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.

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.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) IN GENERAL.—This Act may be cited as the ''Medicare Quality Improvement Act of 2004''.

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

SEC. 2. FINDINGS.

The Senate makes the following findings:

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

(2) The New England Journal of Medicine has published research in an article entitled ''The Quality of Health Care Delivered to Adults in the United States'' showing that adults in the United States receive recommended health care only about ½ of the time.

(3) Payment policies under the medicare program do not include mechanisms designed to improve the quality of care.

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

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

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

(6) A more aggressive research agenda on the development of appropriate quality measurement and payment methodologies under the medicare program is necessary.

SEC. 3. MEDICARE ADVANTAGE AND REASONABLE COST REIMBURSEMENT CONTRACT QUALITY PERFORMANCE INCENTIVE PAYMENT PROGRAM.

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

''QUALITY PERFORMANCE INCENTIVE PAYMENT PROGRAM

''SEC. 1860C–2. (a) PROGRAM.—

''(1) IN GENERAL.—The Secretary shall establish a program under which financial incentive payments are provided each year to Medicare Advantage organizations offering Medicare Advantage plans and organizations that are providing benefits under

a reasonable cost reimbursement contract under section 1876(h) that demonstrate the provision of superior quality health care to enrollees under the plan or contract.

''(2) PROGRAM TO BEGIN IN 2007.—The Secretary shall establish the program so that National Performance Quality Payments (described in subsection (c)) and National Quality Improvement Payments (described in subsection (d)) are made with respect to 2007 and each subsequent year.

''(3) REQUIREMENT.—In order for an organization to be eligible for a financial incentive payment under this section with respect to a Medicare Advantage plan or a reasonable cost reimbursement contract under section 1876(h), the organization shall—

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

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

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

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

''(5) TIMING OF QUALITY INCENTIVE PAYMENTS.—The Secretary shall ensure that financial incentive payments under this section with respect to a year are made by March 1 of the subsequent year.

''(6) APPLICABILITY OF PROGRAM TO MA PLANS.—For purposes of this section, the term 'Medicare Advantage plan' shall—

''(A) include both MA regional plans and MA local plans; and

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

''(b) QUALITY INCENTIVE PAYMENTS.—

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

''(A) The per beneficiary payment amount for National Performance Quality Payments established under paragraph (2) shall be greater

than the per beneficiary payment amount for National Quality Improvement Payments established under such paragraph.

''(B) With respect to National Performance Quality Payments, the per beneficiary payment amount established under paragraph (2) shall be greatest for the organizations offering the highest performing plans or contracts.

''(C) With respect to National Quality Improvement Payments, the per beneficiary payment amount established under paragraph (2) shall be greatest for the organizations offering plans or contracts with the highest degree of improvement.

''(2) AMOUNT OF QUALITY INCENTIVE PAYMENT.—

''(A) IN GENERAL.—The amount of a financial incentive payment under subsection (c) or (d) to a Medicare Advantage organization with respect to a Medicare Advantage plan or to an organization with respect to a reasonable cost reimbursement contract under section 1876(h) shall be determined by multiplying the number of beneficiaries enrolled under the plan or contract on the first day of the year for

which the payment is provided by a dollar amount established by the Secretary (in this section referred to as the 'per beneficiary payment amount') that is the same for all beneficiaries enrolled under the plan or contract.

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

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

''(A) To reduce any beneficiary cost-sharing applicable under the plan or contract.

''(B) To reduce any beneficiary premiums applicable under the plan or contract.

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

''(D) To improve the benefit package under the plan or contract.

''(4) REPORTING ON USE OF QUALITY INCENTIVE PAYMENTS.—Beginning in 2008, each MA or-

ganization that receives a financial incentive payment under this section shall report to the Secretary pursuant to section 1854(a)(7) on how the organization will use such payment.

''(5) LIMITATIONS ON QUALITY INCENTIVE PAYMENTS.—

''(A) PLAN ONLY ELIGIBLE FOR 1 PAYMENT IN A YEAR.—A Medicare Advantage organization offering a Medicare Advantage plan or an organization that is providing benefits under a reasonable cost reimbursement contract under section 1876(h) may not receive more than 1 financial incentive payment under this section in a year with respect to such plan or contract. If an organization with respect to the plan or contract is eligible for a National Performance Quality Payment and a National Quality Improvement Payment, the organization shall be given the National Performance Quality Payment.

