115TH CONGRESS
1ST SESSION

S. 1317

To amend titles XI and XIX of the Social Security Act to establish a comprehensive and nationwide system to evaluate the quality of care provided to beneficiaries of Medicaid and the Children's Health Insurance Program and to provide incentives for voluntary quality improvement.

IN THE SENATE OF THE UNITED STATES

JUNE 8, 2017

Mr. BROWN introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend titles XI and XIX of the Social Security Act to establish a comprehensive and nationwide system to evaluate the quality of care provided to beneficiaries of Medicaid and the Children's Health Insurance Program and to provide incentives for voluntary quality improvement.

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 "Medicaid and CHIP Quality Improvement Act of 2017".

SEC. 2. FINDINGS.

Congress finds the following:

(1) Despite the fact that Federal and State governments spend hundreds of billions of dollars every year on care for Americans through the Medicaid and CHIP programs, there is no nationwide, systematic method of reporting, collecting, evaluating, or improving the quality of care across all payment and delivery systems (fee-for-service, managed care, primary care case management, or other mechanisms).

(2) Although the quality of care delivered through Medicaid health plans is frequently measured, there is no method or mechanism to systematically improve the quality of care provided to all Medicaid and CHIP beneficiaries.

(3) For the majority of Medicaid and CHIP enrollees who are served by primary care case management or fee-for-service arrangements, there are no Federal requirements for comparable quality monitoring or improvement. Thus there currently is no ability to make fair assessments across all modes of care for Medicaid and CHIP enrollees.

(4) State flexibility and the resulting opportunities for innovation are hallmarks of the partnership between Federal and State governments in the Med-

icaid and CHIP programs. Without a way to systematically measure quality, however, policymakers cannot know which innovations are the most effective.

SEC. 3. MEASURING AND REPORTING ON COMPARABLE HEALTH CARE QUALITY MEASURES FOR ALL PERSONS ENROLLED IN MEDICAID.

(a) QUALITY ASSURANCE STANDARDS.—Section 1932(c)(1)(A) of the Social Security Act (42 U.S.C. 1396u–2(c)(1)(A)) is amended by inserting ''or comparable primary care case management services providers described in section 1905(t) as well as health care services furnished in fee-for-service settings or other delivery systems'' after ''1903(m)''.

(b) ADULT HEALTH QUALITY MEASURES.—Section 1139B of the Social Security Act (42 U.S.C. 1320b–9b) is amended—

(1) in subsection (b)—

(A) by redesignating paragraphs (4) and (5) as paragraphs (5) and (6), respectively; and

(B) by inserting after paragraph (3), the following:

''(4) QUALITY REPORTING FOR MEDICAID ELIGIBLE ADULTS.—Beginning not later than January 1 of the calendar year that begins on or after the date that is 2 years after the date of enactment of

the Medicaid and CHIP Quality Improvement Act of 2017, and annually thereafter, the Secretary shall require States to use the measures and approaches identified in paragraph (3) to report on the initial core set of quality measures for Medicaid eligible adults identified in paragraph (2), subject to revisions made in accordance with paragraph (6)(B). Such reporting shall be stratified by delivery system, including managed care organizations under section 1932, benchmark plans under section 1937, primary care case management services providers described in section 1905(t), health care services in fee-for-service settings, and other delivery systems, except that the Secretary may determine that reporting on certain measures should not be stratified by delivery system because such stratification would not be feasible or the delivery systems are not comparable with respect to the application of such measures. In addition to the stratification required under the previous sentence, the Secretary shall have the discretion to further stratify reporting on certain measures based on factors such as eligibility category, income level, or other differentiating factors that could have an impact on the comparability of the measure.''; and

(2) in subsection (d)—

(A) in paragraph (1)(A), by striking ''under the such plan'' and all that follows through ''subsection (a)(5)'' and inserting ''under such plan or waiver, including measures described in subsection (b)(2), subject to revisions made in accordance with subsection (b)(6)(B)'';

(B) in paragraph (1)(B), by inserting '', or comparable primary care case management services providers described in section 1905(t), as well as health care services furnished in fee-for-service settings or other delivery systems'' after ''section 1937''; and

(C) in paragraph (2), by inserting before the period the following: '', including analysis of comparable quality measures for Medicaid eligible adults who receive their health services through managed care, primary care case management, and fee-for-service settings or other delivery systems''.

