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2^D SESSION

S. 1980

To amend titles XIX and XXI of the Social Security Act to provide for 12-month continuous enrollment under the Medicaid program and Children’s Health Insurance Program and to promote quality care.

IN THE SENATE OF THE UNITED STATES

FEBRUARY 3, 2014

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

A BILL

To amend titles XIX and XXI of the Social Security Act to provide for 12-month continuous enrollment under the Medicaid program and Children’s Health Insurance Program and to promote quality care.

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 Continuous Quality Act of 2014”.

6 **SEC. 2. FINDINGS.**

7 Congress finds the following:

1 (1) Every year millions of people are enrolled in
2 Medicaid and the Children’s Health Insurance Pro-
3 gram (in this section referred to as “CHIP”), but
4 subsequently lose their coverage, despite still being
5 eligible, because of inefficient and cumbersome pa-
6 perwork and logistical requirements.

7 (2) Data show that the typical enrollee receives
8 Medicaid coverage for about three-quarters of the
9 year. Coverage periods are lower for non-elderly,
10 non-disabled adults than for those with disabilities,
11 seniors, and children.

12 (3) Medicaid enrollees with coverage disruption
13 are more likely to be hospitalized for illnesses like
14 asthma, diabetes, or cardiovascular disease that can
15 be effectively managed through ongoing primary
16 medical care and medication, are less likely to be
17 screened for breast cancer, and may have poorer
18 cancer outcomes.

19 (4) Children enrolled in CHIP also experience
20 disruptions in health coverage and care. For exam-
21 ple, during just a one-year period, over one-third of
22 CHIP enrollees were also enrolled in a State’s Med-
23 icaid program. Transitions between Medicaid and
24 CHIP can cause disruptions in care because the

1 health care coverage and participating providers vary
2 between the two programs.

3 (5) Interruptions in coverage can impair the re-
4 ceipt of effective primary care and lead to expensive
5 hospitalizations or emergency room visits.

6 (6) Unnecessary enrollment, disenrollment and
7 reenrollment in Medicaid and CHIP result in higher
8 administrative expenses for reenrollment and result
9 in more people uninsured at any given time.

10 (7) Stable coverage under Medicaid and CHIP
11 lowers average monthly medical costs. Continuous
12 enrollment also permits better prevention and dis-
13 ease management, leading to fewer serious illnesses
14 and hospitalizations.

15 (8) Children with stable coverage are less likely
16 to have unmet medical needs, allowing children to
17 receive the preventive care that is necessary to help
18 them grow into healthy adults.

19 (9) For the majority of Medicaid enrollees who
20 are served by Primary Care Case Management
21 (PCCM) or fee-for-service arrangements, there are
22 no Federal requirements for comparable quality
23 monitoring or improvement. No structured oversight
24 exists for Medicaid enrollees when they move be-
25 tween fee-for-service and capitated managed care

1 plans. Thus, there currently is no ability to make
 2 fair assessments across all modes of care for Med-
 3 icaid enrollees.

4 **SEC. 3. 12-MONTH CONTINUOUS ENROLLMENT.**

5 (a) REQUIREMENT OF 12-MONTH CONTINUOUS EN-
 6 ROLLMENT UNDER MEDICAID.—

7 (1) IN GENERAL.—Section 1902(e)(12) of the
 8 Social Security Act (42 U.S.C. 1396a(e)), is amend-
 9 ed to read as follows:

10 “(12) 12-MONTH CONTINUOUS ENROLLMENT.—

11 “(A) IN GENERAL.—Notwithstanding any
 12 other provision of this title, a State plan ap-
 13 proved under this title (or under any waiver of
 14 such plan approved pursuant to section 1115 or
 15 section 1915), shall provide that an individual
 16 who is determined to be eligible for benefits
 17 under such plan (or waiver) shall remain eligi-
 18 ble and enrolled for such benefits through the
 19 end of the month in which the 12-month period
 20 (beginning on the date of determination of eligi-
 21 bility) ends.

22 “(B) PROMOTING RETENTION OF ELIGI-
 23 BLE AND ENROLLED PERSONS BEYOND 12
 24 MONTHS.—The Secretary shall—

1 “(i) identify methods that promote the
2 retention of individuals who are enrolled
3 under the State plan and who remain eligi-
4 ble for medical assistance beyond the 12-
5 month period described in subparagraph
6 (A); and

7 “(ii) actively promote the adoption of
8 such enrollment retention methods by
9 States, which should include but not be
10 limited to issuing guidance and developing
11 resources on State best practices.