''(B) PLAN MUST BE AVAILABLE FOR ENTIRE YEAR.—A Medicare Advantage organization offering a Medicare Advantage plan or an organization that is providing benefits under a reasonable cost reimbursement contract under

section 1876(h) is not eligible for a financial incentive payment under this section with respect to such plan or contract unless the plan or contract offers benefits throughout the year in which the payment is provided.

''(c) NATIONAL PERFORMANCE QUALITY PAYMENTS.—The Secretary shall make National Performance Quality Payments to the Medicare Advantage organizations and organizations offering reasonable cost reimbursement contracts under section 1876(h) with respect to each Medicare Advantage plan or reasonable cost contract offered by the organization that receives ratings for the year in the top applicable percent of all plans and contracts rated by the Secretary pursuant to subsection (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.—

''(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall make National Quality Improvement Payments to Medicare Advantage organizations and organizations offering reasonable cost reimbursement contracts under section 1876(h) with

respect to each Medicare Advantage plan or reasonable cost reimbursement contract offered by the organization that receives a rating under subsection (e) for the payment year that exceeds the rating received under such subsection for the plan or contract for the baseline year.

''(2) NATIONAL IMPROVEMENT STANDARD.—Beginning with 2009, the Secretary may implement a national improvement standard that Medicare Advantage plans and reasonable cost reimbursement contracts must meet in order to receive a National Quality Improvement Payment.

''(3) APPLICATION OF THRESHOLDS.—In determining whether a rating received under subsection (e) for the payment year exceeds the rating received under such subsection for the baseline year, the Secretary shall hold any applicable thresholds constant. For purposes of the preceding sentence, the term 'threshold' means norms used to assess performance.

''(4) BASELINE YEAR DEFINED.—In this subsection, the term 'baseline year' means the year prior to the payment year.

''(e) RATING METHODOLOGY.—

''(1) SCORING AND RANKING SYSTEMS.—

''(A) IN GENERAL.—The Secretary shall develop separate scoring and ranking systems for purposes of determining which organizations offering Medicare Advantage plans and reasonable cost reimbursement contracts under section 1876(h) qualify for—

''(i) National Performance Quality Payments; and

''(ii) National Quality Improvement Payments.

''(B) REQUIREMENTS.—In developing, implementing, and updating the scoring and ranking systems, the Secretary shall—

''(i) consult with the Quality Advisory Board established under section 1898;

''(ii) take into account the report on health care performance measures submitted by the Institute of Medicine of the National Academy of Sciences under section 238 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003; and

''(iii) take into account the Managed Care Organization (MCO) standards and 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 Assessment of Health Plans Survey (CAHPS) measures).

''(2) MEASURES.—

''(A) IN GENERAL.—Subject to subparagraph (B), in developing the scoring and ranking 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 Accreditation of Healthcare Organizations core measures.

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

tem for National Performance Quality Payments shall only include measures of clinical effectiveness.

''(3) WEIGHTS OF MEASURES.—In developing the scoring and ranking systems under paragraph (1), the Secretary shall assign weights to the measures used by the Secretary under such system pursuant to paragraph (2). In assigning such weights, the Secretary shall provide greater weight to the measures that measure clinical effectiveness.

''(4) RISK ADJUSTMENT.—In developing the scoring and ranking systems under paragraph (1), the Secretary shall establish procedures for adjusting the data used under the system to take into account differences in the health status of individuals enrolled under Medicare Advantage plans and reasonable cost contracts.

''(5) UPDATE.—

''(A) IN GENERAL.—The Secretary shall as determined appropriate, but in no case more often than once each 12-month period, update the scoring and ranking systems developed under paragraph (1), including the measures used by the Secretary under such system pursuant to paragraph (2), the weights established

pursuant to paragraph (3), and the risk adjustment procedures established pursuant to paragraph (4).

''(B) COMPARISON FOR NATIONAL QUALITY IMPROVEMENT PAYMENTS.—Each update under subparagraph (A) of the scoring and ranking system for National Quality Improvement Payments shall allow for the comparison of data from one year to the next for purposes of identifying which plans or contracts will receive such Payments.

