109TH CONGRESS
1ST SESSION

S. 1356

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

IN THE SENATE OF THE UNITED STATES

JUNE 30, 2005

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

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A BILL

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

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

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCE TO SECRETARY; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Value Purchasing Act of 2005''.

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this

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

(c) REFERENCE TO SECRETARY.—In this Act, the term ''Secretary'' means the Secretary of Health and Human Services.

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

SEC. 2. FINDINGS; PURPOSE.

(a) FINDINGS.—Congress makes the following findings:

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

(A) we rank 37th in health care quality according to the World Health Organization; and

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

(2) The Institute of Medicine of the National Academy of Sciences has highlighted problems with our health care system in the areas of quality and patient safety, and has concluded that the United States should commit to building an information infrastructure to support health care delivery, quality measurement and improvement, consumer health, public accountability, research, education, and evidence-based medicine.

(3) 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 half of the time.

(4) Health Affairs has published an article entitled ''Medicare Spending, the Physician Workforce,

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

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

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

(7) Payment policies under the medicare program under title XVIII of the Social Security Act do not include mechanisms designed to improve the quality of care.

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

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

(10) Reimbursement for items and services furnished under the medicare program should be based on a value-based purchasing system.

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

TITLE I—MEASURING QUALITY AND EFFICIENCY OF CARE

SEC. 101. ESTABLISHMENT OF QUALITY MEASUREMENT SYSTEMS FOR MEDICARE VALUE-BASED PURCHASING PROGRAMS.

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

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

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

''PART E—VALUE-BASED PURCHASING

''QUALITY MEASUREMENT SYSTEMS FOR VALUE-BASED PURCHASING PROGRAMS

''SEC. 1860E–1. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary shall develop quality measurement systems for purposes of providing value-based payments to—

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

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

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

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

"(E) home health agencies pursuant to section 1860E–6.

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

"(3) HIGH QUALITY HEALTH CARE DEFINED.—In this part, the term 'high quality health care' means health care that is safe, effective, patient-centered, timely, equitable, efficient, necessary, and appropriate.

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

"(1) MEASURES.—

"(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall select measures of quality to be used by the Secretary under each system.

''(B) REQUIREMENTS.—In selecting the measures to be used under each system pursuant to subparagraph (A), the Secretary shall, to the extent feasible, ensure that—

''(i) such measures are evidence-based, reliable and valid, and feasible to collect and report;

''(ii) measures of process, structure, outcomes, beneficiary experience, efficiency, and equity are included;

''(iii) measures of overuse and underuse of health care items and services are included;

''(iv)(I) at least 1 measure of health information technology infrastructure that enables the provision of high quality health care and facilitates the exchange of health information, such as the use of one or more elements of a qualified health information system (as defined in subparagraph (E)), is included during the first year each system is implemented; and

''(II) additional measures of health information technology infrastructure are included in subsequent years;

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

''(vi) measures that assess the quality of care furnished to frail individuals over the age of 75 and to individuals with multiple complex chronic conditions are included.

''(C) REQUIREMENT FOR COLLECTION OF DATA ON A MEASURE FOR 1 YEAR PRIOR TO USE UNDER THE SYSTEMS.—Data on any measure selected by the Secretary under subparagraph (A) must be collected by the Secretary for at least a 12-month period before such measure may be used to determine whether a provider receives a value-based payment under a program described in subsection (a)(1).

''(D) AUTHORITY TO VARY MEASURES.—

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

plicable to hospitals under section 1860E–2, the Secretary may vary the measures selected under subparagraph (A) by hospital depending on the size of, and the scope of services provided by, the hospital.

''(ii) UNDER SYSTEM APPLICABLE TO PHYSICIANS AND PRACTITIONERS.—In the case of the system applicable to physicians and practitioners under section 1860E–3, the Secretary may vary the measures selected under subparagraph (A) by physician or practitioner depending on the specialty of the physician, the type of practitioner, or the volume of services furnished to beneficiaries by the physician or practitioner.

''(iii) UNDER SYSTEM APPLICABLE TO ESRD PROVIDERS AND FACILITIES.—In the case of the system applicable to providers of services and renal dialysis facilities under section 1860E–5, the Secretary may vary the measures selected under subparagraph (A) by provider or facility depending on the type of, the size of, and the scope

of services provided by, the provider or facility.

''(iv) UNDER SYSTEM APPLICABLE TO HOME HEALTH AGENCIES.—In the case of the system applicable to home health agencies under section 1860E–6, the Secretary may vary the measures selected under subparagraph (A) by agency depending on the size of, and the scope of services provided by, the agency.

''(E) QUALIFIED HEALTH INFORMATION SYSTEM DEFINED.—For purposes of subparagraph (B)(iv)(I), the term 'qualified health information system' means a computerized system (including hardware, software, and training) that—

''(i) protects the privacy and security of health information and properly encrypts such health information;

''(ii) maintains and provides access to patients' health records in an electronic format;

''(iii) incorporates decision support software to reduce medical errors and enhance health care quality;

''(iv) is consistent with data standards and certification processes recommended by the Secretary;

''(v) allows for the reporting of quality measures; and

''(vi) includes other features determined appropriate by the Secretary.

''(2) WEIGHTS OF MEASURES.—

''(A) IN GENERAL.—The Secretary shall assign weights to the measures used by the Secretary under each system.

''(B) CONSIDERATION.—If the Secretary determines appropriate, in assigning the weights under subparagraph (A)—

''(i) measures of clinical effectiveness shall be weighted more heavily than measures of beneficiary experience; and

''(ii) measures of risk adjusted outcomes shall be weighted more heavily than measures of process; and

''(3) RISK ADJUSTMENT.—The Secretary shall establish procedures, as appropriate, to control for differences in beneficiary health status and beneficiary characteristics. To the extent feasible, such

procedures may be based on existing models for controlling for such differences.

''(4) MAINTENANCE.—

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

''(i) the addition of more accurate and precise measures under the systems and the retirement of existing outdated measures under the system;

''(ii) the refinement of the weights assigned to measures under the system; and

''(iii) the refinement of the risk adjustment procedures established pursuant to paragraph (3) under the system.

''(B) UPDATE SHALL ALLOW FOR COMPARISON OF DATA.—Each update under subparagraph (A) of a quality measurement system shall allow for the comparison of data from one year to the next for purposes of providing value-based payments under the programs described in subsection (a)(1).

''(5) USE OF MOST RECENT QUALITY DATA.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the Secretary shall use the most recent quality data with respect to the provider involved that is available to the Secretary.

''(B) INSUFFICIENT DATA DUE TO LOW VOLUME.—If the Secretary determines that there is insufficient data with respect to a measure or measures because of a low number of services provided, the Secretary may aggregate data across more than 1 fiscal or calendar year, as the case may be.

''(c) REQUIREMENTS FOR DEVELOPING AND UPDATING THE SYSTEMS.—In developing and updating each quality measurement system under this section, the Secretary shall—

''(1) take into account the quality measures developed by nationally recognized quality measurement organizations, researchers, health care provider organizations, and other appropriate groups;

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

''(3) consult with provider-based groups and clinical specialty societies;

''(4) take into account existing quality measurement systems that have been developed through a rigorous process of validation and with the involvement of entities and persons described in subsection (e)(2)(B); and

''(5) take into account—

''(A) each of the reports by the Medicare Payment Advisory Commission that are required under the Medicare Value Purchasing Act of 2005;

''(B) the results of—

''(i) the demonstrations required under such Act;

''(ii) the demonstration program under section 1866A;

''(iii) the demonstration program under section 1866C; and

''(iv) any other demonstration or pilot program conducted by the Secretary relating to measuring and rewarding quality and efficiency of care; and

''(C) the report by the Institute of Medicine of the National Academy of Sciences under section 238(b) of the Medicare Prescription

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

''(d) REQUIREMENTS FOR IMPLEMENTING THE SYSTEMS.—In implementing each quality measurement system under this section, the Secretary shall consult with entities—

''(1) that have joined together to develop strategies for quality measurement and reporting, including the feasibility of collecting and reporting meaningful data on quality measures; and

''(2) that involve representatives of health care providers, health plans, consumers, employers, purchasers, quality experts, government agencies, and other individuals and groups that are interested in quality of care.

''(e) ARRANGEMENT WITH AN ENTITY TO PROVIDE ADVICE AND RECOMMENDATIONS.—

''(1) ARRANGEMENT.—On and after July 1, 2006, the Secretary shall have in place an arrangement with an entity that meets the requirements described in paragraph (2) under which such entity provides the Secretary with advice on, and recommendations with respect to, the development and updating of the quality measurement systems under

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

''(2) REQUIREMENTS DESCRIBED.—The requirements described in this paragraph are the following:

''(A) The entity is a private nonprofit entity governed by an executive director and a board.

