109TH CONGRESS
2D SESSION

S. 3900

To amend title XVIII of the Social Security Act to improve the quality and efficiency of health care, to provide the public with information on provider and supplier performance, and to enhance the education and awareness of consumers for evaluating health care services through the development and release of reports based on Medicare enrollment, claims, survey, and assessment data.

IN THE SENATE OF THE UNITED STATES

SEPTEMBER 14, 2006

Mr. GREGG (for himself, Mr. FRIST, Mr. BURR, Mr. CORNYN, and Mr. BENNETT) 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 improve the quality and efficiency of health care, to provide the public with information on provider and supplier performance, and to enhance the education and awareness of consumers for evaluating health care services through the development and release of reports based on Medicare enrollment, claims, survey, and assessment data.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medicare Quality Enhancement Act of 2006''.

SEC. 2. QUALITY AND EFFICIENCY REPORTS BASED ON MEDICARE ENROLLMENT, CLAIMS, SURVEY, AND ASSESSMENT DATA.

Title XVIII of the Social Security Act is amended by adding at the end the following new section:

''QUALITY AND EFFICIENCY REPORTS BASED ON MEDICARE DATA

''SEC. 1898. (a) PURPOSE.—The purpose of this section is to provide for the development of reports based on Medicare data and private data that is publicly available or is provided by the entity making the request for the report in order to—

''(1) improve the quality and efficiency of health care;

''(2) enhance the education and awareness of consumers for evaluating health care services; and

''(3) provide the public with reports on national, regional, and provider- and supplier-specific performance, which may be in a provider- or supplier-identifiable format.

''(b) PROCEDURES FOR THE DEVELOPMENT OF REPORTS.—

''(1) IN GENERAL.—Notwithstanding section 552(b)(6) or 552a(b) of title 5, United States Code, not later than 12 months after the date of enactment of the Medicare Quality Enhancement Act of 2006, the Secretary, in accordance with the purpose described in subsection (a), shall establish and implement procedures under which an entity may submit a request to a Medicare Quality Reporting Organization for the Organization to develop a report based on—

''(A) Medicare data disclosed to the Organization under subsection (c); and

''(B) private data that is publicly available or is provided to the Organization by the entity making the request for the report.

''(2) DEFINITIONS.—In this section:

''(A) MEDICARE DATA.—The term 'Medicare data' means—

''(i) enrollment data under this title, including de-identified beneficiary enrollment data;

''(ii) all claims for reimbursement for all items and services furnished by a provider of services (as defined in section 1861(u)) or a supplier (as defined in sec-

tion 1861(d)) under part A or B in a research identifiable format;

''(iii) on and after January 1, 2008, all data relating to enrollment in, and coverage for, qualified prescription drug coverage under part D; and

''(iv) additional data files relating to the program under this title collected by the Secretary for the purpose of nationwide quality measurement and reporting based on surveys and assessment data determined appropriate by the Secretary.

''(B) MEDICARE QUALITY REPORTING ORGANIZATION.—The term 'Medicare Quality Reporting Organization' means an entity with a contract under subsection (d).

''(c) ACCESS TO MEDICARE DATA.—

''(1) IN GENERAL.—The procedures established under subsection (b)(1) shall provide for the disclosure of Medicare data to each Medicare Quality Reporting Organization.

''(2) ALL DATA.—The Secretary shall ensure that all Medicare data files (beginning with files from January 1, 1998) are disclosed under paragraph (1), including the most recent data files avail-

able to the Secretary. Not less than every 6 months, the Secretary shall update the information disclosed under paragraph (1) to Medicare Quality Reporting Organizations.

''(d) MEDICARE QUALITY REPORTING ORGANIZATIONS.—

''(1) IN GENERAL.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall enter into a contract with at least 4 private entities to serve as Medicare Quality Reporting Organizations under which an entity shall—

''(i) store the Medicare data that is to be disclosed under subsection (c); and

''(ii) develop and release reports pursuant to subsection (e).

''(B) REQUIREMENT.—The Secretary shall enter into contracts with a sufficient number of entities to develop and release such reports in a timely manner.

''(2) QUALIFICATIONS.—The Secretary shall enter into a contract with an entity under paragraph (1) only if the Secretary determines that the entity—

''(A) has the research capability to conduct and complete reports under this section;

''(B) has in place–

''(i) an information technology infrastructure to support the entire database of Medicare data; and

''(ii) operational standards to provide security for such database;

''(C) has experience with, and expertise on, the development of reports on health care quality and efficiency based on Medicare or private sector claims data; and

''(D) has a significant business presence in the United States.