''(C) CONSULTATION.—In determining when and how to update the scoring and ranking systems under subparagraph (A), the Secretary shall consult with the Quality Advisory Board.

''(f) FUNDING OF PAYMENTS.—The amount available for financial incentive payments under this section with respect to a year shall be equal to the amount of the reduction in expenditures under the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in the year as a result of the amendments made by section 3(b) of the Medicare Quality Improvement Act of 2004.''.

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

(1) MA PAYMENTS.—

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

(i) in subparagraphs (A) and (B) of paragraph (1), by inserting ''and, beginning in 2007, reduced by 2 percent in the case of an MA plan described in subparagraph (A)(i) or (C) of section 1851(a)(2)'' before the semicolon at the end; and

(ii) in paragraph (2), by inserting ''and, beginning in 2007, reduced by 2 percent in the case of an MA plan described in subparagraph (A)(i) or (C) of section 1851(a)(2)'' before the period at the end.

(B) REDUCTIONS IN PAYMENTS DO NOT EFFECT THE GOVERNMENT SAVINGS FOR BIDS BELOW THE BENCHMARK.—Section 1854(b)(1)(C)(i) of the Social Security Act (42 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

eligible organizations for the provision of qualified prescription drug coverage under part D.''.

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

(c) REQUIREMENT FOR REPORTING ON USE OF FINANCIAL INCENTIVE PAYMENTS.—

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

(A) in paragraph (1)(A)(i), by striking ''or (6)(A)'' and inserting ''(6)(A), or (7)''; and

(B) by adding at the end the following:

''(7) SUBMISSION OF INFORMATION OF HOW FINANCIAL INCENTIVE PAYMENTS WILL BE USED BEGINNING IN 2008.—For an MA plan described in subparagraph (A)(i) or (C) of section 1851(a)(2) for

a plan year beginning on or after January 1, 2008, the information described in this paragraph is a description of how the organization offering the plan will use any financial incentive payment that the organization received under section 1860C–2 with respect to the plan.''.

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

''(7)(A) Not later than July 1 of each year (beginning in 2008), any eligible entity with a reasonable cost reimbursement contract under this subsection that receives a financial incentive payment under section 1860C–2 with respect to each plan year shall submit to the Secretary a report containing the information described in subparagraph (B).

''(B) The information described in this subparagraph is a description of how the organization offering the plan will use any financial incentive payment that the organization received under section 1860C–2 with respect to the plan.''.

(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

under this part. Although such reporting requirements shall be coordinated pursuant to the preceding sentence, the use of the data reported may vary.''.

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

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

''(B) The Secretary shall establish procedures to ensure the coordination of the reporting requirement under subparagraph (A) with reporting requirements for the entity under this title relating to individuals enrolled with the entity but not receiving benefits under this title.''.

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

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

(1) in paragraph (11)(B), by striking ''paragraphs (12) and (13)'' and inserting ''paragraphs (12), (13), and (14)'';

(2) in paragraph (12), by striking ''In lieu of'' and inserting ''Subject to paragraph (14), in lieu of'';

(3) in paragraph (13)(A), in the matter preceding clause (i), by striking ''The payment amounts'' and inserting ''Subject to paragraph (14), the payment amounts''; and

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

''(14) RENAL DIALYSIS PERFORMANCE INCENTIVE PAYMENT PROGRAM.—

''(A) ESTABLISHMENT OF PROGRAM.—

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

nancial incentive payments are provided each year to providers of services and renal dialysis facilities that receive payments under paragraph (12) or (13) and demonstrate the provision of superior quality health care to individuals with end stage renal disease.

''(ii) PROGRAM TO BEGIN IN 2007.—The Secretary shall establish the program so that National Performance Quality Payments (described in subparagraph (C)) and National Quality Improvement Payments (described in subparagraph (D)) are made with respect to 2007 and each subsequent year.

