

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

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.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Medicaid and CHIP
5 Quality Improvement Act of 2017”.

1 **SEC. 2. FINDINGS.**

2 Congress finds the following:

3 (1) Despite the fact that Federal and State
4 governments spend hundreds of billions of dollars
5 every year on care for Americans through the Med-
6 icaid and CHIP programs, there is no nationwide,
7 systematic method of reporting, collecting, evalu-
8 ating, or improving the quality of care across all
9 payment and delivery systems (fee-for-service, man-
10 aged care, primary care case management, or other
11 mechanisms).

12 (2) Although the quality of care delivered
13 through Medicaid health plans is frequently meas-
14 ured, there is no method or mechanism to systemati-
15 cally improve the quality of care provided to all Med-
16 icaid and CHIP beneficiaries.

17 (3) For the majority of Medicaid and CHIP en-
18 rollees who are served by primary care case manage-
19 ment or fee-for-service arrangements, there are no
20 Federal requirements for comparable quality moni-
21 toring or improvement. Thus there currently is no
22 ability to make fair assessments across all modes of
23 care for Medicaid and CHIP enrollees.

24 (4) State flexibility and the resulting opportuni-
25 ties for innovation are hallmarks of the partnership
26 between Federal and State governments in the Med-

1 icaid and CHIP programs. Without a way to system-
 2 atically measure quality, however, policymakers can-
 3 not know which innovations are the most effective.

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

7 (a) **QUALITY ASSURANCE STANDARDS.**—Section
 8 1932(c)(1)(A) of the Social Security Act (42 U.S.C.
 9 1396u–2(c)(1)(A)) is amended by inserting “or com-
 10 parable primary care case management services providers
 11 described in section 1905(t) as well as health care services
 12 furnished in fee-for-service settings or other delivery sys-
 13 tems” after “1903(m)”.

14 (b) **ADULT HEALTH QUALITY MEASURES.**—Section
 15 1139B of the Social Security Act (42 U.S.C. 1320b–9b)
 16 is amended—

17 (1) in subsection (b)—

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

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

22 “(4) **QUALITY REPORTING FOR MEDICAID ELI-**
 23 **GIBLE ADULTS.**—Beginning not later than January
 24 1 of the calendar year that begins on or after the
 25 date that is 2 years after the date of enactment of

1 the Medicaid and CHIP Quality Improvement Act of
2 2017, and annually thereafter, the Secretary shall
3 require States to use the measures and approaches
4 identified in paragraph (3) to report on the initial
5 core set of quality measures for Medicaid eligible
6 adults identified in paragraph (2), subject to revi-
7 sions made in accordance with paragraph (6)(B).
8 Such reporting shall be stratified by delivery system,
9 including managed care organizations under section
10 1932, benchmark plans under section 1937, primary
11 care case management services providers described
12 in section 1905(t), health care services in fee-for-
13 service settings, and other delivery systems, except
14 that the Secretary may determine that reporting on
15 certain measures should not be stratified by delivery
16 system because such stratification would not be fea-
17 sible or the delivery systems are not comparable with
18 respect to the application of such measures. In addi-
19 tion to the stratification required under the previous
20 sentence, the Secretary shall have the discretion to
21 further stratify reporting on certain measures based
22 on factors such as eligibility category, income level,
23 or other differentiating factors that could have an
24 impact on the comparability of the measure.”; and
25 (2) in subsection (d)—

1 (A) in paragraph (1)(A), by striking
2 “under the such plan” and all that follows
3 through “subsection (a)(5)” and inserting
4 “under such plan or waiver, including measures
5 described in subsection (b)(2), subject to revi-
6 sions made in accordance with subsection
7 (b)(6)(B)”;

8 (B) in paragraph (1)(B), by inserting “, or
9 comparable primary care case management
10 services providers described in section 1905(t),
11 as well as health care services furnished in fee-
12 for-service settings or other delivery systems”
13 after “section 1937”; and

14 (C) in paragraph (2), by inserting before
15 the period the following: “, including analysis of
16 comparable quality measures for Medicaid eligi-
17 ble adults who receive their health services
18 through managed care, primary care case man-
19 agement, and fee-for-service settings or other
20 delivery systems”.

21 (c) PEDIATRIC HEALTH CARE MEASURES.—

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

24 (A) in subsection (a)—

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

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

6 “(5) REPORTING OF PEDIATRIC HEALTH CARE
7 MEASURES.—Beginning not later than January 1 of
8 the calendar year that begins on or after the date
9 that is 2 years after the date of enactment of the
10 Medicaid and CHIP Quality Improvement Act of
11 2017, and annually thereafter, the Secretary shall
12 require States to use the measures and approaches
13 identified in paragraph (4) to report on the initial
14 core child health care quality measures established
15 under this subsection and as such measures subse-
16 quently are updated under subsection (b)(5). Such
17 reporting shall be stratified by delivery system, in-
18 cluding managed care organizations under section
19 1932, benchmark plans under sections 1937 and
20 2103, primary care case management services pro-
21 viders described in section 1905(t), health care serv-
22 ices in fee-for-service settings, and other delivery
23 systems, except that the Secretary may determine
24 that reporting on certain measures should not be
25 stratified by delivery system because such stratifica-