''(3) CONTRACT REQUIREMENTS.—Each contract with an entity under paragraph (1) shall contain the following requirements:

''(A) ENSURING BENEFICIARY PRIVACY.—The entity shall provide assurances that the entity will not use the Medicare data disclosed under subsection (c) in a manner that violates—

''(i) the Federal regulations (concerning the privacy of individually identifiable beneficiary health information) pro-

mulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996; or

''(ii) sections 552 or 552a of title 5, United States Code, with regards to the privacy of individually identifiable beneficiary health information.

''(B) DISCLOSURE.—The entity shall disclose—

''(i) any financial, reporting, or contractual relationship between the entity and any provider of services (as defined in section 1861(u)) or supplier (as defined in section 1861(d)); and

''(ii) if applicable, the fact that the entity is not managed, controlled, and operated independently from any such provider of services or supplier.

''(C) COMPONENT OF ANOTHER ORGANIZATION.—If the entity is a component of another organization—

''(i) the entity shall maintain Medicare data and reports separately from the rest of the organization and establish appropriate security measures to maintain

the confidentiality and privacy of the Medicare data and reports; and

''(ii) the entity shall not make an unauthorized disclosure to the rest of the organization of Medicare data or reports in breach of such confidentiality and privacy requirement.

''(D) TERMINATION OR NONRENEWAL.—If a contract under this section is terminated or not renewed, the following requirements shall apply:

''(i) CONFIDENTIALITY AND PRIVACY PROTECTIONS.—The entity shall continue to comply with the confidentiality and privacy requirements under this section with respect to all Medicare data disclosed to the entity and each report developed by the entity.

''(ii) DISPOSITION OF DATA AND REPORTS.—The entity shall—

''(I) return to the Secretary all Medicare data disclosed to the entity and each report developed by the entity; or

''(II) if returning the Medicare data and reports is not practicable, destroy the reports and Medicare data.

''(4) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Federal Procurement Policy Act) shall be used to enter into contracts under paragraph (1).

''(5) REVIEW OF CONTRACT IN THE EVENT OF A MERGER OR ACQUISITION.—The Secretary shall review the contract with a Medicare Quality Reporting Organization under this section in the event of a merger or acquisition of the Organization in order to ensure that the requirements under this section will continue to be met.

''(e) DEVELOPMENT AND RELEASE OF REPORTS BASED ON REQUESTS.—

''(1) REQUEST FOR A REPORT.—

''(A) REQUEST.—

''(i) IN GENERAL.—The procedures established under subsection (b)(1) shall include a process for an entity to submit a request to a Medicare Quality Reporting Organization for a report based on Medicare data and private data that is publicly

available or is provided by the entity making the request for the report. Such request shall comply with the purpose described in subsection (a).

''(ii) REQUEST FOR SPECIFIC METHODOLOGY.—The process described in clause (i) shall permit an entity making a request for a report to request that a specific methodology be used by the Medicare Quality Reporting Organization in developing the report. The Organization shall work with the entity making the request to finalize the methodology to be used.

''(iii) REQUEST FOR A SPECIFIC MQRO.—The process described in clause (i) shall permit an entity to submit the request for a report to any Medicare Quality Reporting Organization.

''(B) RELEASE TO PUBLIC.—The procedures established under subsection (b)(1) shall provide that at the time a request for a report is finalized under subparagraph (A) by a Medicare Quality Reporting Organization, the Organization shall make available to the public, through the Internet website of the Centers for

Medicare & Medicaid Services and other appropriate means, a brief description of both the requested report and the methodology to be used to develop such report.

''(2) DEVELOPMENT AND RELEASE OF REPORT.—

''(A) DEVELOPMENT.—

''(i) IN GENERAL.—If the request for a report complies with the purpose described in subsection (a), the Medicare Quality Reporting Organization may develop the report based on the request.

''(ii) REQUIREMENT.—A report developed under clause (i) shall include a detailed description of the standards, methodologies, and measures of quality used in developing the report.

''(B) REVIEW OF REPORT BY SECRETARY TO ENSURE COMPLIANCE WITH PRIVACY REQUIREMENT.—Prior to a Medicare Quality Reporting Organization releasing a report under subparagraph (C), the Secretary shall review the report to ensure that the report complies with the Federal regulations (concerning the privacy of individually identifiable beneficiary

health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 and sections 552 or 552a of title 5, United States Code, with regards to the privacy of individually identifiable beneficiary health information. The Secretary shall act within 30 business days of receiving such report.

''(C) RELEASE OF REPORT.—

''(i) RELEASE TO ENTITY MAKING REQUEST.—If the Secretary finds that the report complies with the provisions described in subparagraph (B), the Medicare Quality Reporting Organization shall release the report to the entity that made the request for the report.