''(iii) REQUIREMENT.—In order for a provider of services or a renal dialysis facility to be eligible for a financial incentive payment under this section, the provider or facility shall, not later than a date specified by the Secretary during the baseline year (as defined in subparagraph (D)(iv)), submit such data on the quality measures as the Secretary determines appropriate

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

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

''(v) PEDIATRIC FACILITIES NOT INCLUDED IN PROGRAM.—For purposes of this paragraph, including subparagraph (F)(i), the terms 'renal dialysis facility' and 'facility' do not include a renal dialysis facility at least 50 percent of whose patients are individuals under 18 years of age.

''(B) PAYMENTS.—

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

''(I) The amount allocated for National Performance Quality Payments shall be greater than the

amount allocated for National Quality Improvement Payments.

''(II) With respect to National Performance Quality Payments, the per capita amount of the payments shall be greatest for the organizations offering the highest performing plans or contracts.

''(III) With respect to National Quality Improvement Payments, the per capita amount of the payments shall be greatest for the organizations offering plans or contracts with the highest degree of improvement.

''(ii) AMOUNT OF QUALITY INCENTIVE PAYMENT.—

''(I) IN GENERAL.—The amount of a financial incentive payment under subparagraph (C) or (D) to a provider of services or renal dialysis facility shall be determined by multiplying the number of beneficiaries who received dialysis services from the provider or facility during the year for which the payment is provided by a dollar

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

''(II) LIMITATION ON TOTAL AMOUNT OF QUALITY INCENTIVE PAYMENTS.—The total amount of all the financial incentive payments given with respect to a year shall be equal to the amount available for such payments in the year under subparagraph (F)(ii).

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

''(I) To invest in information technology systems that will improve the quality of care provided to individuals with end stage renal disease.

''(II) To initiate, continue, or enhance health care quality programs for individuals with end stage renal disease.

"(III) Any other purpose determined appropriate by the Secretary.

"(iv) LIMITATIONS ON QUALITY INCENTIVE PAYMENTS.—

"(I) ONLY ELIGIBLE FOR 1 PAYMENT IN A YEAR.—A provider of services or a renal dialysis facility may not receive more than 1 financial incentive payment under this paragraph in a year. If a provider of services or a renal dialysis facility is eligible for a National Performance Quality Payment and a National Quality Improvement Payment, the organization shall be given the National Performance Quality Payment.

"(II) SERVICES MUST BE AVAILABLE FOR ENTIRE YEAR.—A provider of services or renal dialysis facility is not eligible for a financial incentive payment under this paragraph unless the provider or facility is in operation and providing dialysis services for the entire year for which the payment is 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

Secretary shall have the authority to implement a national improvement standard that providers of services and renal dialysis facilities must meet in order to receive a National Quality Improvement Payment.

''(iii) APPLICATION OF THRESHOLDS.—In determining whether a rating received under subparagraph (E) for the payment year exceeds the rating received under such subsection for the baseline year, the Secretary shall hold any applicable thresholds constant.

''(iv) BASELINE YEAR DEFINED.—In this subparagraph, the term 'baseline year' means the year prior to the payment year.

''(E) RATING METHODOLOGY.—

''(i) SCORING AND RANKING SYSTEMS.—

''(I) IN GENERAL.—The Secretary shall develop separate scoring and ranking systems for purposes of determining which providers of services and renal dialysis facilities qualify for—

"(aa) National Performance Quality Payments; and

"(bb) National Quality Improvement Payments.

"(II) REQUIREMENTS.—In developing, implementing, and updating the scoring and ranking systems, the Secretary shall—

"(aa) consult with the Quality Advisory Board established under section 1898 and the network administrative organizations designated under subsection (c)(1)(A)(i)(II); and

"(bb) take into account the report on health care performance measures submitted by the Institute of Medicine of the National Academy of Sciences under section 238 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

"(ii) MEASURES.—

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

ing and ranking system under clause (i), the Secretary shall use all measures determined appropriate by the Secretary. Such measures may include the following:

"(aa) The measures profiled in the ESRD Clinical Performance Measures (CPM) project of the Centers for Medicare & Medicaid Services.

"(bb) The measures for bone disease to be determined by the K-DOQI project of the National Kidney Foundation.

"(II) Scoring and ranking system for national performance quality payments only based on measures of clinical effectiveness.—The scoring and ranking system for National Performance Quality Payments shall only include measures of clinical effectiveness.