''(B) The members of the entity include representatives of—

''(i)(I) health plans and providers receiving reimbursement under this title for the provision of items and services, including health plans and providers with experience in the care of the frail elderly and individuals with multiple complex chronic conditions; or

''(II) groups representing such health plans and providers;

''(ii) groups representing individuals receiving benefits under this title;

''(iii) purchasers and employers or groups representing purchasers or employers;

''(iv) organizations that focus on quality improvement as well as the measurement and reporting of quality measures;

''(v) State government health programs;

''(vi) persons skilled in the conduct and interpretation of biomedical, health services, and health economics research and with expertise in outcomes and effectiveness research and technology assessment; and

''(vii) persons or entities involved in the development and establishment of standards and certification for health information technology systems and clinical data.

''(C) The membership of the entity is representative of individuals with experience with—

''(i) urban health care issues;

''(ii) safety net health care issues; and

''(iii) rural and frontier health care issues.

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

entity related to the arrangement with the Secretary under paragraph (1). If the entity does require a fee for membership for participation in other functions of the entity, there shall be no linkage between such fee and participation in the work of the entity related to such arrangement with the Secretary.

''(E) The entity—

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

''(ii) ensures that such members have an equal vote on such matters .

''(F) With respect to matters related to the arrangement with the Secretary under paragraph (1), the entity conducts its business in an open and transparent manner and provides the opportunity for public comment.

''(G) The entity operates as a voluntary consensus standards setting organization as defined for purposes of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (Public Law 104–113) and Office of Management and Budget Revised Circular

A–119 (published in the Federal Register on February 10, 1998).

''(3) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out the provisions of this subsection, there are authorized to be appropriated—

''(A) for each of the fiscal years 2006 and 2007, $3,000,000; and

''(B) for fiscal year 2008 and each subsequent fiscal year, an amount equal to the sum of—

''(i) $3,000,000; and

''(ii) such amount multiplied by the percentage (if any) by which the average of the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with June of the calendar year in which such fiscal year begins exceeds such average for the 12-month period ending with June 2006.''.

(b) CONFORMING REFERENCES TO PREVIOUS PART E.—Any reference in law (in effect before the date of the enactment of this Act) to part E of title XVIII of the Social Security Act is deemed a reference to part F of such title (as in effect after such date).

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

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on how the medicare value-based purchasing programs under part E of title XVIII of the Social Security Act, as added by this Act, will impact medicare beneficiaries, medicare providers, and the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund under sections 1817 and 1841, respectively, of the Social Security Act (42 U.S.C. 1395i; 1395t), including how such programs will impact the access of such beneficiaries to items and services under the medicare program and the volume and utilization of such items and services.

(b) REPORTS.—

(1) INITIAL REPORT.—

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

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

(i) an analysis of the impact of the data collection and submission and reporting requirements under the amendments

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

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

(II) physicians with a low number of patient encounters in a year;

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

(iii) recommendations for such legislation and administrative actions as the Commission considers appropriate.

(2) INTERIM AND FINAL REPORT.—

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

retary on the study conducted under subsection (a).

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

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

(ii) an analysis of the impact of the payment changes on providers under the medicare program by reason of the amendments made by this Act; and

(iii) recommendations for such legislation and administrative actions as the Commission considers appropriate.

TITLE II—VALUE-BASED PURCHASING FOR HOSPITALS

Subtitle A—PPS Hospitals

SEC. 201. PPS HOSPITAL VALUE-BASED PURCHASING PROGRAM.

(a) VOLUNTARY SUBMISSION OF HOSPITAL QUALITY DATA.—

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

(A) in clause (vii)—

(i) in subclause (I), by striking ''for each of fiscal years 2005 through 2007'' and inserting ''for fiscal years 2005 and 2006''; and

(ii) in subclause (II), by striking ''Each'' and inserting ''For fiscal years 2005 and 2006, each''; and

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

''(viii)(I) For purposes of clause (i)(XX), for fiscal year 2007 and each subsequent fiscal year, in the case of a subsection (d) hospital that does not submit data in accordance with subclause (II) with respect to such a fiscal year, the applicable percentage increase under such clause for such fiscal year shall be reduced by 2 percentage points. Such reduction shall apply only with respect to the fiscal year involved, and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i)(XX) for a subsequent fiscal year.

''(II) For fiscal year 2007 and each subsequent fiscal year, each subsection (d) hospital shall submit to the Secretary such data that the Secretary determines is appropriate for the measurement of health care quality, including data necessary for the operation of the PPS hospital

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

''(III) The Secretary shall establish procedures for making data submitted under subclause (II) available to the public in a clear and understandable form. Such procedures shall ensure that a subsection (d) hospital has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public.''.

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

(A) in subclause (XIX), by striking ''2007'' and inserting ''2006''; and

(B) in subclause (XX)—

(i) by striking ''2008'' and inserting ''2007''; and

(ii) by inserting ''subject to clause (viii),'' after ''fiscal year,''.

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

''PPS HOSPITAL VALUE-BASED PURCHASING PROGRAM

''SEC. 1860E–2. (a) PROGRAM.—

''(1) IN GENERAL.—The Secretary shall establish a program under which value-based payments are provided each fiscal year to hospitals that demonstrate the provision of high quality health care to individuals who are entitled to benefits under part A and are inpatients of the hospital.

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

''(3) APPLICABILITY OF PROGRAM TO HOSPITALS.—For purposes of this section, the term 'hospital' means a subsection (d) hospital (as defined in section 1886(d)(1)(B)).

''(b) VALUE-BASED PAYMENTS.—

''(1) IN GENERAL.—Subject to paragraph (4), the Secretary shall make a value-based payment to a hospital with respect to a fiscal year if the Secretary determines that the quality of the care provided in that year to individuals who are entitled to benefits under part A and are inpatients of the hospital—

''(A) has substantially improved (as determined by the Secretary) over the prior year; or

''(B) exceeds a threshold established by the Secretary.

''(2) USE OF SYSTEM.—In determining which hospitals qualify for a value-based payment under paragraph (1), the Secretary shall use the quality measurement system developed for this section pursuant to section 1860E–1(a).

''(3) DETERMINATION OF AMOUNT OF AWARD AND ALLOCATION OF AWARDS.—

''(A) IN GENERAL.—The Secretary shall determine—

''(i) the amount of a value-based payment under paragraph (1) provided to a hospital; and

''(ii) subject to subparagraph (B), the allocation of the total amount available under subsection (d) for value-based payments for any fiscal year between payments with respect to hospitals that meet the requirement under subparagraph (A) of paragraph (1) and hospitals that meet the requirement under subparagraph (B) of such paragraph.

''(B) REQUIREMENTS REGARDING THE AMOUNT OF FUNDING AVAILABLE FOR VALUE-

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

''(i) a majority of the total amount available under subsection (d) for value-based payments for any fiscal year is provided to hospitals that are receiving such payments because they meet the requirement under paragraph (1)(B); and

''(ii) with respect to fiscal year 2008 and each subsequent fiscal year, the percentage of the total amount available under subsection (d) for value-based payments for any fiscal year that is used to make payments to hospitals that meet such requirement is greater than such percentage in the previous fiscal year.

''(4) REQUIREMENTS.—

''(A) REQUIRED SUBMISSION OF DATA.—In order for a hospital to be eligible for a value-based payment for a fiscal year, the hospital must have complied with the requirements under section 1886(b)(3)(B)(viii)(II) with respect to that fiscal year.

"(B) ATTESTATION REGARDING DATA.—In order for a hospital to be eligible for a value-based payment for a fiscal year, the hospital must have provided the Secretary (under procedures established by the Secretary) with an attestation that the data submitted under section 1886(b)(3)(B)(viii)(II) for the fiscal year is complete and accurate.

"(5) TOTAL AMOUNT OF VALUE-BASED PAYMENTS EQUAL TO TOTAL AMOUNT OF AVAILABLE FUNDING.—The Secretary shall establish payment amounts under paragraph (3)(A) so that, as estimated by the Secretary, the total amount of value-based payments made in a fiscal year under paragraph (1) is equal to the total amount available under subsection (d) for such payments for the year.

"(6) PAYMENT METHODS AND TIMING OF PAYMENTS.—

"(A) IN GENERAL.—Subject to subparagraph (B), the payment of value-based payments under paragraph (1) shall be based on such a method as the Secretary determines appropriate.

