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109TH CONGRESS
2D SESSION

H. R. 5866

To amend titles XI and XVIII of the Social Security Act to reform physician payment under the Medicare Program, to modernize the quality improvement organization (QIO) program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JULY 24, 2006

Mr. BURGESS (for himself, Mr. NORWOOD, Mr. WELDON of Florida, and Mr. BOUSTANY) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend titles XI and XVIII of the Social Security Act to reform physician payment under the Medicare Program, to modernize the quality improvement organization (QIO) program, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Physician Payment Reform and Quality Improvement Act of 2006''.

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

TITLE I—MEDICARE PHYSICIAN PAYMENT REFORM

SEC. 101. MEDICARE PHYSICIAN PAYMENT UPDATE REFORM.

(a) SUBSTITUTION OF MEI INCREASE FOR SGR ADJUSTMENTS.—Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) is amended—

(1) in paragraph (1)(A), by inserting ''and before 2007'' after ''beginning with 2001'';

(2) in paragraph (1)(A), by inserting before the period at the end the following: ", and for years beginning with 2007, multiplied by the update established under paragraph (7) applicable to the year involved"; and

(3) in paragraph (4)—

(A) in the heading by striking "YEARS BEGINNING WITH 2001" and inserting "2001, 2002, AND 2003"; and

(B) in subparagraph (A), by inserting "and ending with 2003" after "beginning with 2001"; and

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

"(7) UPDATE BEGINNING WITH 2007.—The update to the single conversion factor established in paragraph (1)(C) for 2007 and each succeeding year shall be the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved minus 1 percentage point.".

(b) ENDING APPLICATION OF SUSTAINABLE GROWTH RATE (SGR).—Section 1848(f)(1)(B) of such Act (42 U.S.C. 1395w–4(f)(1)(B)) is amended by inserting "(and before 2006)" after "each succeeding year".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payment for services furnished on or after January 1, 2007.

SEC. 102. VOLUNTARY REPORTING OF QUALITY MEASURES FOR PHYSICIANS' SERVICES.

(a) REPORTING PROGRAM.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended by adding at the end the following new subsection:

''(k) QUALITY IMPROVEMENT.—

''(1) SELECTION OF QUALITY MEASURES (Q MEASURES).—

''(A) IN GENERAL.—Not later than January 1, 2009, the Secretary shall provide for the selection of quality measures (in this subsection referred to as 'Q-measures') consistent with and in accordance with this paragraph and paragraph (2).

''(B) LEVEL OF MEASUREMENT.—Q-measures shall be measures that provide for assessment of quality in the provision of services to individuals enrolled under this part at the level of a billing unit under this part.

''(C) CHARACTERISTICS OF MEASURES.—To the extent feasible and practicable, Q measures shall—

''(i) include a mixture of outcome measures, process measures (such as furnishing a service), and structural measures (such as the use of physician extenders, disease management, and health information technology for submission of measures);

''(ii) include measures of care furnished to frail individuals over the age of 75 and to individuals with multiple complex chronic conditions;

''(iii) be evidence-based, if pertaining to clinical care;

''(iv) be consistent, valid, practicable, and not overly burdensome to collect;

''(v) be relevant to physicians and other practitioners and individuals enrolled under this part;

''(vi) include measures that, taken as a whole, provide a balanced measure of performance of a billing unit under this part; and

''(vii) include measures that capture individuals' assessment of clinical care provided.

''(D) FAIRNESS.—To the extent feasible and practicable, this subsection shall be implemented in a manner that—

''(i) takes into account differences in individual health status;

''(ii) takes into account individual's compliance with orders;

''(iii) does not directly or indirectly encourage patient selection or de-selection by billing units under this part;

''(iv) reduces health disparities across groups and areas; and

''(v) uses appropriate statistical techniques to ensure valid results.

''(E) APPLICATION TO NON-PHYSICIAN PRACTITIONERS AND OTHER SUPPLIERS FOR WHICH PAYMENT IS MADE UNDER OR IN RELATION TO PHYSICIAN FEE SCHEDULE.—Insofar as physicians' services under this section are furnished by non-physician practitioner or a supplier other than a physician—

''(i) any reference in this subsection to a physician shall be a reference to such practitioner or supplier; and

''(ii) any reference to a physician specialty organization is deemed a reference to a specialty organization representing the speciality of such practitioners or suppliers.

''(F) DEVELOPMENT.—In developing Q measures, the Secretary shall provide for—

''(i) measurement of quality by stratified groups and the review of the absolute level of quality provided by a physician or medical group; and

''(ii) including practicing physicians with expertise in eliminating racial and ethnic health disparities in the design, implementation and evaluation of the program.

''(2) SELECTION PROCESS FOR MEASURES.—

''(A) SUBMISSION OF PROPOSED MEASURES TO CONSENSUS-BUILDING ORGANIZATION.—

''(i) BY PHYSICIAN SPECIALTY ORGANIZATIONS.—The Secretary shall request each physician specialty organization to submit to the consensus-building organization by January 1, 2008, proposed Q

measures described in clauses (i) through (vi) of paragraph (1)(C) that would be applicable to core clinical services that billing units under this part practicing in the specialty provide to individuals enrolled under this part.

