—The Secretary of Health and  
7 Human Services (in this section referred to as the  
8 “Secretary”) shall conduct a 3-year demonstration  
9 program to examine the development and use of  
10 quality measures, pay-for-performance programs,  
11 and other strategies in order to encourage providers  
12 to furnish superior quality health care to individuals  
13 under 18 years of age under the medicaid program  
14 under title XIX of the Social Security Act (42  
15 U.S.C. 1396 et seq.) and under the SCHIP program  
16 under title XXI of such Act (42 U.S.C. 1397aa et  
17 seq.).

18 (2) AUTHORITY.—The Secretary shall conduct  
19 the demonstration program under this section pursu-  
20 ant to the authority provided under this section and  
21 not under the authority provided under section 1115  
22 of the Social Security Act (42 U.S.C. 1315).

23 (b) SITES TO INCLUDE MULTIPLE SETTINGS AND  
24 PROVIDERS.—In selecting the demonstration program  
25 sites under this section, the Secretary shall ensure that  
26 the sites include health care delivery in multiple settings

1 and through multiple providers, such as school-based set-  
2 tings and mental health providers.

3 (c) WAIVER AUTHORITY.—The Secretary may waive  
4 such requirements of titles XI, XIX, and XXI of the Social  
5 Security Act (42 U.S.C. 1301 et seq.; 1396 et seq.;  
6 1397aa et seq.) as may be necessary to carry out the pur-  
7 poses of the demonstration program under this section.

8 (d) FUNDING.—

9 (1) IN GENERAL.—Subject to paragraph (2),  
10 for purposes of conducting the demonstration pro-  
11 gram under this section, expenditures under the  
12 demonstration program shall be treated as medical  
13 assistance under section 1903 of the Social Security  
14 Act (42 U.S.C. 1396) or child health assistance  
15 under section 2105 of such Act (42 U.S.C. 1397).

16 (2) BUDGET NEUTRALITY.—In conducting the  
17 demonstration program under this section, the Sec-  
18 retary shall ensure that the aggregate expenditures  
19 made by the Secretary do not exceed the amount  
20 which the Secretary would have expended if the  
21 demonstration program under this section had not  
22 been implemented.

23 (e) REPORT.—Not later than 6 months after the date  
24 on which the demonstration program under this section  
25 ends, the Secretary shall submit to Congress a report on



1 the demonstration program together with such rec-  
 2 ommendations for legislation or administrative action as  
 3 the Secretary determines appropriate.

4 **SEC. 11. PROVISIONS RELATING TO MEDICAID QUALITY IM-**  
 5 **PROVEMENTS.**

6 (a) AUTHORIZATION FOR ADDITIONAL STAFF AT  
 7 THE CENTER FOR MEDICAID AND STATE OPERATIONS.—

8 (1) ADDITIONAL STAFF.—The Secretary of  
 9 Health and Human Services shall have the authority  
 10 to hire 5 full-time employees to be employed within  
 11 the Center for Medicaid and State Operations within  
 12 the Centers for Medicare & Medicaid Services from  
 13 among individuals who have experience with, or have  
 14 been trained as, health professionals and who have  
 15 experience in any of the following areas:

16 (A) Quality improvement.

17 (B) Chronic care management.

18 (C) Care coordination.

19 (2) REQUIREMENT FOR EXPERIENCE WITH PE-  
 20 DIATRIC POPULATIONS.—At least 1 of the individ-  
 21 uals employed within the Center for Medicaid and  
 22 State Operations pursuant to paragraph (1) shall  
 23 have experience with pediatric populations.

24 (3) DUTIES OF ADDITIONAL STAFF.—The em-  
 25 ployees hired under paragraph (1) shall be respon-

sible for developing strategies to access and promote quality improvement, chronic care management, and care coordination with the medicaid program and for providing technical assistance to the States.

(4) AUTHORIZATION OF APPROPRIATIONS.—

There are authorized to be appropriated such sums as may be necessary to carry out this subsection.

(b) CMS STUDY AND REPORT ON MEDICARE AND MEDICAID DATA COORDINATION.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study to identify—

(A) efforts to coordinate and integrate data from the medicare program under title XVIII of the Social Security Act and the medicaid program under title XIX of such Act;

(B) barriers to data coordination;

(C) the potential benefits of data integration as perceived by medicare and medicaid program officials, policymakers, health care providers, and beneficiaries; and

(D) steps necessary to coordinate and integrate the beneficiary data from the medicare and medicaid programs.