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

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

''(c) DESCRIPTION OF HOW HOSPITALS WOULD HAVE FARED UNDER PROGRAM IF PROGRAM HAD APPLIED TO FISCAL YEAR 2006.—Not later than January 1, 2007, the Secretary shall provide each hospital with a description of the Secretary's estimate of how payments to the hospital under this title would have been affected with respect to items and services furnished in fiscal year 2006 if the program under this section (and the amendments made by subsections (a) and (c) of section 201 of the Medicare Value Purchasing Act of 2005) had been in effect with respect to fiscal year 2006.

''(d) FUNDING.—

''(1) AMOUNT.—The amount available for value-based payments under this section with respect to a fiscal year shall be equal to the amount of the reduction in expenditures under the Federal Hospital Insurance Trust Fund under section 1817 in the year as a result of the amendments made by section 201(c) of the Medicare Value Purchasing Act of 2005, as estimated by the Secretary.

''(2) PAYMENTS FROM TRUST FUND.—Payments to hospitals under this section shall be made from the Federal Hospital Insurance Trust Fund.''.

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

(1) IN GENERAL.—Section 1886(d)(3)(B) (42 U.S.C. 1395ww(d)(3)(B)) is amended to read as follows:

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

"(i) OUTLIER PAYMENTS.—The Secretary shall reduce each of the average standardized amounts determined under subparagraph (A) (and determined without regard to any reduction under clause (ii)) by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary as if the applicable percent in clause (ii) were zero) based on DRG prospective payment amounts which are additional payments described in paragraph (5)(A) (relating to outlier payments).

"(ii) VALUE-BASED PURCHASING PROGRAM.—In the case of a subsection (d) hospital that complies with the submission requirements under subsection (b)(3)(B)(viii))(II) for a fiscal year, in addition to the reduction under clause

(i), the Secretary shall reduce each of the average standardized amounts determined under subparagraph (A) for that fiscal year (and determined without regard to any reduction under clause (i)) by the applicable percent (as defined in clause (iii)) for that fiscal year.

''(iii) APPLICABLE PERCENT.—For purposes of clause (ii), the term 'applicable percent' means—

''(I) for fiscal year 2007, 1.0 percent;

''(II) for fiscal year 2008, 1.25 percent;

''(III) for fiscal year 2009, 1.5 percent;

''(IV) for fiscal year 2010, 1.75 percent; and

''(V) for fiscal year 2011 and each subsequent year, 2.0 percent.''.

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

Subtitle B—Critical Access Hospitals

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

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the advisability and feasibility of establishing a value-based purchasing program under the medicare program under title XVIII of the Social Security Act for critical access hospitals (as defined in section 1861(mm)(1) of such Act (42 U.S.C. 1395x(mm)(1)).

(b) REPORT.—Not later than March 1, 2007, the Commission shall submit a report to Congress and the Secretary on the study conducted under subsection (a) together with recommendations for such legislation and administrative actions as the Commission considers appropriate.

SEC. 212. VALUE-BASED PURCHASING DEMONSTRATION PROGRAM FOR CRITICAL ACCESS HOSPITALS.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Secretary shall establish a demonstration program

under which the Secretary establishes a value-based purchasing program under the medicare program under title XVIII of the Social Security Act for critical access hospitals (as defined in section 1861(mm)(1) of such Act (42 U.S.C. 1395x(mm)(1)) in order to test innovative methods of measuring and rewarding quality health care furnished by such hospitals.

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

(3) SITES.—The Secretary shall conduct the demonstration program under this section at 6 critical access hospitals. The Secretary shall ensure that such hospitals are representative of the spectrum of such hospitals that participate in the medicare program.

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

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

1395i) of such funds as are necessary for the costs of carrying out the demonstration program under this section.

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

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

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

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

SEC. 301. PHYSICIAN AND PRACTITIONER VALUE-BASED PURCHASING PROGRAM.

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

(1) UPDATE FOR PHYSICIANS AND PRACTITIONERS THAT SUBMIT QUALITY DATA.—Section 1848(d)(4) (42 U.S.C. 1395w–4(d)(4)) is amended

by adding at the end the following new subparagraph:

"(G) ADJUSTMENT IF QUALITY DATA NOT SUBMITTED.—

"(i) ADJUSTMENT.—For 2007 and each subsequent year, in the case of services furnished by a physician or a practitioner (as defined in section 1860E–3(a)(3)) that does not submit data in accordance with clause (ii) with respect to such a year, the update under subparagraph (A) shall be reduced by 2 percentage points. Such reduction shall apply only with respect to the year involved, and the Secretary shall not take into account such reduction in computing the conversion factor for a subsequent year.

"(ii) SUBMISSION OF QUALITY DATA.—For 2007 and each subsequent year, each physician and practitioner (as defined in section 1860E–3(a)(3)) shall submit to the Secretary such data that the Secretary determines is appropriate for the measurement of health outcomes and other indices of quality, including data necessary

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

''(iii) AVAILABLE TO THE PUBLIC.—

''(I) IN GENERAL.—Subject to subclause (II), the Secretary shall establish procedures for making data submitted under clause (ii), with respect to items and services furnished on or after January 1, 2008, available to the public in a clear and understandable form. Such procedures shall ensure that a physician or practitioner has the opportunity to review the data that is to be made public with respect to the physician or practitioner prior to such data being made public.

''(II) EXCEPTIONS.—The Secretary shall establish exceptions to the requirement for making data available to the public under the first sentence of subclause (I). In providing for such

exceptions, the Secretary shall take into account the size and specialty representation of the practice involved.''.

(2) CONFORMING AMENDMENT.—Section 1848(d)(4)(A) (42 U.S.C. 1395w–4(d)(4)(A)) is amended, in the matter preceding clause (i), by striking ''subparagraph (F)'' and inserting ''subparagraphs (F) and (G)''.

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

''PHYSICIAN AND PRACTITIONER VALUE-BASED PURCHASING PROGRAM

''SEC. 1860E–3. (a) PROGRAM.—

''(1) IN GENERAL.—The Secretary shall establish a program under which value-based payments are provided each year to physicians and practitioners that demonstrate the provision of high quality health care to individuals enrolled under part B.

''(2) PROGRAM TO BEGIN IN 2008.—The Secretary shall establish the program under this section so that value-based payments described in subsection (b) are made with respect to 2008 and each subsequent year.

"(3) DEFINITION OF PHYSICIAN AND PRACTITIONER.—In this section:

"(A) PHYSICIAN.—The term 'physician' has the meaning given that term in section 1861(r).

"(B) PRACTITIONER.—The term 'practitioner' means—

"(i) a practitioner described in section 1842(b)(18)(C);

"(ii) a physical therapist (as described in section 1861(p));

"(iii) an occupational therapist (as so described); and

"(iv) a qualified speech-language pathologist (as defined in section 1861(ll)(3)(A)).

"(4) IDENTIFICATION OF PHYSICIANS AND PRACTITIONERS.—For purposes of applying this section and paragraphs (4)(G) and (6) of section 1848(d), the Secretary shall establish procedures for the identification of physicians and practitioners, such as through physician or practitioner billing units or other units.

"(b) VALUE-BASED PAYMENTS.—

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

''(A) has substantially improved (as determined by the Secretary) over the prior year; or

''(B) exceeds a threshold established by the Secretary.

''(2) USE OF SYSTEMS AND DATA.—

''(A) IN GENERAL.—In determining which physicians and practitioners qualify for a value-based payment under paragraph (1), the Secretary shall use—

''(i) the quality measurement system developed for this section pursuant to section 1860E–1(a) with respect to the quality of the care provided by the physician or practitioner; and

''(ii) the comparative utilization system developed under subsection (c) with respect to the efficiency of such care.

''(3) DETERMINATION OF AMOUNT OF AWARD AND ALLOCATION OF AWARDS.—

''(A) IN GENERAL.—The Secretary shall determine—

''(i) the amount of a value-based payment under paragraph (1) provided to a physician or a practitioner; and

''(ii) subject to subparagraph (B), the allocation of the total amount available under subsection (e) for value-based payments for any year between payments with respect to physicians and practitioners that meet the requirement under subparagraph (A) of paragraph (1) and physicians and practitioners that meet the requirement under subparagraph (B) of such paragraph.