''(ii) BY SECRETARY.—If the physician specialty organization for a physician specialty has not submitted proposed Q measures under clause (i) by January 1, 2008, the Secretary shall submit, as soon as possible but not later than February 1, 2008, proposed Q measures described in clauses (i) through (vi) of paragraph (1)(C) for such specialty to the consensus-building organization.

''(iii) CONSENSUS-BUILDING ORGANIZATION DEFINED.—For purposes of this paragraph, the term 'consensus-building organization' means an organization, such as the National Quality Forum, that the Secretary identifies as—

''(I) having experience in using a process (such as the process described in OMB circular A–119 published in

the Federal Register on February 10, 1998) for reaching a group consensus with respect to measures, such as Q measures, relating to performance of those providing health care services; and

''(II) including in such process representatives of the Secretary, practicing physicians (and, as provided under paragraph (1)(E), practicing non-physician practitioners and other suppliers), practitioners with experience in the care of the frail elderly and individuals with multiple complex chronic conditions, organizations and individuals representative of the specialty involved, individuals enrolled under this part, experts in health care quality, and individuals with experience in the delivery of health care in urban, rural, and frontier areas and to underserved populations and those who serve a disproportionate number of minority patients.

''(B) RECOMMENDATIONS BY CONSENSUS-BUILDING ORGANIZATION.—The consensus-building organization that receives proposed measures under subparagraph (A) is requested to submit to the Secretary by May 1, 2008, recommendations respecting the Q measures described in clauses (i) through (vi) of paragraph (1)(C) to be implemented under this subsection.

''(C) SECRETARIAL SELECTION.—The Secretary shall select Q measures described in paragraph (1)(C) for purposes of this subsection consistent with the following:

''(i) USE OF RECOMMENDATIONS FOR CLINICAL CARE MEASURES SUBMITTED BY CERTAIN ORGANIZATIONS.—Except as provided in clause (ii), the Secretary shall not select a Q measure described in clauses (i) through (vi) of paragraph (1)(C) and relating to clinical care unless that measure has been submitted by a physician specialty organization (or through a physician-consensus building process, such as the Physician Consortium for Performance Improvement) and recommended by the consensus-

building organization under subparagraph (B).

"(ii) PROVISION BY REGULATION.—The Secretary may by regulation select—

"(I) Q measures described in clauses (i) through (vi) of paragraph (1)(C) and relating to clinical care that do not meet the requirements of clause (i) only if the Secretary determines that there were no, or insufficient, recommendations regarding such Q measures under such clause and only if the Secretary takes into account research-based peer-reviewed medical publications in selecting such measures; and

"(II) Q measures described in clause (vii) or (viii) of paragraph (1)(C) and Q measures described in clause (i) through (vi) of such paragraph that do not relate to clinical care.

"(D) PERIODIC REVISION OF SELECTION.—The Secretary shall provide for the periodic revision and selection of Q measures con-

sistent with the provisions of this paragraph and paragraph (1) and the application of such revised Q measures on a prospective basis for a following year.

''(3) RATINGS OF PHYSICIANS BASED ON MEASURES.—

''(A) RATINGS AND IDENTIFICATION OF QUALITY PERFORMANCE.—

''(i) IN GENERAL.—The Secretary shall determine a single rating of each billing unit under this part based on Q measures selected under paragraph (2) and information reported under paragraph (4). Such a rating shall be determined for a billing unit based on its performance on Q measures relative to the performance of its peers taking into account the voluntary nature of the reporting system under this subsection.

''(ii) NO DIRECT DISCLOSURE OF RATING.—Subject to subparagraph (B), the Secretary shall not make such ratings of identifiable billing units under this part available other than to the respective unit.

"(iii) IMPROVEMENT AND PERFORMANCE THRESHOLDS.—For specification of improvement and performance thresholds, see paragraph (5)(C).

"(B) DISCLOSURE OF PERFORMANCE IN RELATION TO PERFORMANCE THRESHOLDS.—

"(i) IN GENERAL.—Subject to the succeeding provisions of this subparagraph, each year the Secretary shall make widely available to the public the following information regarding a billing unit's performance on the Q measures:

"(I) Whether the unit was a new billing unit or otherwise had insufficient data to provide for a measurement of whether it met the performance objectives under paragraph (5)(C).

"(II) For any other unit, whether the unit met the performance objectives under such paragraph.

"(ii) LIMITATION DURING FIRST 2 YEARS.—During 2009 and 2010, the Secretary shall not make the information under clause (i) with respect to an identifi-

able billing unit available other than to the respective unit.

