

Congress an interim report on the scope of implementation of the programs under subsection (b) of such section, the design of the programs, and preliminary cost and quality findings with respect to those programs based on the following measures of the programs:

(A) Quality improvement measures, such as adherence to evidence-based guidelines and rehospitalization rates.

(B) Beneficiary and provider satisfaction.

(C) Health outcomes.

(D) Financial outcomes.

(2) Not later than 3 years and 6 months after the date of the implementation of such section the Secretary shall submit to Congress an update to the report required under paragraph (1) on the results of such programs.

(3) The Secretary shall submit to Congress 2 additional biennial reports on the chronic care improvement programs conducted under such section. The first such report shall be submitted not later than 2 years after the report is submitted under paragraph (2). Each such report shall include information on—

(A) the scope of implementation (in terms of both regions and chronic conditions) of the chronic care improvement programs;

(B) the design of the programs; and

(C) the improvements in health outcomes and financial efficiencies that result from such implementation.

SEC. 722. MEDICARE ADVANTAGE QUALITY IMPROVEMENT PROGRAMS.

(a) IN GENERAL.—Section 1852(e) (42 U.S.C. 1395w-22(e)) is amended—

(1) in the heading, by striking “ASSURANCE” and inserting “IMPROVEMENT”;

(2) by amending paragraphs (1) through (3) to read as follows:

“(1) IN GENERAL.—Each MA organization shall have an ongoing quality improvement program for the purpose of improving the quality of care provided to enrollees in each MA plan offered by such organization (other than an MA private fee-for-service plan or an MSA plan).

“(2) CHRONIC CARE IMPROVEMENT PROGRAMS.—As part of the quality improvement program under paragraph (1), each MA organization shall have a chronic care improvement program. Each chronic care improvement program shall have a method for monitoring and identifying enrollees with multiple or sufficiently severe chronic condi-

tions that meet criteria established by the organization for participation under the program.

“(3) DATA.—

“(A) COLLECTION, ANALYSIS, AND REPORTING.—

“(i) IN GENERAL.—Except as provided in clauses (ii) and (iii) with respect to plans described in such clauses and subject to subparagraph (B), as part of the quality improvement program under paragraph (1), each MA organization shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality.

“(ii) APPLICATION TO MA REGIONAL 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 regional plans. Such requirements may not exceed the requirements under this subparagraph with respect to MA local plans that are preferred provider organization plans.

“(iii) APPLICATION TO PREFERRED PROVIDER

ORGANIZATIONS.—Clause (i) shall apply to MA organizations with respect to MA local plans that are preferred provider organization plans only insofar as services are furnished by providers or services, physicians, and other health care practitioners and suppliers that have contracts with such organization to furnish services under such plans.

“(iv) DEFINITION OF PREFERRED PROVIDER

ORGANIZATION PLAN.—In this subparagraph, the term ‘preferred provider organization plan’ means an MA plan that—

“(I) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

“(II) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

“(III) is offered by an organization that is not licensed or organized under State law as a health maintenance organization.

“(B) LIMITATIONS.—

“(i) TYPES OF DATA.—The Secretary shall not collect under subparagraph (A) data on quality, outcomes, and beneficiary satisfaction to facilitate consumer choice and program administration other than the types of data that were collected by the Secretary as of November 1, 2003.

“(ii) CHANGES IN TYPES OF DATA.—Subject to subclause (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 in consultation with MA organizations and private accrediting bodies.

“(iii) CONSTRUCTION.—Nothing in the subsection shall be construed as restricting the ability of the Secretary to carry out the duties under section 1851(d)(4)(D).”;

(3) in paragraph (4)(B)—

(A) by amending clause (i) to read as follows:

“(i) Paragraphs (1) through (3) of this subsection (relating to quality improvement programs).”; and

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

“(vii) The requirements described in section 1860D–4(j), to the extent such requirements apply under section 1860D–21(c).”; and

(4) by striking paragraph (5).

(b) CONFORMING AMENDMENT.—Section 1852(c)(1)(I) (42 U.S.C. 1395w–22(c)(1)(I)) is amended to read as follows:

“(I) QUALITY IMPROVEMENT PROGRAM.—A description of the organization’s quality improvement program under subsection (e).”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contract years beginning on and after January 1, 2006.

SEC. 723. CHRONICALLY ILL MEDICARE BENEFICIARY RESEARCH, DATA, DEMONSTRATION STRATEGY.

(a) DEVELOPMENT OF PLAN.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall develop a plan to improve quality of care and reduce the cost of care for chronically ill medicare beneficiaries.

(b) PLAN REQUIREMENTS.—The plan will utilize existing data and identify data gaps, develop research initiatives, and propose intervention demonstration programs to provide better health care for chronically ill medicare beneficiaries. The plan shall—

(1) integrate existing data sets including, the Medicare Current Beneficiary Survey (MCBS), Minimum Data Set (MDS), Outcome and Assessment Information Set (OASIS), data from Quality Improvement Organizations (QIO), and claims data;

(2) identify any new data needs and a methodology to address new data needs;

(3) plan for the collection of such data in a data warehouse; and

(4) develop a research agenda using such data.

(c) CONSULTATION.—In developing the plan under this section, the Secretary shall consult with experts in the fields of care for the chronically ill (including clinicians).

(d) IMPLEMENTATION.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall implement the plan developed under this section. The Secretary may contract with appropriate entities to implement such plan.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary such sums as may be necessary in fiscal years 2004 and 2005 to carry out this section.