''(B) REQUIREMENTS REGARDING THE AMOUNT OF FUNDING AVAILABLE FOR VALUE-BASED PAYMENTS FOR PHYSICIANS AND PRACTITIONERS EXCEEDING A THRESHOLD.—The Secretary shall ensure that—

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

physicians and practitioners that are receiving such payments because they meet the requirement under paragraph (1)(B); and

"(ii) with respect to 2009 and each subsequent year, the percentage of the total amount available under subsection (e) for value-based payments for any year that is used to make payments to physicians and practitioners that meet such requirement is greater than such percentage in the previous year.

"(4) REQUIREMENTS.—

"(A) REQUIRED SUBMISSION OF DATA.—In order for a physician or a practitioner to be eligible for a value-based payment for a year, the physician or practitioner must have complied with the requirements under section 1848(d)(6)(B)(ii) with respect to that year.

"(B) ATTESTATION REGARDING DATA.—In order for a physician or a practitioner to be eligible for a value-based payment for a year, the physician or practitioner must have provided the Secretary (under procedures established by the Secretary) with an attestation that the data

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

''(5) TOTAL AMOUNT OF VALUE-BASED PAYMENTS EQUAL TO TOTAL AMOUNT OF AVAILABLE FUNDING.—The Secretary shall establish payment amounts under paragraph (3)(A) so that, as estimated by the Secretary, the total amount of value-based payments made in a year under paragraph (1) is equal to the total amount available under subsection (e) for such payments for the year.

''(6) PAYMENT METHODS AND TIMING OF PAYMENTS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the payment of value-based payments under paragraph (1) shall be based on such a method as the Secretary determines appropriate.

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

''(c) COMPARATIVE UTILIZATION SYSTEM.—

''(1) DEVELOPMENT.—The Secretary shall develop a comparative utilization system for purposes

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

''(2) ADDITIONAL MEASURES OF EFFICIENT RESOURCE USE.—The comparative utilization system developed under paragraph (1) shall measure the efficiency of the care provided by a physician or practitioner.

''(3) REQUIREMENTS FOR SYSTEM.—Under the comparative utilization system described in paragraph (1), the Secretary shall do the following:

''(A) MEASURES.—The Secretary shall select measures of efficiency to be used by the Secretary under the system.

''(B) USE OF CLAIMS DATA FOR UTILIZATION PATTERNS AND EFFICIENCY.—

''(i) REVIEW OF CLAIMS DATA.—The Secretary shall review claims data with respect to services furnished or ordered by physicians and practitioners.

''(ii) USE OF MOST RECENT CLAIMS DATA.—The Secretary shall use the most recent claims data with respect to the physician or practitioner that is available to the Secretary.

"(C) RISK ADJUSTMENT.—The Secretary shall establish procedures, as appropriate, to control for differences in beneficiary health status and beneficiary characteristics.

"(4) ANNUAL REPORTS.—Beginning in 2006, the Secretary shall provide physicians and practitioners with annual reports on the utilization of items and services under this title based upon the review of claims data under paragraph (3)(B). With respect to reports provided in 2006 and 2007, such reports are confidential and the Secretary shall not make such reports available to the public.

"(d) DESCRIPTION OF HOW PHYSICIANS AND PRACTITIONERS WOULD HAVE FARED UNDER PROGRAM IF PROGRAM HAD APPLIED TO 2007.—Not later than March 1, 2008, the Secretary shall provide each physician and practitioner with a description of the Secretary's estimate of how payments to the physician or practitioner under this title would have been affected with respect to items and services furnished in 2007 if the program under this section (and the amendments made by subsections (a) and (c) of section 301 of the Medicare Value Purchasing Act of 2005) had been in effect with respect to 2007.

"(e) FUNDING.—

''(1) AMOUNT.—The amount available for value-based 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 under section 1841 in the year as a result of the amendments made by section 301(c) of the Medicare Value Purchasing Act of 2005, as estimated by the Secretary.

''(2) PAYMENTS FROM TRUST FUND.—Payments to physicians and practitioners under this section shall be made from the Federal Supplementary Medical Insurance Trust Fund.''.

(c) REDUCTION IN CONVERSION FACTOR FOR PHYSICIANS AND PRACTITIONERS THAT SUBMIT QUALITY DATA IN ORDER TO FUND PROGRAM.—

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

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

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

a practitioner (as defined in section 1860E–3(a)(3)) that complies with the requirements under paragraph (4)(G)(ii) for the year (determined after application of the update under paragraph (4)) shall be reduced by the applicable percent.

''(B) APPLICABLE PERCENT.—For purposes of subparagraph (A), the term 'applicable percent' means—

''(i) for 2008, 1.0 percent;

''(ii) for 2009, 1.25 percent;

''(iii) for 2010, 1.5 percent;

''(iv) for 2011, 1.75 percent; and

''(v) for 2012 and each subsequent year, 2.0 percent.''.

(2) CONFORMING AMENDMENT.—Section 1848(d)(1)(A) (42 U.S.C. 1395w–4(d)(1)(A)) is amended by striking ''The conversion factor'' and inserting ''Subject to paragraph (6), the conversion factor''.

SEC. 302. DEMONSTRATION PROJECT ON DATA COORDINATION THROUGH THE USE OF HEALTH INFORMATION TECHNOLOGY.

(a) DEMONSTRATION PROJECT.—

(1) ESTABLISHMENT.—Not later than 6 months after the date of enactment of this Act, the Secretary, in consultation with the National Coordinator for Health Information Technology, shall establish a demonstration project to determine the threshold amount of information technology connectivity that is necessary in order to improve the ability of physicians and practitioners (as defined in section 1860E–3(a)(3) of the Social Security Act, as added by section 301(b)) in rural and frontier areas to—

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

(B) use such data as a resource for improving the quality and efficiency of the care provided to medicare beneficiaries by such physicians and practitioners.

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

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

(4) PARTICIPANTS.—Participants in the demonstration project under this section may include regional networks, public-private partnerships includ-

ing health care providers, persons or entities involved in the delivery of health care through the use of telemedicine and telehealth, and other persons or entities determined appropriate by the Secretary.

(5) REQUIREMENT FOR PARTICIPANTS.—Participants in the demonstration project under this section shall comply with any interoperability and certification standards and processes that have been developed or adopted by the Secretary or a designee of the Secretary.

(b) REPORT.—

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

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

(A) an analysis of—

(i) the types of information accessed, transferred, and exchanged through different models for information technology connectivity;

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

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

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

(B) recommendations for such legislation and administrative actions as the Secretary considers appropriate.

(c) FUNDING.—There are authorized to be appropriated to the Secretary such sums as may be necessary to carry out this section.

SEC. 303. SENSE OF THE SENATE REGARDING PAYMENTS UNDER MEDICARE PHYSICIAN FEE SCHEDULE.

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

(1) Based on current projections, estimates suggest that, absent any action, payment amounts under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) will be reduced by 4.3 percent in 2006 and further reduced each year thereafter until 2011.

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

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

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

(A) has not been successful in appropriately controlling the volume of services provided by physicians; and

(B) is not a sustainable model for determining physician payments under the medicare program in the future.

(4) The Centers for Medicare & Medicaid Services should use its administrative authority to exclude medicare-covered drugs and biologicals from the formula used under the physician fee schedule and accurately reflect in the formula the direct and indirect cost of increases due to coverage decisions, administrative actions, and rules and regulations.

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

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

(1) the long-term stability of the medicare payment system for items and services furnished by physicians and other health care professionals;

(2) appropriate reimbursement under the medicare program for such items and services that is consistent with high quality and efficient delivery of such items and services; and

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

TITLE IV—VALUE-BASED PURCHASING FOR PLANS

Subtitle A—Medicare Advantage Plans

SEC. 401. PLAN VALUE-BASED PURCHASING PROGRAM.

(a) SUBMISSION OF QUALITY DATA.—

(1) MEDICARE ADVANTAGE ORGANIZATIONS.—Section 1852(e) (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) in paragraph (3)—

(i) in subparagraph (A)—

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

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

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

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

''(v) AVAILABILITY TO THE PUBLIC.—The Secretary shall establish procedures for making data reported under this subparagraph available to the public in a clear

and understandable form. Such procedures shall ensure that an MA organization has the opportunity to review the data that is to be made public with respect to the plan offered by the organization prior to such data being made public.''; and

(ii) in subparagraph (B)—

(I) in clause (i), by striking ''The'' and inserting ''Subject to clause (ii), the''; and

(II) by striking clause (ii) and inserting the following new clause:

''(ii) CHANGES IN TYPES OF DATA.—Subject to clause (iii), the Secretary may only change the types of data that are required to be submitted under subparagraph (A) after submitting to Congress a report on the reasons for such changes that was prepared—

''(I) in the case of data necessary for the operation of the plan value-based purchasing program under section 1860E–4, after the requirements under subsections (c) and (d) of sec-

tion 1860E–1 have been complied with; and

"(II) in the case of any other data, in consultation with MA organizations and private accrediting bodies.".