''(iii) PHYSICIAN NOTIFICATION AND OPPORTUNITY FOR COMMENT OR APPEAL.—Before making information under clause (i) available with respect to a billing unit under this part for years beginning with 2010, the Secretary shall notify the unit of the performance on Q measures (including information on the unit's performance in relation to performance objectives and aggregate information regarding the performance of peers) and provide the opportunity for the unit to provide written comments regarding the unit's performance. The Secretary shall respond in writing to the comments and seek to reach agreement on the unit's performance and shall establish a formal appeals process in the event of continued disagreement concerning such performance. Upon conclusion of the appeals process, if the unit provides comments relating directly to the final determination under clause (i) respecting such performance, the Secretary shall dis-

close such comments with the disclosure of the information under such clause.

''(iv) APPLICATION OF HIPAA PRIVACY RULES.—Nothing in this subparagraph shall be construed as changing or affecting the application of rules promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

''(C) PEERS DEFINED.—For purposes of this subsection, the term 'peers' means, with respect to a billing unit under this part that practices in a specialty in an MA region (as established under section 1858(a)(2)), other billing units under this part that practice in the same specialty in the same region, or, beginning with the update for 2013, or in the United States.

''(4) REPORTING ON PERFORMANCE BEGINNING WITH 2008.—Beginning with 2008, each billing unit under this part may submit information on performance on the Q measures selected under this subsection with respect to individuals enrolled under this part. Such information shall be submitted in a form and manner and time specified by the Secretary, which may include submission as part of claims data under this part. The Secretary shall pro-

vide a process for auditing the accuracy of the information submitted under this paragraph.

''(5) INFORMATIONAL PERFORMANCE STANDARDS AND THRESHOLDS.—

''(A) IN GENERAL.—For purposes of disclosure under paragraph (3)(B), the Secretary shall establish quality performance objectives for billing units under this part.

''(B) DISCLOSURE.—For purposes of paragraph (3)(B), such a billing unit is considered to meet performance objectives for a year if, based on the unit's rating under paragraph (3)(A), the unit's performance meets or exceeds the performance thresholds specified by the Secretary under subparagraph (C).

''(C) IMPROVEMENT STANDARDS AND PERFORMANCE THRESHOLDS.—The Secretary shall specify the performance thresholds under subparagraphs (B) before the beginning of the year involved.

''(D) TREATMENT OF CASES OF INSUFFICIENT INFORMATION.—A billing unit is deemed to meet performance objectives under subparagraphs (B) and (C) if the unit complied with the reporting requirement under paragraph (4)

but there was insufficient information, as determined by the Secretary, to provide a valid measure of performance.

''(6) REVIEW OF ADDITIONAL EXPENSES.—Not later than January 1, 2010, and after consultation with the medical community, the Secretary shall review, and report to Congress on, the extent to which billing unit compliance with the reporting provisions of paragraph (4) results in increased work and practice expenses to billing units and whether participating billing units showed a demonstrable improvement in the delivery of quality health care.

''(7) PHYSICIAN AND BENEFICIARY EDUCATION.—During 2008, the Secretary shall establish a program to educate billing units under this part and individuals enrolled under this part about the voluntary quality disclosure system under this subsection and recommendations on training opportunities to improve ratings and performance on Q measures .

''(8) ANNUAL REPORT ON GROWTH IN VOLUME OF PHYSICIANS' SERVICES.—

''(A) IN GENERAL.—The Secretary shall report to the Medicare Payment Advisory Commission and Congress by April 1 of each year

(beginning with 2008) information on the growth in volume of services per enrollee and growth in expenditures per enrollee, based upon services and expenditures for which payment is based, or related to, the fee schedule established under this section.

''(B) DETAILS.—The information under subparagraph (A) shall—

''(i) be disaggregated by type of service, by geographic area, and by specialty of physicians (or, if applicable, of non-physician practitioners or suppliers);

''(ii) distinguish between growth in expenditures due to price change versus volume change and intensity change, including growth due to the development and improvement of procedures; and

''(iii) identify types of service or geographic areas where changes in volume or expenditures are inappropriate or unjustified, taking into account clinical outcomes.

''(C) RECOMMENDATIONS.—Each such report shall include recommendations to respond to inappropriate growth in service volume. Such

recommendations may include regulatory or legislative changes, or both.

''(D) MEDPAC RESPONSE.—The Medicare Payment Advisory Committee shall review each report submitted under this paragraph, including recommendations included under subparagraph (C). The Commission shall include in its report to Congress in June following each such report an analysis of the Secretary's findings and recommendations.

''(9) EVALUATION; REPORT.—

''(A) EVALUATION.—The Secretary shall provide for an evaluation of the operation of this subsection during the 5-year period in which this subsection is first applied. Such evaluation shall review the impact of this subsection on improving the quality of services and on access to such services and on the fairness of its implementation. Such evaluation shall include a study of the extent to which—

''(i) payment policies under this section exacerbate or diminish racial and ethnic health disparities; and

''(ii) there has been improvement in meeting performance measures for racial

and ethnic minorities through the operation of this section.

The Secretary is authorized to enter into a contract with the Institute of Medicine of the National Academy of Sciences for the conduct of the evaluation under this subparagraph.

''(B) REPORT.—The Secretary shall submit to Congress a report on such evaluation by not later than September 30, 2012.