1 tion would not be feasible or the delivery systems are
2 not comparable with respect to the application of
3 such measures. In addition to the stratification re-
4 quired under the previous sentence, the Secretary
5 shall have the discretion to further stratify reporting
6 on certain measures based on factors such as eligi-
7 bility category, income level, or other differentiating
8 factors that could have an impact on the com-
9 parability of the measure.”; and

10 (B) in subsection (c)—

11 (i) in paragraph (1)(A), by striking
12 “measures described in subparagraphs (A)
13 and (B) of subsection (a)(6)” and inserting
14 “the core measures described in subsection
15 (a), as revised in accordance with sub-
16 section (b)(5)”;

17 (ii) in paragraph (1)(B), by inserting
18 before the period the following: “, or com-
19 parable primary care case management
20 services providers described in section
21 1905(t), as well as healthcare services fur-
22 nished in fee-for-service settings or other
23 delivery systems”; and

24 (iii) in paragraph (2), by inserting be-
25 fore the period the following: “, including

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

8 (2) EFFECTIVE DATE.—The amendments made
9 by this subsection shall take effect as if included in
10 the enactment of section 1139A of the Social Secu-
11 rity Act, as added by section 401(a) of the Chil-
12 dren’s Health Insurance Program Reauthorization
13 Act of 2009 (Public Law 111–3).

14 **SEC. 4. PERFORMANCE BONUSES FOR SIGNIFICANT**
15 **ACHIEVEMENT IN MEDICAID AND CHIP QUAL-**
16 **ITY PERFORMANCE.**

17 Section 1903 of the Social Security Act (42 U.S.C.
18 1396b) is amended by adding at the end the following new
19 subsection:

20 “(aa) PERFORMANCE BONUS FOR QUALITY PER-
21 FORMANCE ACHIEVEMENT.—

22 “(1) IN GENERAL.—The Secretary shall estab-
23 lish a Medicaid Quality Performance Bonus fund for
24 awarding performance bonuses to States for high at-
25 tainment and improvement on a core set of quality

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

3 “(2) QUALITY PERFORMANCE BONUS METHODOLOGY.—Not later than 3 years after the date of en-
4 actment of the Medicaid and CHIP Quality Im-
5 provement Act of 2017, the Secretary shall establish
6 a methodology for awarding Medicaid quality per-
7 formance bonuses to States not less than annually in
8 accordance with paragraph (3) and subject to the
9 availability of appropriations. Medicaid quality per-
10 formance bonuses shall be awarded on the basis of
11 the annual State reports required under sections
12 1139A and 1139B and in accordance with regula-
13 tions promulgated by the Secretary.

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

17 “(A) The top 5 States achieving the des-
18 ignation of superior quality performing State
19 under criteria established by the Secretary.

20 “(B) The 5 States that—

21 “(i) are not among the States de-
22 scribed in subparagraph (A); and

23 “(ii) demonstrate the greatest relative
24 level of annual improvement in quality per-
25

1 formance under criteria established by the
2 Secretary.

3 “(4) INITIAL APPROPRIATION.—

4 “(A) IN GENERAL.—The total amount of
5 Medicaid quality performance bonuses made
6 under this subsection for all fiscal years shall be
7 equal to \$500,000,000, to be available until ex-
8 pended.

9 “(B) BUDGET AUTHORITY.—This para-
10 graph constitutes budget authority in advance
11 of appropriations Acts and represents the obli-
12 gation of the Secretary to provide for the pay-
13 ment of amounts provided under this para-
14 graph.

15 “(5) USE OF QUALITY PERFORMANCE BONUS
16 FUNDS.—

17 “(A) DESIGNATION FOR QUALITY IM-
18 PROVEMENT ACTIVITIES.—As a condition of re-
19 ceiving a Medicaid quality performance bonus
20 under this subsection, a State shall agree to
21 designate at least 75 percent of the bonus funds
22 paid to the State under this subsection for a
23 fiscal year for the development and operation of
24 quality-related initiatives that will directly ben-
25 efit providers or managed care entities partici-

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

3 “(i) pay-for-performance programs;

4 “(ii) collaboration initiatives that have
5 been demonstrated to improve performance
6 on quality;

7 “(iii) quality improvement initiatives,
8 including those aimed at improving care
9 for special and hard-to-reach populations,
10 and those directed to managed care enti-
11 ties; and

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

16 “(B) STATE OPTION TO ESTABLISH CRI-
17 TERIA.—A State may establish criteria for the
18 State performance program carried out under
19 subparagraph (A) that limits the award to a
20 particular provider or entity type, that limits
21 application to a specific geographic area, or
22 that directs incentive programs for quality re-
23 lated activities for specific populations, includ-
24 ing individuals eligible under this title and title
25 XVIII and hard-to-reach populations.

1 “(C) REMAINING BONUS FUNDS.—A State
2 may designate up to 25 percent of the bonus
3 funds paid to the State under this subsection
4 for a fiscal year for activities related to the
5 goals and purposes of the State program under
6 this title.”.

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