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

"(6)(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 submit to the Secretary such data that the Secretary determines is appropriate for the measurement of health outcomes and other indices of quality, including data necessary for the operation of the plan value-based purchasing program under section 1860E–4. Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

"(B) The Secretary shall establish procedures for making data reported under subparagraph (A) available to the public in a clear and understandable form. Such procedures shall ensure that an eligible entity has the opportunity to review the data that is to be made public with

respect to the contract prior to such data being made public.''.

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

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

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

''PLAN VALUE-BASED PURCHASING PROGRAM

''SEC. 1860E–4. (a) PROGRAM.—

''(1) IN GENERAL.—The Secretary shall establish a program under which value-based payments are provided each year to Medicare Advantage organizations offering Medicare Advantage plans under

part C that demonstrate the provision of high quality health care to enrollees under the plan.

''(2) PROGRAM TO BEGIN IN 2009.—The Secretary shall establish the program under this section so that value-based payments under subsection (b) are made with respect to 2009 and each subsequent year.

''(3) DEFINITIONS OF MEDICARE ADVANTAGE ORGANIZATION AND PLAN.—

''(A) IN GENERAL.—In this section:

''(i) MEDICARE ADVANTAGE ORGANIZATION.—The term 'Medicare Advantage organization' has the meaning given such term in section 1859(a)(1).

''(ii) MEDICARE ADVANTAGE PLAN.—The term 'Medicare Advantage plan' has the meaning given such term in section 1859(b)(1).

''(B) APPLICABILITY OF PROGRAM TO MEDICARE ADVANTAGE REGIONAL AND LOCAL PLANS.—For purposes of this section, the term 'Medicare Advantage plan' shall include both Medicare Advantage regional plans (as defined in section 1859(b)(4)) and Medicare Advantage local plans (as defined in section 1859(b)(5)).

''(C) APPLICABILITY OF PROGRAM TO REASONABLE COST CONTRACTS.—Except for paragraphs (5) and (6) of subsection (b), for purposes of this section, the terms—

''(i) 'Medicare Advantage organization' and 'organization' include an organization that is providing benefits under a reasonable cost reimbursement contract under section 1876(h); and

''(ii) 'Medicare Advantage plan' and 'plan' include such a contract.

''(b) VALUE-BASED PAYMENTS.—

''(1) IN GENERAL.—Subject to paragraph (4), the Secretary shall make value-based payments to Medicare Advantage organizations with respect to each Medicare Advantage plan offered by the organization during a year if the Secretary determines that the quality of the care provided under the plan—

''(A) has substantially improved (as determined by the Secretary) over the prior year; or

''(B) exceeds a threshold established by the Secretary.

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

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

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

"(B) ensure that awards are based on data from a full 12-month period (or 24-month period in the case of an award described in paragraph (1)(A)), such periods determined without regard to calendar year periods.

"(3) DETERMINATION OF AMOUNT OF AWARD AND ALLOCATION OF AWARDS.—

"(A) IN GENERAL.—The Secretary shall determine—

"(i) the amount of a value-based payment under paragraph (1) provided to an organization with respect to a plan; and

"(ii) subject to subparagraph (B), the allocation of the total amount available under subsection (d) for value-based payments for any year between payments with respect to plans that meet the requirement under subparagraph (A) of paragraph (1) and plans that meet the requirement under subparagraph (B) of such paragraph.

"(B) REQUIREMENT REGARDING THE AMOUNT OF FUNDING AVAILABLE FOR VALUE-BASED PAYMENTS FOR PLANS EXCEEDING A THRESHOLD.—The Secretary shall ensure that—

"(i) a majority of the total amount available under subsection (d) for value-based payments for any year is provided to organizations, with respect to plans offered by such organizations, that are receiving such payments because they meet the requirement under paragraph (1)(B); and

"(ii) with respect to 2010 and each subsequent year, the percentage of the total amount available under subsection (d) for value-based payments for any year that is used to make payments to organizations, with respect to plans offered by such organizations, that meet such requirement is greater than such percentage in the previous year.

"(4) USE OF PAYMENTS.—Value-based payments received under this section may only be used for the following purposes:

"(A) To invest in quality improvement programs operated by the organization with respect to the plan.

"(B) To enhance beneficiary benefits under the plan.

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

"(6) NO EFFECT ON MEDICARE ADVANTAGE PLAN BIDS.—In order for a Medicare Advantage organization to be eligible for a value-based payment for a year with respect to a Medicare Advantage plan, the organization must have provided the Secretary with an attestation that the program under this section, including the payment adjustments made by reason of the amendments made by section 401(c)(1) of the Medicare Value Purchasing Act of 2005, had no effect on the integrity and actuarial

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

''(7) TOTAL AMOUNT OF VALUE-BASED PAYMENTS EQUAL TO TOTAL AMOUNT OF REDUCTION IN PAYMENTS.—The Secretary shall establish payment amounts under paragraph (3)(A) so that, as estimated by the Secretary, the total amount of value-based payments made in a year under paragraph (1) is equal to the total amount available under subsection (d) for such payments for the year.

''(8) PAYMENT METHODS AND TIMING OF PAYMENTS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the payment of value-based payments under paragraph (1) shall be based on such a method as the Secretary determines appropriate.

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

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

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

''(d) FUNDING.—

''(1) AMOUNT.—The amount available for value-based 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 under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 in the year as a result of the amendments made by section 401(c) of the Medicare Value Purchasing Act of 2005, as estimated by the Secretary.

''(2) PAYMENTS FROM TRUST FUNDS.—Payments to organizations under this section shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in the same proportion as payments to Medicare Advantage organizations are

made from such Trust Funds under the first sentence of section 1853(f).''.

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

(1) MEDICARE ADVANTAGE PAYMENTS.—

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

(i) in clauses (i) and (ii) of subparagraph (B), by inserting ''and, for 2009 and each subsequent year, except in the case of an MSA plan or an MA plan for which there was no contract under section 1857 during either of the preceding 2 years, reduced by the applicable percent (as defined in subparagraph (I))'' after ''(G)''; and

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

''(I) APPLICABLE PERCENT.—For purposes of clauses (i) and (ii) of subparagraph (B), the term 'applicable percent' means—

''(i) for 2009, 1.0 percent;

"(ii) for 2010, 1.25 percent;

"(iii) for 2011, 1.5 percent;

"(iv) for 2012, 1.75 percent; and

"(v) for 2013 and each subsequent year, 2.0 percent.".

(B) REDUCTIONS IN PAYMENTS DO NOT AFFECT THE REBATE FOR BIDS BELOW THE BENCHMARK.—The amendments made by subparagraph (A) shall not be construed to have any effect on—

(i) the determination of whether a Medicare Advantage plan has average per capita monthly savings described in paragraph (3)(C) or (4)(C) of section 1854(b) of the Social Security Act (42 U.S.C. 1395w–24(b)); or

(ii) the amount of such savings.

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

"(7) 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, 2009, by an

amount equal to the applicable percent (as defined in section 1853(a)(1)(I)) 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.''.

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

(1) MA PLANS.—Section 1854(a) (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 VALUE-BASED PAYMENTS WILL BE USED.—For an MA plan for a plan year beginning on or after January 1, 2011, the information described in this paragraph is a description of how the organization offering the plan will use any value-based payments that the organization received under section 1860E–4 with respect to the plan for the year preceding the year in which such information is submitted.''.

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

''(8) Not later than July 1 of each year (beginning in 2010), any eligible entity with a reasonable cost reimbursement contract under this subsection that received a value-based payment under section 1860E–4 with respect to the contract for the preceding year shall submit to the Secretary a report containing a description of how the organization will use such payments under the contract.''.

Subtitle B—Plans Offering Part D Prescription Drug Coverage

SEC. 411. MEDPAC STUDY AND REPORT REGARDING A VALUE-BASED PURCHASING PROGRAM FOR PLANS OFFERING PART D PRESCRIPTION DRUG COVERAGE.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the advisability and feasibility of establishing a value-based purchasing program under the medicare program under title XVIII of the Social Security Act with respect to the provision of prescription drug coverage under part D of such title under prescription drug plans and fallback prescription drug plans under such part D, under Medicare Advantage plans

under part C of such Act, and under reasonable cost contracts under section 1876(h) of such Act (42 U.S.C. 1395mm).