''(10) WAIVER OF ADMINISTRATIVE AND JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869 or otherwise of—

''(A) the selection of Q measures under paragraphs (1) and (2);

''(B) the development and computation of ratings under paragraph (3)(A), standards and thresholds under paragraph (5)(C), and the application of such standards and thresholds under paragraphs (3)(B) and (5)(B); and

''(C) the definition of peers and new billing units under this subsection.''.

(b) CONFORMING MEDPAC DUTIES.—Section 1805(b)(2) of such Act (42 U.S.C. 1395b–6(b)(2)) is amended by adding at the end the following new subparagraph:

''(D) REVIEW OF REPORT ON GROWTH IN PHYSICIAN SERVICES.—Specifically, under section 1848(k)(8)(D), the Commission shall review and make recommendations concerning the Secretary's report on the growth of physicians' services under section 1848.''.

SEC. 103. REMOVING LIMITATIONS ON BALANCE BILLING WITH BENEFICIARY NOTICE FOR HIGHEST INCOME BENEFICIARIES.

(a) IN GENERAL.—Section 1848(g) of the Social Security Act (42 U.S.C. 1395w–4(g)) is amended—

(1) in paragraph (1)(A), in the matter before clause (i), by inserting '', subject to subparagraph (D),'' after ''enrolled under this part'';

(2) in paragraph (1), by adding at the end the following new subparagraph:

''(D) EXCEPTION FOR HIGHEST INCOME BENEFICIARIES.—Subparagraph (A) shall not apply with respect to physicians' services furnished in a month to an individual with respect to whom and for such month a reduction in premium subsidy is in effect under section 1839(i) if the individual furnishing such services provides the advance notice of such non-participation and non-acceptance of assignment

under paragraph (8) and (for services furnished on or after January 1, 2008) submits information in accordance with subsection (k)(4).''; and

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

''(8) NOTICE OF NON-PARTICIPATION AND NON-ACCEPTANCE OF ASSIGNMENT.—For purposes of paragraph (1)(D), the advance notice of non-participation and non-acceptance of assignment shall be, with respect to an item or service furnished under this part by (or under the supervision of) a physician, a notice (that may be in the form of a posting in a conspicuous place in a physician's office or on patient information forms) that is posted or otherwise furnished in a manner so as to inform the individual receiving the item or service that—

''(A) the physician furnishing (or supervising the furnishing of) the items or service is not a participating physician and does not accept assignment with respect to the service; and

''(B) because of such non-acceptance, in the case of physicians' services furnished in a month to an individual with respect to whom and for such month a reduction in premium subsidy is in effect under section 1839(i), the

charge imposed is not limited and may exceed the limiting charge described in paragraph (2).''.

(b) CONFORMING AMENDMENT TO PRIVATE CONTRACT PROVISIONS.—Section 1802 of such Act (42 U.S.C. 1395a) is amended by adding at the end the following new paragraph:

''(6) EXCEPTION FOR HIGHEST INCOME BENEFICIARIES.—The previous provisions of this subsection shall not apply to physicians' services furnished in a month to an individual with respect to whom and for such month a reduction in premium subsidy is in effect under section 1839(i) if the advance notice described in section 1848(g)(8) has been provided and (for services furnished on or after January 1, 2008) the physician furnishing the services submits information in accordance with section 1848(k)(4).''.

(c) CONFORMING AMENDMENT TO PARTICIPATION PROVISIONS.—Section 1842(h) of such Act (42 U.S.C. 1395u) is amended by adding at the end the following new paragraph:

''(8) The previous provisions of this subsection, insofar as they limit the charges that a participating physician may impose, shall not apply to physicians' services fur-

nished in a month to an individual with respect to whom and for such month a reduction in premium subsidy is in effect under section 1839(i) if the advance notice described in section 1848(g)(8) has been provided and (for services furnished on or after January 1, 2008) the physician furnishing the services submits information in accordance with section 1848(k)(4).''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2008.

(e) REVIEW AND REPORT ON IMPACT.—

(1) REVIEW.—The Secretary of Health and Human Services shall monitor and review the impact of the amendments made by this section on the access of medicare beneficiaries to physicians' services.

(2) REPORT.—Not later than January 1, 2009, the Secretary shall submit to Congress a report on such review and shall include such recommendations regarding changes in the amendments made by this section (such as reducing the income threshold applied for purposes of determining applicability of such amendments and thereby expanding the application of such amendments) as the Secretary deems appropriate.

TITLE II—QUALITY IMPROVEMENT ORGANIZATION (QIO) MODERNIZATION

SEC. 201. QUALITY IMPROVEMENT ACTIVITIES.

(a) INCLUSION OF QUALITY IMPROVEMENT FUNCTIONS.—Section 1154(a) of the Social Security Act (42 U.S.C. 1320c–3(a)) is amended by adding at the end the following new paragraph: ‘‘

‘‘(18) The organization shall offer quality improvement assistance to providers, practitioners, Medicare Advantage organizations offering Medicare Advantage plans under part C of title XVIII, and prescription drug sponsors offering prescription drug plans under part D of such title, including the following:

‘‘(A) Education on quality improvement initiatives, strategies and techniques.