(c) PEDIATRIC HEALTH CARE MEASURES.—

(1) IN GENERAL.—Section 1139A of the Social Security Act (42 U.S.C. 1320b–9a) is amended—

(A) in subsection (a)—

(i) by redesignating paragraphs (5) through (8) as paragraphs (6) through (9), respectively; and

(ii) by inserting after paragraph (4) the following:

''(5) REPORTING OF PEDIATRIC HEALTH CARE MEASURES.—Beginning not later than January 1 of the calendar year that begins on or after the date that is 2 years after the date of enactment of the Medicaid and CHIP Quality Improvement Act of 2017, and annually thereafter, the Secretary shall require States to use the measures and approaches identified in paragraph (4) to report on the initial core child health care quality measures established under this subsection and as such measures subsequently are updated under subsection (b)(5). Such reporting shall be stratified by delivery system, including managed care organizations under section 1932, benchmark plans under sections 1937 and 2103, primary care case management services providers described in section 1905(t), health care services in fee-for-service settings, and other delivery systems, except that the Secretary may determine that reporting on certain measures should not be stratified by delivery system because such stratifica-

tion would not be feasible or the delivery systems are not comparable with respect to the application of such measures. In addition to the stratification required under the previous sentence, the Secretary shall have the discretion to further stratify reporting on certain measures based on factors such as eligibility category, income level, or other differentiating factors that could have an impact on the comparability of the measure.''; and

(B) in subsection (c)—

(i) in paragraph (1)(A), by striking ''measures described in subparagraphs (A) and (B) of subsection (a)(6)'' and inserting ''the core measures described in subsection (a), as revised in accordance with subsection (b)(5)'';

(ii) in paragraph (1)(B), by inserting before the period the following: '', or comparable primary care case management services providers described in section 1905(t), as well as healthcare services furnished in fee-for-service settings or other delivery systems''; and

(iii) in paragraph (2), by inserting before the period the following: '', including

analysis of comparable quality measures for children eligible for medical assistance under title XIX or child health assistance under title XXI who receive their health services through managed care, primary care case management, and fee-for-service settings or other delivery systems''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall take effect as if included in the enactment of section 1139A of the Social Security Act, as added by section 401(a) of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3).

SEC. 4. PERFORMANCE BONUSES FOR SIGNIFICANT ACHIEVEMENT IN MEDICAID AND CHIP QUALITY PERFORMANCE.

Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end the following new subsection:

''(aa) PERFORMANCE BONUS FOR QUALITY PERFORMANCE ACHIEVEMENT.—

''(1) IN GENERAL.—The Secretary shall establish a Medicaid Quality Performance Bonus fund for awarding performance bonuses to States for high attainment and improvement on a core set of quality

measures related to the goals and purposes of the Medicaid program under this title.

''(2) QUALITY PERFORMANCE BONUS METHODOLOGY.—Not later than 3 years after the date of enactment of the Medicaid and CHIP Quality Improvement Act of 2017, the Secretary shall establish a methodology for awarding Medicaid quality performance bonuses to States not less than annually in accordance with paragraph (3) and subject to the availability of appropriations. Medicaid quality performance bonuses shall be awarded on the basis of the annual State reports required under sections 1139A and 1139B and in accordance with regulations promulgated by the Secretary.

''(3) QUALITY PERFORMANCE MEASUREMENT BONUSES.—Medicaid quality performance bonuses shall be awarded to the following 10 States:

''(A) The top 5 States achieving the designation of superior quality performing State under criteria established by the Secretary.

''(B) The 5 States that—

''(i) are not among the States described in subparagraph (A); and

''(ii) demonstrate the greatest relative level of annual improvement in quality per-

formance under criteria established by the Secretary.

''(4) INITIAL APPROPRIATION.—

''(A) IN GENERAL.—The total amount of Medicaid quality performance bonuses made under this subsection for all fiscal years shall be equal to $500,000,000, to be available until expended.

''(B) BUDGET AUTHORITY.—This paragraph constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this paragraph.

''(5) USE OF QUALITY PERFORMANCE BONUS FUNDS.—

''(A) DESIGNATION FOR QUALITY IMPROVEMENT ACTIVITIES.—As a condition of receiving a Medicaid quality performance bonus under this subsection, a State shall agree to designate at least 75 percent of the bonus funds paid to the State under this subsection for a fiscal year for the development and operation of quality-related initiatives that will directly benefit providers or managed care entities partici-

pating in the State plan under this title or under a waiver of such plan, including—

"(i) pay-for-performance programs;

"(ii) collaboration initiatives that have been demonstrated to improve performance on quality;

"(iii) quality improvement initiatives, including those aimed at improving care for special and hard-to-reach populations, and those directed to managed care entities; and

"(iv) such other Secretary-approved activities and initiatives that a State may pursue to encourage quality improvement and patient-focused high value care.

"(B) STATE OPTION TO ESTABLISH CRITERIA.—A State may establish criteria for the State performance program carried out under subparagraph (A) that limits the award to a particular provider or entity type, that limits application to a specific geographic area, or that directs incentive programs for quality related activities for specific populations, including individuals eligible under this title and title XVIII and hard-to-reach populations.

''(C) REMAINING BONUS FUNDS.—A State may designate up to 25 percent of the bonus funds paid to the State under this subsection for a fiscal year for activities related to the goals and purposes of the State program under this title.''.

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