(b) REPORT.—Not later than March 1, 2007, the Commission shall submit a report to Congress and the Secretary on the study conducted under subsection (a) together with recommendations for such legislation and administrative actions as the Commission considers appropriate.

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

SEC. 501. END STAGE RENAL DISEASE PROVIDER AND FACILITY VALUE-BASED PURCHASING PROGRAM.

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

''(14) By not later than July 31, 2006, the Secretary shall establish procedures under which providers of services and renal dialysis facilities that receive payments under paragraph (12) or (13) may

submit to the Secretary data that permits the measurement of health outcomes and other indices of quality.''.

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

''ESRD PROVIDER AND FACILITY VALUE-BASED PURCHASING PROGRAM

''SEC. 1860E–5. (a) PROGRAM.—

''(1) IN GENERAL.—The Secretary shall establish a program under which value-based payments are provided each year to providers of services and renal dialysis facilities that—

''(A) provide items and services to individuals with end stage renal disease who are enrolled under part B; and

''(B) demonstrate the provision of high quality health care to such individuals.

''(2) PROGRAM TO BEGIN IN 2007.—The Secretary shall establish the program under this section so that value-based payments described in subsection (b) are made with respect to 2007 and each subsequent year.

''(3) EXCLUSIONS FROM PROGRAM.—

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

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

''(B) PROVIDERS AND FACILITIES CURRENTLY PARTICIPATING IN BUNDLED CASE-MIX DEMONSTRATION NOT INCLUDED IN PROGRAM.—Any provider of services or renal dialysis facility that is currently participating in the bundled case-mix adjusted payment system for ESRD services demonstration project under section 623(e) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) shall not be included in the program under this section, but only for so long as the provider or facility is so participating.

''(b) VALUE-BASED PAYMENTS.—

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

"(A) has substantially improved (as determined by the Secretary) over the prior year; or

"(B) exceeds a threshold established by the Secretary.

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

"(3) DETERMINATION OF AMOUNT OF AWARD AND ALLOCATION OF AWARDS.—

"(A) IN GENERAL.—The Secretary shall determine—

"(i) the amount of a value-based payment under paragraph (1) provided to a provider of services or a renal dialysis facility; and

"(ii) subject to subparagraphs (B) and (C), the allocation of the total amount available under subsection (c) for value-based payments for any year between payments with respect to providers and facilities that meet the requirement under subparagraph (A) of paragraph (1) and pro-

viders and facilities that meet the requirement under subparagraph (B) of such paragraph.

''(B) REQUIREMENT REGARDING AMOUNT OF FUNDING AVAILABLE FOR VALUE-BASED PAYMENTS FOR PROVIDERS AND FACILITIES EXCEEDING A THRESHOLD.—The Secretary shall ensure that—

''(i) a majority of the total amount available under subsection (c) for value-based payments for any year is provided to providers of services and renal dialysis facilities that are receiving such payments because they meet the requirement under paragraph (1)(B); and

''(ii) with respect to 2009 and each subsequent year, the percentage of the total amount available under subsection (c) for value-based payments for any year that is used to make payments to providers and facilities that meet such requirement is greater than such percentage in the previous year.

''(C) ONLY VALUE-BASED PAYMENTS FOR PROVIDERS AND FACILITIES EXCEEDING A

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

''(4) REQUIREMENTS.—

''(A) REQUIRED SUBMISSION OF DATA.—

''(i) IN GENERAL.—In order for a provider of services or a renal dialysis facility to be eligible for a value-based payment for a year, the provider or facility must have provided for the submission of data in accordance with clause (ii) with respect to that year.

''(ii) SUBMISSION OF DATA.—For 2007 and each subsequent year, each provider of services and renal dialysis facility that receives payments under paragraph (12) shall submit to the Secretary such data that the Secretary determines is appropriate for the measurement of health outcomes and other indices of quality, including data necessary for the operation of the program under this section. Such data

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

''(iii) AVAILABILITY TO THE PUBLIC.—The Secretary shall establish procedures for making data submitted under clause (ii) available to the public in a clear and understandable form. Such procedures shall ensure that a provider or facility has the opportunity to review the data that is to be made public with respect to the provider or facility prior to such data being made public.

''(B) ATTESTATION REGARDING DATA.—In order for a provider of services or a renal dialysis facility to be eligible for a value-based payment for a year, the provider or facility must have provided the Secretary (under procedures established by the Secretary) with an attestation that the data submitted under subparagraph (A)(ii) for the year is complete and accurate.

''(5) TOTAL AMOUNT OF VALUE-BASED PAYMENTS EQUAL TO TOTAL AMOUNT OF AVAILABLE FUNDING.—The Secretary shall establish payment

amounts under paragraph (3)(A) so that, as estimated by the Secretary, the total amount of value-based payments made in a year under paragraph (1) is equal to the total amount available under subsection (c) for such payments for the year.

''(6) PAYMENT METHODS AND TIMING OF PAYMENTS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the payment of value-based payments under paragraph (1) shall be based on such a method as the Secretary determines appropriate.

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

''(c) FUNDING.—

''(1) AMOUNT.—The amount available for value-based 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 under section 1841 in the year by reason of the application of section 1881(b)(12)(G), as estimated by the Secretary.

''(2) PAYMENTS FROM TRUST FUND.—Payments to providers of services and renal dialysis facilities under this section shall be made from the Federal Supplementary Medical Insurance Trust Fund.''.

(c) REDUCTION IN CASE-MIX ADJUSTED PROSPECTIVE PAYMENT AMOUNT IN ORDER TO FUND PROGRAM.—Section 1881(b)(12) (42 U.S.C. 1395rr(b)(12)) is amended—

(1) by redesignating subparagraph (G) as subparagraph (H); and

(2) by inserting after subparagraph (F) the following new subparagraph:

''(G)(i) In the case of any payment made under this paragraph for an item or service furnished on or after January 1, 2007, such payment shall be reduced by the applicable percent. The preceding sentence shall not apply to a payment for an item or service furnished by a provider of services or a renal dialysis facility that is excluded from the program under section 1860E–5 by reason of subsection (a)(3) of such section at the time the item or service is furnished.

''(ii) For purposes of clause (i), the term 'applicable percent' means—

''(I) for 2007, 1.0 percent;

''(II) for 2008, 1.25 percent;

''(III) for 2009, 1.5 percent;

''(IV) for 2010, 1.75 percent; and

''(V) for 2011 and each subsequent year, 2.0 percent.''.

SEC. 502. VALUE-BASED PURCHASING UNDER THE DEMONSTRATION OF BUNDLED CASE-MIX ADJUSTED PAYMENT SYSTEM FOR ESRD SERVICES.

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

''(7) VALUE-BASED PURCHASING PROGRAM.—As part of the demonstration project under this subsection, the Secretary shall, beginning January 1, 2007, implement a value-based purchasing program for providers and facilities participating in the demonstration project. The Secretary shall implement such value-based purchasing program in a similar manner as the ESRD provider and facility value-based purchasing program is implemented under section 1860E–5 of the Social Security Act, including the funding of such program.''.

SEC. 503. CHRONIC KIDNEY DISEASE DEMONSTRATION PROJECTS.

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

(1) increase public awareness about—

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

(B) how to prevent such disease;

(C) how to treat such disease; and

(D) how to avoid kidney failure;

(2) enhance surveillance systems and expand research to better assess the prevalence and incidence of chronic kidney disease; and

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

(b) SCOPE AND DURATION.—

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

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

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

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

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

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

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the advisability and feasibility of—

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

the value-based purchasing program under such section 1860E–5; or

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

(b) REPORT.—Not later than June 1, 2007, the Commission shall submit a report to Congress and the Secretary on the study conducted under subsection (a) together with recommendations for such legislation and administrative actions as the Commission considers appropriate.

SEC. 505. MEDPAC REPORT ON ESRD PROVIDER AND FACILITY VALUE-BASED PURCHASING PROGRAM.

(a) REPORT.—Not later than June 1, 2008, the Medicare Payment Advisory Commission shall submit a report to Congress and the Secretary on the implementation of the ESRD provider and facility value-based purchasing program under section 1860E–5 of the Social Security Act, as added by section 501(b).

(b) CONTENTS.—The report submitted under subsection (a) shall include—

(1) a detailed description of issues for the Secretary to consider in operating the ESRD provider

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

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

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

SEC. 506. SENSE OF THE SENATE REGARDING AN UPDATE TO THE COMPOSITE RATE PAYMENT FOR DIALYSIS SERVICES.