‘‘(B) Instruction on how to collect, submit, aggregate and interpret data on measures that may be used for quality improvement, public reporting and payment.

‘‘(C) Instruction on how to conduct root-cause analyses.

''(D) Technical assistance for providers and practitioners in beneficiary education to facilitate patient self-management.

''(E) Facilitating cooperation among various local stakeholders in quality improvement.

''(F) Facilitating adoption of procedures that encourage timely candid feedback from patients and their families concerning perceived problems.

''(G) Guidance on redesigning clinical processes, including the adoption and effective use of health information technology, to improve the coordination, effectiveness, and safety of care.

''(H) Assistance in improving the quality of care delivered in rural and frontier areas and reducing health care disparities among racial and ethnic minorities, as well as gender disparities.''.

(b) MEDICARE QUALITY ACCOUNTABILITY PROGRAM.—Paragraph (14) of section 1154(a) of such Act (42 U.S.C. 1320c–3(a)) is amended to read as follows: ''

''(14)(A) The organization shall conduct an appropriate review of all written complaints about the quality of services (for which payment may otherwise be made under title XVIII) not meeting profes-

sionally recognized standards of health care, if the complaint is filed with the organization by an individual entitled to benefits for such services under such title (or a person acting on the individual's behalf). Before the organization concludes that the quality of services does not meet professionally recognized standards of health care, the organization must provide the practitioner or person concerned with reasonable notice and opportunity for discussion.

''(B) The organization shall establish and operate a Medicare quality accountability program consistent with the following:

''(i) The organization shall actively educate Medicare beneficiaries of their right to bring quality concerns to Quality Improvement Organizations.

''(ii) The organization shall report findings of its investigations to complainants, the beneficiary involved, or their representative, whether the complaint findings involve physicians or institutional providers, practitioners, or Medicare Advantage plans, but such complaint findings may not be used in any form in a medical malpractice action.

''(iii) The organization shall assist providers, practitioners, and plans in adopting best practices for soliciting and welcoming feedback about patient concerns, and assist providers, practitioners, and plans in remedying patient-reported problems that are confirmed by the organization and shall report findings of patient reported problems to the provider, practitioner, or plan involved before disclosing investigation results to the patient or patient's representative.

''(iv) The organization shall determine whether the complaint allegations about clinical quality of care are confirmed and assist provider, practitioners, and plans in remedying confirmed complaints.

''(v) The organization shall respond supportively to quality problems caused by unsafe systems, and refer for enforcement providers who are unwilling or unable to improve.

''(vi) The organization shall publish annual quality reports in each State in which the organization operates, including aggregate complaint data and provider performance on standardized quality measures.

''(vii) The organization shall promote beneficiary awareness of standardized quality measures that may be used for evaluating care and for choosing providers, practitioners and plans

''(C) The Secretary shall monitor and report to Congress, regarding—

''(i) the reliability of complaint determinations by Quality Improvement Organizations;

''(ii) the effect of disclosure of complaint findings on the availability of primary- and specialty-care physician reviewers;

''(iii) changes resulting from the systems change process described in subparagraph (B)(v); and

''(iv) trends in civil litigation filed by complainants.''.

SEC. 202. IMPROVED PROGRAM ADMINISTRATION.

Part B of title XI of the Social Security Act is amended by adding at the end the following new section:

''PROGRAM ADMINISTRATION

''SEC. 1164. (a) IMPROVED PROGRAM MANAGEMENT.—

''(1) REPORT ON MANAGEMENT OF THE QIO PROGRAM.—The Comptroller General of the United States shall submit to Congress, no later than March 31, 2010, a report on the implementation by

the Secretary and the Director of the Office of Management and Budget of this part and their overall management of the program under this part.

''(2) PROGRAM MANAGEMENT.—The report under paragraph (1) shall include a review of all of the following:

''(A) Implementation of the priorities, recommendations, and strategies of the strategic advisory committee under subsection (c)(1).

''(B) Implementation of appropriate program and contractor evaluation.

''(C) Ensuring timely issuance of statements of work.

''(D) Ensuring timely and priority QIO access to Medicare data for quality improvement purposes.

''(E) Ensuring timely apportionment of funding.

''(F) Ensuring funding levels for new work are added to the QIO contract, as described in the second sentence of section 1159(b)(1).

''(G) The process of developing the apportionment request and determining the funding allocation to QIOs.

''(H) The identification of and progress towards measures of effective management by the Secretary of the QIO program.

''(I) A review of the experience and qualifications of staff of the Centers for Medicare & Medicaid Services in overseeing the program.

''(3) INNOVATION.—The Secretary shall ensure that such staff Quality Improvement Organizations are provided maximum freedom in designing and applying intervention strategies for local quality improvement.