''(ii) RELEASE TO PUBLIC.—The procedures established under subsection (b)(1) shall provide for the following:

''(I) UPDATED DESCRIPTION.—At the time of the release of a report by a Medicare Quality Reporting Organization under clause (i), the entity shall make available to the public, through the Internet website of the

Centers for Medicare & Medicaid Services and other appropriate means, an updated brief description of both the requested report and the methodology used to develop such report.

"(II) COMPLETE REPORT.—Not later than 1 year after the date of the release of a report under clause (i), the report shall be made available to the public through the Internet website of the Centers for Medicare & Medicaid Services and other appropriate means.

"(f) PERIODIC REVIEW OF REPORTS.—The Secretary shall periodically review reports released under subsection (e)(2)(C) to ensure that such reports comply with the purpose described in subsection (a). The Secretary may terminate a contract with a Medicare Quality Reporting Organization if the Secretary determines that there is a pattern of reports being released by the Organization that do not comply with such purpose.

"(g) FEES.—

"(1) FEES FOR SECRETARY.—The Secretary shall charge a Medicare Quality Reporting Organization a fee for—

''(A) disclosing the data under subsection (c); and

''(B) conducting the review under subsection (e)(2)(B).

The Secretary shall ensure that such fees are sufficient to cover the costs of the activities described in subparagraph (A) and (B).

''(2) FEES FOR MQRO.—A Medicare Quality Reporting Organization may charge an entity making a request for a report a reasonable fee for the development and release of the report.

''(h) REGULATIONS.—Not later than 6 months after the date of enactment of the Medicare Quality Enhancement Act of 2006, the Secretary shall prescribe regulations to carry out this section.

''(i) GAO STUDIES AND REPORT.—

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

''(A) The feasibility of requiring Medicare Advantage organizations under part C to share utilization and quality data with the Secretary for the purpose of releasing such information to Medicare Quality Reporting Organizations under this section.

''(B) The Medicare data released to Medicare Quality Reporting Organizations under subsection (c) in order to determine the accuracy of such data with respect to—

''(i) the coding of demographic data;

''(ii) diagnosis and procedures; and

''(iii) any other data elements important for the development of reports under this section in accordance with the purpose described in subsection (a).

''(2) REPORT.—Not later than 12 months after the date of enactment of the Medicare Quality Enhancement Act of 2006, the Comptroller General of the United States shall submit a report to Congress on each of the studies conducted under paragraph (1) together with recommendations for such legislation and administrative actions as the Comptroller General considers appropriate.''.

SEC. 3. QUALITY ADVISORY BOARD.

(a) ESTABLISHMENT.—Not later than 12 months after the date of enactment of this Act, the Secretary of Health and Human Services shall establish within the Office of the Secretary a board to be known as the Quality Advisory Board (in this section referred to as the ''Board'').

(b) MEMBERSHIP.—The members of the Board shall include, but not be limited to, an appropriate number of representatives of—

(1) groups representing Medicare beneficiaries;

(2) groups representing providers of services (as defined in subsection (u) of section 1861 of the Social Security Act (42 U.S.C. 1395x)) and suppliers (as defined in subsection (d) of such section) receiving reimbursement under the Medicare program;

(3) purchasers and employers or groups representing purchasers and employers;

(4) organizations focused on the development of quality health care measures;

(5) researchers or research institutions with experience in the measurement of, and reporting on, health care quality; and

(6) health plans or groups representing health plans.

(c) DUTIES.—The duties of the Board are as follows:

(1) To coordinate existing collaborative efforts identifying quality and efficiency health care measures.

(2) To provide the Secretary of Health and Human Services with recommendations for the de-

velopment of model quality health care measurements.

(3) To submit requests to Medicare Quality Reporting Organizations under section 1898 of the Social Security Act, as added by section 2, for reports on existing recommended model quality and efficiency health care measures.

(4) To examine how clinical registries can be linked to Medicare data (as defined in subsection (b)(2)(A) of such section 1898) in order to develop reports on the quality and efficiency of providers of services (as defined in subsection (u) of section 1861 of the Social Security Act (42 U.S.C. 1395x)) and suppliers (as defined in subsection (d) of such section).

(5) Other duties determined appropriate by the Secretary.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of Health and Human Services such sums as may be necessary for the purpose of carrying out this section.

SEC. 4. RESEARCH ACCESS TO MEDICARE DATA AND REPORTING ON PERFORMANCE.

The Secretary of Health and Human Services shall permit researchers that meet existing criteria used to

evaluate the appropriateness of the release of Centers for Medicare & Medicaid Services (CMS) data for research purposes to—

(1) have access to all Medicare data (as defined in section 1898(b)(2)(A) of the Social Security Act, as added by section 2); and

(2) report on the performance of providers of services (as defined in subsection (u) of section 1861 of such Act (42 U.S.C. 1395x)) and suppliers (as defined in subsection (d) of such section), including reporting in a provider- or supplier-identifiable format.

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