It is the sense of the Senate that—

(1) while the provisions of, and amendments made by, this Act develop a value-based purchasing program for providers of services and renal dialysis facilities furnishing dialysis services to medicare beneficiaries, Congress should address the need for an update to the composite rate payment for dialysis services under section 1881(b)(12) of the Social Security Act (42 U.S.C. 1395rr(b)(12)) in order to ensure—

(A) appropriate reimbursement under the medicare program for such services that is consistent with high quality and efficient delivery of such services; and

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

(2) if Congress determines that an update to such composite rate payment is appropriate, Congress should ensure that the update takes into account any change in the costs of furnishing dialysis services resulting from—

(A) the adoption of scientific and technological innovations used to provide such services;

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

(C) productivity improvements in the furnishing of such services.

TITLE VI—VALUE-BASED PURCHASING FOR HOME HEALTH AGENCIES

SEC. 601. HOME HEALTH AGENCY VALUE-BASED PURCHASING PROGRAM.

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

(1) in clause (ii)(IV), by inserting ''subject to clause (v),'' after ''subsequent year,''; and

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

''(v) ADJUSTMENT IF QUALITY DATA NOT SUBMITTED.—

''(I) ADJUSTMENT.—For purposes of clause (ii)(IV), for 2007 and each subsequent year, in the case of a home health agency that does not submit data in accordance with subclause (II) with respect to such a year, the home health market basket percentage increase applicable under such clause for such year shall be reduced by 2 percentage points. Such reduction shall apply only with respect to the

year involved, and the Secretary shall not take into account such reduction in computing the prospective payment amount under this section for a subsequent year.

''(II) SUBMISSION OF QUALITY DATA.—For 2007 and each subsequent year, each home health agency shall submit to the Secretary such data that the Secretary determines is appropriate for the measurement of health care quality, including data necessary for the operation of the home health agency value-based purchasing program under section 1860E–6. Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this clause.

''(III) The Secretary shall establish procedures for making data submitted under subclause (II) available to the public in a clear and understandable form.''.

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

''HOME HEALTH AGENCY VALUE-BASED PURCHASING PROGRAM

''SEC. 1860E–6. (a) PROGRAM.—

''(1) IN GENERAL.—The Secretary shall establish a program under which value-based payments are provided each year to home health agencies that demonstrate the provision of high quality health care to individuals entitled to benefits under part A or enrolled under part B.

''(2) PROGRAM TO BEGIN IN 2008.—The Secretary shall establish the program under this section so that value-based payments described in subsection (b) are made with respect to 2008 and each subsequent year.

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

''(b) VALUE-BASED PAYMENTS.—

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

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

"(A) has substantially improved (as determined by the Secretary) over the prior year; or

"(B) exceeds a threshold established by the Secretary.

"(2) USE OF SYSTEM.—In determining which home health agencies qualify for a value-based payment under paragraph (1), the Secretary shall use the quality measurement system developed for this section pursuant to section 1860E–1(a).

"(3) DETERMINATION OF AMOUNT OF AWARD AND ALLOCATION OF AWARDS.—

"(A) IN GENERAL.—The Secretary shall determine—

"(i) the amount of a value-based payment under paragraph (1) provided to a home health agency; and

"(ii) subject to subparagraph (B), the allocation of the total amount available under subsection (d) for value-based payments for any year between payments with respect to agencies that meet the requirement under subparagraph (A) of paragraph (1) and agencies that meet the re-

quirement under subparagraph (B) of such paragraph.

''(B) REQUIREMENTS REGARDING THE AMOUNT OF FUNDING AVAILABLE FOR VALUE-BASED PAYMENTS FOR AGENCIES EXCEEDING A THRESHOLD.—The Secretary shall ensure that—

''(i) a majority of the total amount available under subsection (d) for value-based payments for any year is provided to home health agencies that are receiving such payments because they meet the requirement under paragraph (1)(B); and

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

''(4) REQUIREMENTS.—

''(A) REQUIRED SUBMISSION OF DATA.—In order for a home health agency to be eligible for a value-based payment for a year, the agency must have complied with the requirements

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

''(B) ATTESTATION REGARDING DATA.—In order for a home health agency to be eligible for a value-based payment for a year, the agency must have provided the Secretary (under procedures established by the Secretary) with an attestation that the data submitted under section 1895(b)(3)(B)(v)(II) with respect to that year is complete and accurate.

''(5) TOTAL AMOUNT OF VALUE-BASED PAYMENTS EQUAL TO TOTAL AMOUNT OF AVAILABLE FUNDING.—The Secretary shall establish payment amounts under paragraph (3)(A) so that, as estimated by the Secretary, the total amount of value-based payments made in a year under paragraph (1) is equal to the total amount available under subsection (d) for such payments for the year.

''(6) PAYMENT METHODS AND TIMING OF PAYMENTS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the payment of value-based payments under paragraph (1) shall be based on such a method as the Secretary determines appropriate.

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

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

''(d) FUNDING.—

''(1) AMOUNT.—The amount available for value-based payments under this section with respect to a year shall be equal to the amount of the reduction in expenditures under the the Federal Hospital Insurance Trust Fund under section 1817 and Federal Supplementary Medical Insurance Trust Fund under section 1841 in the year as a result of the application of section 1895(b)(3)(D), as estimated by the Secretary.

''(2) PAYMENTS FROM TRUST FUND.—Payments to home health agencies under this section shall be made from the the Federal Hospital Insurance Trust Fund and Federal Supplementary Medical Insurance Trust Fund, in the same proportion as payments for home health services are made from such trust funds.''.

(c) REDUCTION IN STANDARD PROSPECTIVE PAYMENT AMOUNT FOR AGENCIES THAT SUBMIT QUALITY DATA IN ORDER TO FUND PROGRAM.—Section 1895(b)(3) (42 U.S.C. 1395fff(b)(3)) is amended by adding at the end the following new subparagraph:

''(D) REDUCTION IN ORDER TO FUND VALUE-BASED PURCHASING PROGRAM.—

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

''(ii) APPLICABLE PERCENT.—For purposes of clause (i), the term 'applicable percent' means—

''(I) for 2008, 1.0 percent;

''(II) for 2009, 1.25 percent;

''(III) for 2010, 1.5 percent;

''(IV) for 2011, 1.75 percent; and

''(V) for 2012 and each subsequent year, 2.0 percent.''.

TITLE VII—VALUE-BASED PURCHASING FOR SKILLED NURSING FACILITIES

SEC. 701. REQUIREMENT FOR SKILLED NURSING FACILITIES TO REPORT FUNCTIONAL CAPACITY OF MEDICARE RESIDENTS UPON ADMISSION AND DISCHARGE.

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

''(9) REPORTING FUNCTIONAL CAPACITY AT ADMISSION AND DISCHARGE.—

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

pacity of each resident who is entitled to benefits under this part at the time of—

"(i) the admission of such resident; and

"(ii) the discharge of such resident.

"(B) TIMEFRAME.—A report required under subparagraph (A) shall be submitted within 10 days of the admission or discharge, as the case may be.".

SEC. 702. HHS STUDY ON MEASURES OF QUALITY FOR SKILLED NURSING FACILITIES; VOLUNTARY REPORTING OF SKILLED NURSING FACILITY QUALITY DATA.

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

(1) STUDY.—The Secretary shall conduct a study to determine the appropriate measures, including process and staffing measures, that should be used to evaluate the quality of the health care provided by skilled nursing facilities to individuals who are entitled to benefits under part A of title XVIII of the Social Security Act.

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

recommendations for such legislation and administrative actions as the Secretary considers appropriate.

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

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

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

(A) in clause (ii)(IV), by inserting ''subject to clause (iii),'' after ''subsequent fiscal year,''; and

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

''(iii) ADJUSTMENT IF QUALITY DATA NOT SUBMITTED.—

''(I) ADJUSTMENT.—For purposes of clause (ii)(IV), for fiscal year 2009 and each subsequent fiscal year,

in the case of a skilled nursing facility that does not submit data in accordance with subclause (II) with respect to such a fiscal year, the skilled nursing facility market basket percentage change applicable under such clause for such fiscal year shall be reduced by 2 percentage points. Such reduction shall apply only with respect to the fiscal year involved, and the Secretary shall not take into account such reduction in computing the Federal per diem rate under this section for a subsequent fiscal year.

''(II) SUBMISSION OF QUALITY DATA.—For fiscal year 2009 and each subsequent fiscal year, each skilled nursing facility shall submit to the Secretary such data that the Secretary determines is appropriate for the measurement of health outcomes and other indices of quality. Such data shall be submitted in a form and manner, and at a time, specified by

the Secretary for purposes of this clause.