''(b) ASSURING DATA ACCESS.—The Secretary shall ensure that Quality Improvement Organizations have timely, top priority access to Medicare data for all parts of Medicare pertinent to the contract activities, in a form allowing the data to be integrated and analyzed by such organizations according to the needs of partners and beneficiaries in each jurisdiction.

''(c) SETTING STRATEGIC PRIORITIES.—

''(1) APPOINTMENT OF STRATEGIC ADVISORY COMMITTEE.—The Secretary shall appoint an independent strategic advisory committee, composed of national quality measurement and improvement experts, representatives of beneficiaries, health care

providers, and practitioners, and organizations holding contracts under this part.

''(2) DUTIES OF COMMITTEE.—Such committee shall set national strategic priorities for improvement in the quality of care, consistent with the Institute of Medicine's six aims for health care improvement, including safety, effectiveness, patient centeredness, timeliness, efficiency and equity, and update these in time to permit preparation of a draft statement of work and funding request for each program cycle under this part.

''(3) INDEPENDENT EVALUATION.—The committee should ensure that the Quality Improvement Organization program is evaluated by an independent entity using a study design, such as to a crossover design, to allow for a reliable assessment of program performance in a way that does not have an adverse impact on providers, practitioners, and plans that may work with the Organization.

''(4) FUNDING.—The Secretary shall allocate funds for the strategic advisory committee from the portion of the additional funding provided under the second sentence of section 1159(b)(1).

''(d) TAKING INTO ACCOUNT RECOMMENDATIONS FROM STAKEHOLDERS IN STATEMENTS OF WORK.—Each

statement of work under this part for a contract period beginning on or after August 1, 2008, shall include a task for the contracting Quality Improvement Organization to convene stakeholders to identify high priority quality problems for work in the contract period that are relevant to Medicare beneficiaries in the State. Each such organization shall propose, as part of such statement, one or more projects to the Secretary taking into consideration the recommendations of such stakeholders recommendations, along with suggested performance measures to evaluate progress on such item.

''(e) ALLOCATION OF RESOURCES TO PRIORITY AREAS.—The Secretary shall allocate at least 20 percent of the additional funding that is provided under the second sentence of section 1159(b)(1) to promote improvement in one or more locally defined priority areas identified under subsection (d).''.

SEC. 203. DATA DISCLOSURE.

Section 1160 of the Social Security Act (42 U.S.C. 1320c–9) is amended—

(1) in subsection (a)(3), by striking ''subsection (b)'' and inserting ''subsections (b) and (f)''; and

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

''(f)(1) An organization with a contract with the Secretary under this part may share individual-specific data with a physician treating the individual, for quality improvement and patient safety purposes.

''(2) The Secretary shall promulgate, not later than 30 days after the date of the enactment of this subsection, a regulation that permits the sharing of data under paragraph (1).

''(3) Nothing in this subsection shall be construed to limit, alter, or affect the requirements imposed the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.''.

SEC. 204. USE OF EVALUATION AND COMPETITION.

Section 1153 of the Social Security Act (42 U.S.C. 1320c–2) is amended—

(1) by amending paragraph (3) of subsection (c) to read as follows:

''(3) subject to subsection (k), the contract shall be for an initial term of five years and shall be renewable for each 5 years thereafter;''; and

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

''(k)(1) Subject to the succeeding provisions of this subsection, at the end of each contract period under sub-

section (c)(3), the contract shall be subject to open competition.

''(2) Before publishing a request for proposal for a contract period, the Secretary shall, in consultation with the strategic advisory committee appointed under section 1164(c)(1), establish measurable goals for each task to be included in such proposal. The contract shall include a performance threshold by which an organization holding a contract under this section may demonstrate excellent performance. The Secretary may not establish such performance thresholds in such a way as to predetermine or limit either the number or percentage of organizations which may demonstrate excellent performance.

''(3) The Secretary shall publish the request for proposals no later than four months prior to the beginning of such contract period.

''(4) The Secretary shall utilize the strategic advisory committee appointed under section 1164(c)(1) to qualify the validity, reliability, and feasibility of measures to be used in evaluating the performance of organizations holding a contract under this section. Before any performance measure may be used for such purpose, it must have been designated by such committee to be valid, reliable, and feasible for use under similar circumstances, as demonstrated in at least one reliable and valid study.

''(5) In the case of an open competition for a contract under this section, if an organization bidding for the contract demonstrates excellent performance in fulfilling the terms of such a contract during the previous contract period, the Secretary shall award the bidder a bonus equivalent to ten percent of the total possible score for the proposal.

''(6) The Secretary may not reduce the amount of a contract award below the amount proposed by the bidder prevailing in a competitive bidding process.

''(7) The Secretary shall design the process for performance evaluation of contracts under this section—

''(A) to avoid interfering with the work of contractors with plans, providers, and practitioners;

''(B) to hold harmless and not penalize contractors when performance is impaired or delayed by failures of the Secretary, personnel of the Department of Health and Human Services, or contractors of the Secretary to provide timely deliverables by other entities;

''(C) to use a continuous measurement strategy with provision for frequent performance updates for evaluating interim progress; and

''(D) to require that evaluation metrics be monitored and adjusted based on experience or evolving science over the course of a contract cycle.