"(iii) WEIGHTS OF MEASURES.—In developing the scoring and ranking systems under clause (i), the Secretary shall

assign weights to the measures used by the Secretary under such system pursuant to clause (ii). In assigning such weights, the Secretary shall provide greater weight to the measures that measure clinical effectiveness.

''(iv) RISK ADJUSTMENT.—In developing the scoring and ranking systems under clause (i), the Secretary shall establish procedures for adjusting the data used under the system to take into account differences in the health status of individuals receiving dialysis services from providers of services and renal dialysis facilities.

''(v) UPDATE.—

''(I) IN GENERAL.—The Secretary shall as determined appropriate, but in no case more often than once each 12-month period, update the scoring and ranking systems developed under clause (i), including the measures used by the Secretary under such system pursuant to clause (ii), the weights established pursuant to clause (iii), and the risk adjustment

procedures established pursuant to clause (iv).

''(II) COMPARISON FOR NATIONAL QUALITY IMPROVEMENT PAYMENTS.—Each update under subclause (I) of the National Quality Improvement Payments shall allow for the comparison of data from one year to the next for purposes of identifying which providers of services and renal dialysis facilities will receive such Payments.

''(III) CONSULTATION.—In determining when and how to update the scoring and ranking systems under subclause (I), the Secretary shall consult with the Quality Advisory Board.

''(F) FUNDING OF PAYMENTS.—

''(i) REDUCTION IN PAYMENTS.—In order to provide the funding for the financial incentive payments under this paragraph, for each year (beginning with 2007), the Secretary shall reduce each payment under paragraphs (12) and (13) to a

provider of service and a renal dialysis facility by an amount equal to 2 percent of the payment.

''(ii) AMOUNT AVAILABLE.—The amount available for financial incentive payments under this section with respect to a year shall be equal to the amount of the reduction in expenditures under the Federal Supplementary Medical Insurance Trust Fund in the year as a result of the application of clause (i).''.

SEC. 5. MEDICARE INNOVATIVE QUALITY PRACTICE AWARD PROGRAM.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a program under which the Secretary shall award bonus payments to entities and individuals providing items and services under the medicare program under title XVIII of the Social Security Act that demonstrate innovative practices, structural improvements, or capacity enhancements that improve the quality of health care provided to medicare beneficiaries by such entities and individuals.

(b) PERIOD OF PROGRAM.—Awards under the program shall be made during 2006, 2007, and 2008.

(c) SELECTION OF RECIPIENTS.—

(1) IN GENERAL.—The Secretary shall ensure that the entities and individuals that receive an award under this section have demonstrated improvements in the quality of health care provided to medicare beneficiaries by such entities and individuals through comparison with a control group or baseline evaluation. For purposes of the program, improvements in the quality of health care provided to medicare beneficiaries shall be defined as providing additional services, such as translator services and health literacy education services, or providing care to an expanded service area or an expanded population through telemedicine, increased cultural competence, or other means, in combination with improved health outcomes or reduced beneficiary costs.

(2) ALL ENTITIES AND INDIVIDUALS ELIGIBLE.—Any entity, including a plan, or individual that is providing services under the medicare program is eligible for receiving an award under this section.

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

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

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

(e) APPLICATION.—An entity or individual desiring an award under this section shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may reasonably require.

(f) AMOUNT OF AWARD.—

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

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

(A) no single award is excessive; and

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

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

islation or administrative action as the Secretary determines appropriate.

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

SEC. 6. QUALITY IMPROVEMENT DEMONSTRATION PROGRAM FOR PEDIATRIC RENAL DIALYSIS FACILITIES PROVIDING CARE TO MEDICARE BENEFICIARIES WITH END STAGE RENAL DISEASE.

(a) DEMONSTRATION PROJECTS.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a 3-year demonstration program under which the Secretary establishes demonstration projects that encourage pediatric dialysis facilities to provide superior quality health care to individuals with end stage renal disease.

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

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

(4) ASSESSMENT OF MEASURES.—The Secretary, in consultation with the Quality Advisory Board, shall assess the validity and reliability of the measures selected under paragraph (2).

(b) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII as may be necessary to carry out the purposes of the demonstration program established under this section.