''(III) The Secretary shall establish procedures for making data submitted under subclause (II) available to the public in a clear and understandable form. Such procedures shall ensure that a facility has the opportunity to review the data that is to be made public with respect to the facility prior to such data being made public.''.

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

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the advisability and feasibility of establishing a value-based purchasing program under the medicare program under title XVIII of the Social Security Act for skilled nursing facilities (as defined in section 1819(a) of such Act (42 U.S.C. 1395i–3(a)).

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

ministrative actions as the Commission considers appropriate.

TITLE VIII—ADDITIONAL PROVISIONS

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

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

(1) in paragraph (3)—

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

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

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

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

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

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

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

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

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

''(J) during the 5-year period beginning on the date the Secretary issues the interim final rule under section 801(c)(1) of the Medicare Value Purchasing Act of 2005, the provision, with or without charge, of any permitted support (as defined in paragraph (4)).''; and

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

''(4) PERMITTED SUPPORT.—

''(A) DEFINITION OF PERMITTED SUPPORT.—Subject to subparagraph (B), in this section, the term 'permitted support' means the provision of any equipment, item, information, right, license, intellectual property, software, training, or service used for developing, implementing, operating, or facilitating the use of systems designed to improve the quality of

health care and to promote the electronic exchange of health information.

''(B) EXCEPTION.—The term 'permitted support' shall not include the provision of—

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

''(ii) any support that has more than incidental utility or value to the recipient beyond the exchange of health care information; or

''(iii) any health information technology system, product, or service that is not capable of exchanging health care information in compliance with data standards consistent with interoperability.

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

''(I) whether the health information technology system, product, or service is

widely accepted within the industry and whether there is sufficient industry experience to ensure successful implementation of the system, product, or service; and

''(II) whether the health information technology system, product, or service improves quality of care, enhances patient safety, or provides greater administrative efficiencies.''.

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

''(9) PERMITTED SUPPORT.—During the 5-year period beginning on the date the Secretary issues the interim final rule under section 801(c)(1) of the Medicare Value Purchasing Act of 2005, the provision, with or without charge, of any permitted support (as defined in section 1128B(b)(4)).''.

(c) REGULATIONS.—In order to carry out the amendments made by this section—

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

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

SEC. 802. NATIONAL HEALTH INFORMATION NETWORK PILOT PROJECT.

(a) PILOT PROJECT.—

(1) ESTABLISHMENT.—For the purpose of improving health care quality, not later than 6 months after the date of enactment of this Act, the Secretary, in consultation with the National Coordinator for Health Information Technology, shall establish a pilot project to facilitate the exchange of—

(A) clinical claims and outcomes data with respect to beneficiaries under the medicare and medicaid programs, particularly such beneficiaries who are dually eligible under such programs; and

(B) clinical research findings and practice guidelines.

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

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

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

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

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

(A) shall include a physician, a physician group practice, a hospital, a free-standing laboratory, a renal dialysis provider or facility, a home health agency, a skilled nursing facility, a safety net provider, and any other entity or person determined appropriate by the Secretary; and

(B) may include regional health information networks, health plans, providers under the medicare program not described in subparagraph (A), vendors of health information technology systems and software, academic entities, and other entities involved in the exchange of data related to patient health status, clinical care guidelines, medical research, billing, claims, and health care quality.

(5) REQUIREMENT FOR PARTICIPANTS.—Participants in the pilot project under this section shall—

(A) comply with any interoperability standards and certification requirements and processes that have been developed or adopted by the Secretary or a designee of the Secretary;

(B) to the extent feasible, use existing resources, including the Internet; and

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

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

(b) REPORTS.—

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

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

(A) an analysis of—

(i) the methodologies for building a National Health Information Infrastructure; and

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

(B) findings regarding access to, and the quality of, care, efficiency of resource use, volume and utilization rates, and the projected future impact on the Medicare Trust Funds and other health care spending if the pilot project is expanded under subsection (c);

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

(D) recommendations for such legislation and administrative actions as the Secretary considers appropriate, including actions related to the nationwide expansion of the pilot project under subsection (c).

(3) MEDICARE TRUST FUNDS DEFINED.—In this title, the term ''Medicare Trust Funds'' means the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t).

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

(d) FUNDING.—There are authorized to be appropriated to the Secretary such sums as may be necessary to carry out this section.

SEC. 803. HEALTH CARE VALUE PROJECT.

(a) PROJECT.—

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

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

(3) PROJECT REQUIREMENTS.—

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

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

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

(B) TEAMS.—

(i) IN GENERAL.—Under the project, the Secretary shall assign to each site selected under subparagraph (A) a team made up of—

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

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

(III) activity-based cost accountants skilled at attaching real costs to health care outcomes.

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

(C) DUTIES.—

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

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

(ii) MEDICARE CLAIMS DATA.—In order to provide for a more complete analysis of the total costs and value of care, the Secretary shall make all medicare claims data available to members of the team so that links can be made to charges associated with physician visits, skilled nursing facility stays, and home health visits, inpatient and outpatient rehabilitation, durable medical equipment, clinical laboratory tests and other diagnostic tests, including imaging, and other items and services furnished to medicare beneficiaries.

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

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

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

(b) REPORT.—

(1) IN GENERAL.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to Congress a report on the project under this section.

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

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

(B) recommendations for such legislation and administrative actions as the Secretary considers appropriate.

(c) FUNDING.—There are authorized to be appropriated to the Secretary such sums as may be necessary to carry out this section.

SEC. 804. DEMONSTRATION PROJECT ON DATA AGGREGATION ACROSS ALL PAYORS OF HEALTH CARE SERVICES.

(a) DEMONSTRATION PROJECT.—

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

evaluate the process, costs, and benefits of aggregating data on quality of care across all payors of health care costs within health care delivery markets.

(2) DATA.—In selecting data to be aggregated under the demonstration project under this section, the Secretary shall give priority to measures which have the most potential to inform health care decisions by consumers and patients, to improve quality and efficiency of care delivered, and to be implemented by providers in a timely manner.

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

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

(5) PARTICIPANTS.—Participants in the demonstration project under this section may include regional health information networks, health plans, self-insured employers, State health programs, and other entities responsible for payment of costs asso-

ciated with health care coverage and with the exchange of data related to patient health status, billing, claims, and health care quality.

(6) REQUIREMENT FOR PARTICIPANTS.—Participants in the demonstration project under this section shall comply with any interoperability and certification standards and processes that have been developed or adopted by the Secretary or a designee of the Secretary.

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

(b) REPORT.—

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

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

(A) an analysis of—

(i) the methodologies for data aggregation, including processes for aggregation, analysis, attribution, risk adjustment, and reporting;

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

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

(iv) the effects of aggregation on the information provided to consumers and patients; and

(B) recommendations for such legislation and administrative actions as the Secretary considers appropriate.

(d) FUNDING.—There are authorized to be appropriated to the Secretary such sums as may be necessary to carry out this section.

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

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

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

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

(3) The accuracy and completeness of the data submitted by organizations pursuant to sections 1852(e)(3) and 1876(h)(6) of the Social Security Act, as added by section 401(a), and the appropriateness of value-based payments made to organizations under section 1860E–4 of such Act, as added by section 401(b), based on such data.

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

(5) The accuracy and completeness of the data submitted by home health agencies pursuant to section 1895(b)(3)(B)(v)(II) of the Social Security Act,

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

(b) REPORTS.—Not later than 2 years after the implementation of each of the value-based purchasing programs under sections 1860E–2, 1860E–3, 1860E–4, 1860E–5, and 1860E–6 of the Social Security Act, as added by this Act, the Comptroller General of the United States shall submit to Congress and the Secretary a report on the study conducted under subsection (a) that relates to data used under the applicable program, together with such recommendations for legislative or administrative action as the Comptroller General determines to be appropriate.

SEC. 806. HHS STUDY AND REPORT REGARDING TELEHEALTH AND TELEMEDICINE.

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

(1) The variation among State laws that relate to the licensure of physicians and practitioners (as defined in section 1860E–3(a)(3) of the Social Security Act, as added by section 301(b)).

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

(3) How such variation impacts the quality and safety of care furnished to, the experience of, and the financial cost incurred by, individuals in underserved and frontier areas who must travel long distances for routine visits with out-of-State physicians and practitioners (as so defined).

(4) The potential for interstate coordination between State licensure boards in regulating the practices of physician and practitioners (as so defined) to improve the matters described in paragraph (3), and the potential costs of such coordination.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit a report to Congress on the study conducted under subsection (a) together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

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