''(8) At the end of each 5-year contract term, the Secretary may, without full and open competition, extend the term for an additional period of 5 years if the Secretary determines that the organization holding the contract has achieved excellent performance during the previous 5-year term. But in no case shall an organization be allowed to maintain such a contract for a period of longer than 10 years without being subject to full and open competition.''.

SEC. 205. QUALITY IMPROVEMENT FUNDING.

Section 1159 of the Social Security Act (42 U.S.C. 1320c–8) is amended—

(1) by inserting ''(a)'' before ''Expenses incurred''; and

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

''(b)(1) The aggregate annual funding under contracts under this part for fiscal year 2007 and each subsequent fiscal year shall not be less than $421,666,000. In addition, there are authorized to be appropriated for contract periods in subsequent fiscal years such additional amounts funds as may be necessary to adequately fund

any resource needs over the amount provided under the previous sentence.

''(2) At least 80 percent of the funding under this part in a contract period shall be expended in support of core contracts held by organizations under this part.

''(3) The Secretary shall determine the resource needs for a contract period in consultation with representatives from existing contractors. The determination shall take into account factors including any new work added via contract modification during the course of the contract period or added from one contract cycle to the next cycle. New work includes—

''(A) additional core contract tasks, requirements, deliverables, and performance thresholds;

''(B) technical assistance for additional providers, practitioners, and health plans and additional provider settings;

''(C) increased outreach and communications to Medicare beneficiaries, providers, practitioners, and plans; and

''(D) increased volume of medical reviews.

''(4) With respect to the apportionment of funds under this part for a contract period—

''(A) the Secretary shall submit a proposed apportionment to the Director of the Office of Manage-

ment and Budget no later than 1 year before the first date of the contract period;

''(B) such Director shall approve or deny the proposed apportionment no later than 9 months before the first date of such contract period;

''(C) for tasks the Secretary proposes to continue from the previous contract period, if the apportionment is not authorized by the deadline specified in subparagraph (B), funding shall continue for the next contract period at a level no less than the level for the previous contract period, increased by the percentage increase in the consumer price index for all urban consumers during the preceding 12-month period.

''(5) Organizations with a contract under this part may enter into contracts with public or private entities including providers, practitioners, and payers other than Secretary, to provide quality improvement or other forms of technical assistance if there were arrangements made to avoid potential conflicts of interest.

''(6) Such organizations shall have the ability to meet the terms of a contract by allocating funds to functions established by the Secretary at its discretion. The Secretary shall review the allocation of these funds and whether the organization met the functions and goals set

out for the organization, regardless of allocation of funds at the initial acceptance of the contract.''.

SEC. 206. QUALIFICATIONS FOR QIOS.

(a) IN GENERAL.—Section 1153(b) of the Social Security Act (42 U.S.C. 1320c–2(b)) is amended by adding at the end the following new paragraph:

''(4) The Secretary shall not enter into or renew a contract under this section with an entity unless the following requirements are met:

''(A) The entity's governing body must reflect representation of consumers and other stakeholders.

''(B) The entity must have demonstrated success in facilitating clinical and administrative system redesign to improve the coordination, effectiveness, and safety of health care, and in facilitating cooperation among stakeholders in quality improvement.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to contract periods beginning after the date of the enactment of this Act.

SEC. 207. COORDINATION WITH MEDICAID.

(a) PERMITTING ALTERNATIVE QUALITY IMPROVEMENT PROGRAM.—Section 1902(a)(30) of the Social Security Act (42 U.S.C. 1396a(a)(30)) is amended by striking ''and'' at the end of subparagraph (A), by adding

''and'' and the end of subparagraph (B), and by adding at the end the following new subparagraph:

''(C) provide, at the discretion of the State plan, for a quality improvement program in place of the program described in subparagraph (A), in whole or in part, that—

''(i) establishes priorities for achieving significant measurable improvement in the quality of health care services provided to individuals eligible under this title, and reviews such priorities at least every five years for the purpose of making appropriate revisions;

''(ii) provides quality improvement assistance to providers and practitioners consistent with such priorities; and

''(iii) provides for an annual report to the Secretary on quality performance under such plan of providers and practitioners using nationally standardized quality measures;''.

(b) ROLE OF QIOS.—Section 1902(d) of such Act (42 U.S.C. 1396a(d)) is amended—

(1) by inserting ''(1)'' after ''(d)''; and

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

''(2) If a State contracts with a Quality Improvement Organization having a contract with the Secretary under part B of title XI for the performance of quality improvement program activities required by subsection (a)(30)(C), such requirements shall be deemed to be met for those activities by delegation to such an Organization if the contract provides for the performance of activities not inconsistent with part B of title XI and provides for such assurances of satisfactory performance by such an entity or organization as the Secretary may prescribe.''.