(c) FUNDING.—

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

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

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

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

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

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

(e) PEDIATRIC RENAL DIALYSIS FACILITY DEFINED.—The term ''pediatric renal dialysis facility'' means a renal dialysis facility that receives payments under paragraph (12) or (13) of section 1881(b) of the Social Security Act (42 U.S.C. 1395rr(b)) and is not eligible to participate in the renal dialysis performance payment program under paragraph (14) of such section (as

added by section 4(4)) because of the application of subparagraph (A)(iv) of such paragraph.

SEC. 7. MEDICARE QUALITY ADVISORY BOARD.

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

''QUALITY ADVISORY BOARD

''SEC. 1898. (a) ESTABLISHMENT.—The Secretary shall establish a Medicare Quality Advisory Board (in this section referred to as the 'Board').

''(b) MEMBERSHIP AND TERMS.—

''(1) IN GENERAL.—Subject to paragraphs (3), (4), and (5), the Board shall be composed of representatives described in paragraph (2) who shall serve for such term as the Secretary may specify.

''(2) REPRESENTATIVES.—Representatives described in this subparagraph include representatives of the following:

''(A) Patients or patient advocate organizations.

''(B) Individuals with expertise in the provision of quality care, such as medical directors, heads of hospital quality improvement commit-

tees, health insurance plan representatives, and academic researchers.

''(C) Health care professionals and providers.

''(D) Organizations that focus on the measurement and reporting of quality indicators.

''(E) State government health care programs.

''(3) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under this title shall not constitute a majority of the membership of the Board.

''(4) EXPERIENCE WITH URBAN AND RURAL HEALTH CARE ISSUES.—The membership of the Board should be representative of individuals with experience with urban health care issues and individuals with experience with rural health care issues.

''(5) EXPERIENCE ACROSS A SPECTRUM OF ACTIVITIES.—The membership of the Board should be representative of individuals with experience across the spectrum of activities that the Secretary is responsible for with respect to this title, including the coverage of new services and technologies, payment

rates and methodologies, beneficiary services, and claims processing.

''(c) DUTIES.—

''(1) INCENTIVE PROGRAMS.—

''(A) ADVICE.—The Board shall advise the Secretary regarding—

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

''(ii) the determination of the applicable percent for national performance quality payments under sections 1860C–2(c) and 1881(b)(14)(C);

''(iii) the selection of recipients of innovative quality practice awards under the program under section 5 of the Medicare Quality Improvement Act of 2004;

''(iv) the selection of demonstration project sites and the assessment of measures of quality of care under the demonstration program under section 6 of the Medicare Quality Improvement Act of 2004; and

''(v) the study and report under section 8(b) of the Medicare Quality Improvement Act of 2004.

''(B) ANNUAL REPORT ON INCENTIVE PROGRAMS.—The Board shall submit an annual report to the Secretary and Congress on the programs under sections 1860C–2 and 1881(b)(14).

''(C) ADDITIONAL DUTIES.—The Board shall perform such additional functions to assist the Secretary in carrying out the programs described in clauses (ii) and (iii) of subparagraph (A) and in subparagraph (B) as the Secretary may specify.

''(2) DEVELOPMENT AND ASSESSMENT OF NATIONAL PRIORITIES AND AGENDA.—The Board shall develop and assess national priorities and an agenda for improving the quality of items and services furnished to individuals entitled to benefits under this title.

''(d) WAIVER OF ADMINISTRATIVE LIMITATION.—The Secretary shall establish the Board notwithstanding any limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise).''.

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

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

(1) STUDY.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall request the Institute of Medicine of the National Academy of Sciences to conduct a study on how the payment mechanisms for items and services under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act effect the quality of such items and services.

(2) REPORT TO CONGRESS.—Not later than January 1, 2006, the Secretary shall submit to Congress a report on the results of the study described in paragraph (1) together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

(b) HHS STUDY AND REPORT ON PROVIDING FINANCIAL INCENTIVES FOR QUALITY SERVICES UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM.—

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

(2) REPORT.—

(A) IN GENERAL.—Not later than January 1, 2008, the Secretary shall submit a report to Congress on the study conducted under paragraph (1).

(B) CONTENTS.—The report submitted under subparagraph (A) shall contain recommendations with respect to—

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

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

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

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

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

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

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

(B) take into account the report on health care performance measures submitted by the Institute of Medicine of the National Academy of Sciences under section 238 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2213).