(2) REPORT TO CONGRESS.—Not later than December 31, 2004, the Secretary of Health and

1 Human Services shall submit to Congress a report  
2 on the results of the study conducted under para-  
3 graph (1) together with such recommendations for  
4 legislation or administrative action as the Secretary  
5 determines appropriate.

6 (c) MEDPAC STUDY AND REPORT ON BENEFICIARIES  
7 WHO ARE DUALY ELIGIBLE FOR MEDICARE AND MED-  
8 ICAID.—

9 (1) STUDY.—The Medicare Payment Advisory  
10 Commission shall conduct a study to determine the  
11 characteristics of individuals who are eligible to re-  
12 ceive benefits under both the medicare and medicaid  
13 programs under titles XVIII and XIX of the Social  
14 Security Act, respectively, identify the costliest  
15 groups of individuals who are eligible for benefits  
16 under both programs, identify the services used by  
17 such individuals, and develop recommendations on  
18 how the provision of those services could be better  
19 coordinated for improved health outcomes and re-  
20 duced costs.

21 (2) REPORT.—Not later than June 30, 2005,  
22 the Commission shall submit a report to Congress  
23 on the study conducted under paragraph (1) to-  
24 gether with recommendations for such legislation

1 and administrative actions as the Commission con-  
2 siders appropriate.

3 (d) MEDPAC STUDY AND REPORT ON CARE COORDI-  
4 NATION PROGRAMS FOR DUAL-ELIGIBLES.—

5 (1) STUDY.—The Medicare Payment Advisory  
6 Commission shall conduct a study on care coordina-  
7 tion programs available to individuals who are eligi-  
8 ble to receive benefits under both the medicare and  
9 medicaid programs under titles XVIII and XIX of  
10 the Social Security Act, respectively, the impact of  
11 such care coordination programs on those individ-  
12 uals, the impact of such care coordination programs  
13 on the costs of the medicare and medicaid programs  
14 to the Federal Government, and whether any savings  
15 from care coordination programs are counted as a  
16 benefit to either program.

17 (2) REPORT.—Not later than June 30, 2005,  
18 the Commission shall submit a report to Congress  
19 on the study conducted under paragraph (1) to-  
20 gether with recommendations for such legislation  
21 and administrative actions as the Commission con-  
22 siders appropriate.

1 **SEC. 12. DEMONSTRATION PROGRAM FOR MEDICAL SMART**  
2 **CARDS.**

3 (a) IN GENERAL.—The Secretary of Health and  
4 Human Services (in this section referred to as the “Sec-  
5 retary”) shall establish a 5-year demonstration program  
6 under which the Secretary shall award grants for the es-  
7 tablishment of demonstration projects to provide for the  
8 development and use of Medical Smart Cards and to ex-  
9 amine the impact of Medical Smart Cards on health care  
10 costs, quality of care, and patient safety.

11 (b) ELIGIBILITY.—To be eligible to receive a grant  
12 under subsection (a), an entity shall be a public or private  
13 nonprofit entity.

14 (c) APPLICATION.—An eligible entity desiring a grant  
15 under this section shall submit an application to the Sec-  
16 retary at such time, in such manner, and accompanied by  
17 such information as the Secretary may reasonably require.

18 (d) APPROVAL OF APPLICATIONS.—

19 (1) IN GENERAL.—The Secretary shall approve  
20 applications for grants under this section in accord-  
21 ance with criteria established by the Secretary.

22 (2) LIMITATION.—The Secretary shall approve  
23 at least 1 application for a demonstration project  
24 that is conducted at a hospital or hospital system  
25 with a large rural service area.

1       (e) USE OF FUNDS.—An eligible entity shall use  
2 amounts received under a grant under this section to carry  
3 out the purposes described in subsection (a).

4       (f) REPORT.—Not later than 6 months after the date  
5 on which the demonstration program established under  
6 subsection (a) ends, the Secretary shall submit to Con-  
7 gress a report on the demonstration program together  
8 with such recommendations for legislation or administra-  
9 tive action as the Secretary determines appropriate.

10      (g) AUTHORIZATION OF APPROPRIATIONS.—There  
11 are authorized to be appropriated such sums as may be  
12 necessary to carry out this section.

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