(c) FUNDING.—Section 1903(a)(3)(C) of such Act (42 U.S.C. 1396b(a)(3)(C)) is amended—

(1) in clause (i), by striking ''1902(d)'' and inserting ''1902(d)(1)''; and

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

''(iii) 75 percent of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of quality improvement program activities by a Quality

Improvement Organization under a contract entered into under section 1902(d)(2); and''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to contract periods beginning after the date of the enactment of this Act

TITLE III—MEDICARE SAVINGS AND OTHER PROVISIONS

SEC. 301. ELIMINATION OF STABILIZATION FUND FOR REGIONAL PPOS.

(a) IN GENERAL.—Except as provided in subsection (b), no funds shall be available for obligation, on or after the date of the enactment of this Act, from the MA Regional Plan Stabilization Fund (under section 1858(e) of the Social Security Act).

(b) AVAILABILITY OF FREED UP FUNDS.—Amounts in such MA Regional Plan Stabilization Fund that are not otherwise obligated shall be transferred and deposited into the Medicare Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t) without additional appropriation to cover additional expenditures resulting from the amendments made by section title I of this Act.

SEC. 302. ONGOING EXAMINATION OF MEDICARE FUNDING.

(a) EXAMINATION BY BOARD OF TRUSTEES.—The Board of Trustees of the Federal Hospital Insurance Trust Fund and of the Federal Supplementary Medical Insurance Trust Fund shall monitor and examine the extent to which the different funding mechanisms under parts A, B, and D of title XVIII of the Social Security Act provide an appropriate alignment with the program goals of the respective parts. Such examination shall include an examination of each of the following:

(1) The extent to which, as volume of services increases in physician settings under such part B, there is a corresponding reduction in similar services provided in a hospital setting under such part A.

(2) The extent to which, as a result of increased coordination between physicians and the delivery of prescription drugs under such part D, particularly with respect to individuals with chronic conditions, there will there be a decrease in hospitalizations under such part A.

(3) The extent to which other changes in physician or other health care practice results in a shifting of expenditures among the various parts.

(b) INCLUSION IN ANNUAL REPORTS.—In each annual report submitted to the Congress after the date of the enactment of this Act under section 1817(b)(2) or sec-

tion 1841(b)(2) of the Social Security Act (42 U.S.C. 1395i(b)(2), 1395t(b)(2)), such Board of Trustees shall include information on the matters described in subsection (a).

SEC. 303. ONE-YEAR DELAY IN MEDICARE ADJUSTMENTS IN PAYMENTS FOR IMAGING SERVICES; IOM STUDY ON UTILIZATION AND APPROPRIATENESS OF IMAGING SERVICES.

(a) DELAY.—Subsections (b)(4)(A), (c)(2)(B)(v)(I), and (c)(2)(B)(v)(II) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by section 5102 of the Deficit Reduction Act of 2005 (Public Law 109–171) are each amended by striking ''2007'' and inserting ''2008''.

(b) STUDY AND REPORT ON UTILIZATION AND APPROPRIATENESS OF IMAGING SERVICES.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall request (and shall enter into a contract with) the Institute of Medicine to conduct a study of the utilization and appropriateness of imaging services described in section 1848(b)(4)(B) of the Social Security Act (42 U.S.C. 1395w–4(b)(4)(B)) under the Medicare program and to submit to the Secretary, not later than April 1, 2007, a report on such study, including recommendations

regarding changes in medicare payment for such services. Such study shall include an examination of—

(A) the role of medical malpractice in the utilization of such services;

(B) the impact of utilization of such services in reducing or increasing the subsequent delivery of services;

(C) the impact of increased disease as a factor in utilization of such services; and

(D) a delineation of factors in utilization and appropriateness by site of service, by modality, and by specialty.

(2) REPORT.—The Secretary shall submit to Congress the report submitted under paragraph (1).

SEC. 304. ELIMINATING PHASE-IN FOR IMPLEMENTATION OF REDUCTION IN PART B PREMIUM SUBSIDY FOR HIGHER INCOME BENEFICIARIES.

Section 1839(i)(3) of the Social Security Act (42 U.S.C. 1395r(i)(3)) is amended—

(1) in subparagraph (A), by striking ''Subject to subparagraph (B), the'' and inserting ''The'';

(2) in subparagraph (A)(i), by striking ''subparagraph (C)'' and inserting ''subparagraph (B)'';

(3) by striking subparagraph (B); and

(4) by redesignating subparagraph (C) as subparagraph (B).

SEC. 305. EXCLUSION OF INDIRECT GRADUATE MEDICAL EDUCATION PAYMENT IN COMPUTATION OF PAYMENTS TO MEDICARE ADVANTAGE ORGANIZATIONS.

(a) IN GENERAL.—Section 1853(c)(1)(D)(i) of the Social Security Act (42 U.S.C. 1395w–23(c)(1)(D)(i)) is amended by inserting ''or under section 1886(d)(5)(B)'' after ''1886(h)''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to payment for years beginning with 2007 and the Secretary of Health and Human Services shall provide for the application of clause (i) of section 1853(c)(1)(D) of the Social Security Act, as so amended, for 2007.

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