SEC. 9. MEDPAC STUDY AND REPORT ON USE OF ADJUSTER MECHANISMS UNDER MEDICARE QUALITY PERFORMANCE INCENTIVE PAYMENT PROGRAMS.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study—

(1) to determine whether it is appropriate to incorporate a geographic adjuster into the quality performance incentive payment programs under sections 1860C–2 and 1881(b)(14) of the Social Security Act, as added by sections 3 and 4, respectively, to account for different environments of care, regional payment variation, regional variation of patient satisfaction, and regional case mix variation; and

(2) on the most appropriate methods to risk adjust data used under the scoring and ranking system under such programs pursuant to sections 1860C–2(e)(4) and 1881(b)(14)(E)(iv) of the Social Security Act.

(b) REPORT.—Not later than January 1, 2006, the Commission shall submit a report to Congress and the Secretary of Health and Human Services on the study conducted under subsection (a) together with recommendations for such legislation and administrative actions as the Commission considers appropriate. If such study concludes that a geographic adjuster described in subsection (a)(1) is appropriate, the Commission shall include in the report recommendations on how such adjuster could be incorporated into the quality performance incentive payment programs described in such subsection.

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

(a) ESTABLISHMENT.—

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

(2) AUTHORITY.—The Secretary shall conduct the demonstration program under this section pursuant to the authority provided under this section and not under the authority provided under section 1115 of the Social Security Act (42 U.S.C. 1315).

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

and through multiple providers, such as school-based settings and mental health providers.

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

(d) FUNDING.—

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

(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate expenditures made by the Secretary do not exceed the amount which the Secretary would have expended if the demonstration program under this section had not been implemented.

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

the demonstration program together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

SEC. 11. PROVISIONS RELATING TO MEDICAID QUALITY IMPROVEMENTS.

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

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

(A) Quality improvement.

(B) Chronic care management.

(C) Care coordination.

(2) REQUIREMENT FOE EXPERIENCE WITH PEDIATRIC POPULATIONS.—At least 1 of the individuals employed within the Center for Medicaid and State Operations pursuant to paragraph (1) shall have experience with pediatric populations.

(3) DUTIES OF ADDITIONAL STAFF.—The employees 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

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

(c) MEDPAC STUDY AND REPORT ON BENEFICIARIES WHO ARE DUALLY ELIGIBLE FOR MEDICARE AND MEDICAID.—

(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study to determine the characteristics of individuals who are eligible to receive benefits under both the medicare and medicaid programs under titles XVIII and XIX of the Social Security Act, respectively, identify the costliest groups of individuals who are eligible for benefits under both programs, identify the services used by such individuals, and develop recommendations on how the provision of those services could be better coordinated for improved health outcomes and reduced costs.

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

and administrative actions as the Commission considers appropriate.

(d) MEDPAC STUDY AND REPORT ON CARE COORDINATION PROGRAMS FOR DUAL-ELIGIBLES.—

(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on care coordination programs available to individuals who are eligible to receive benefits under both the medicare and medicaid programs under titles XVIII and XIX of the Social Security Act, respectively, the impact of such care coordination programs on those individuals, the impact of such care coordination programs on the costs of the medicare and medicaid programs to the Federal Government, and whether any savings from care coordination programs are counted as a benefit to either program.

(2) REPORT.—Not later than June 30, 2005, the Commission shall submit a report to Congress on the study conducted under paragraph (1) together with recommendations for such legislation and administrative actions as the Commission considers appropriate.

SEC. 12. DEMONSTRATION PROGRAM FOR MEDICAL SMART CARDS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a 5-year demonstration program under which the Secretary shall award grants for the establishment of demonstration projects to provide for the development and use of Medical Smart Cards and to examine the impact of Medical Smart Cards on health care costs, quality of care, and patient safety.

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

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

(d) APPROVAL OF APPLICATIONS.—

(1) IN GENERAL.—The Secretary shall approve applications for grants under this section in accordance with criteria established by the Secretary.

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

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

(f) REPORT.—Not later than 6 months after the date on which the demonstration program established under subsection (a) ends, the Secretary shall submit to Congress a report on the demonstration program together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

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

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