12 “(C) ENROLLMENT AND RETENTION RE-
13 PORTING.—

14 “(i) IN GENERAL.—Not later than
15 September 30, 2014, the Secretary shall
16 publish the procedures that States are ex-
17 pected to use to provide annual enrollment
18 and retention reports beginning September
19 30, 2015.

20 “(ii) STATE REPORTING REQUIRE-
21 MENTS.—At a minimum, such reporting
22 procedures shall include a description of
23 State eligibility criteria and enrollment
24 procedures under this title, and data re-
25 garding enrollment and retention using

1 standardized reporting formats determined
2 by the Secretary.

3 “(iii) SECRETARY REPORT AND PUB-
4 LICATION.—The Secretary shall annually
5 publish enrollment and retention perform-
6 ance results for all States beginning not
7 later than June 30, 2016.

8 “(iv) Each such annual report shall
9 include estimates of Medicaid enrollment
10 continuity ratios for each State. In this
11 clause, the term ‘enrollment continuity
12 ratio’ means, for a given group, the ratio
13 of the average monthly enrollment of that
14 group in the fiscal year divided by the total
15 unduplicated enrollment for that group in
16 the fiscal year, expressed as a percentage.

17 “(v) For purposes of such reports, the
18 Secretary shall develop both overall ratios
19 for all enrollees and separate ratios for the
20 following categories:

21 “(I) Children.

22 “(II) Individuals whose eligibility
23 category is related to being equal to
24 or over the age of 65.

1 “(III) Individuals whose eligi-
2 bility category is related to disability
3 or blindness.

4 “(IV) Individuals whose eligibility
5 category is related to their status as
6 parents and caretaker relatives of chil-
7 dren under 19 or who are otherwise
8 not elderly, blind or disabled adults.”.

9 (b) REQUIREMENT OF 12-MONTH CONTINUOUS EN-
10 ROLLMENT UNDER CHIP.—

11 (1) IN GENERAL.—Section 2102(b) of the So-
12 cial Security Act (42 U.S.C. 1397bb(b)) is amended
13 by adding at the end the following new paragraph:

14 “(6) REQUIREMENT FOR 12-MONTH CONTIN-
15 UOUS ENROLLMENT.—Notwithstanding any other
16 provision of this title, a State child health plan that
17 provides child health assistance under this title
18 through a means other than described in section
19 2101(a)(2), shall provide that an individual who is
20 determined to be eligible for benefits under such
21 plan shall remain eligible and enrolled for such bene-
22 fits through the end of the month in which the 12-
23 month period (beginning on the date of determina-
24 tion of eligibility) ends.”.

1 (2) CONFORMING AMENDMENT.—Section
 2 2105(a)(4)(A) of the Social Security Act (42 U.S.C.
 3 1397ee(a)(4)(A)) is amended—

4 (A) by striking “has elected the option of”
 5 and inserting “is in compliance with the re-
 6 quirement for”; and

7 (B) by striking “applying such policy
 8 under its State child health plan under this
 9 title” and inserting “in compliance with section
 10 2102(b)”.

11 (c) EFFECTIVE DATE.—

12 (1) IN GENERAL.—Except as provided in para-
 13 graph (2) or (3), the amendments made by sub-
 14 sections (a) and (b) shall apply to determinations
 15 (and redeterminations) of eligibility made on or after
 16 the date that is 18 months after the date of the en-
 17 actment of this Act.

18 (2) EXTENSION OF EFFECTIVE DATE FOR
 19 STATE LAW AMENDMENT.—In the case of a State
 20 plan under title XIX or State child health plan
 21 under title XXI of the Social Security Act (42
 22 U.S.C. 1396 et seq., 42 U.S.C. 1397aa et seq.)
 23 which the Secretary of Health and Human Services
 24 determines requires State legislation (other than leg-
 25 islation appropriating funds) in order for the respec-

1 tive plan to meet the additional requirement imposed
2 by the amendment made by subsection (a) or (b), re-
3 spectively, the respective plan shall not be regarded
4 as failing to comply with the requirements of such
5 title solely on the basis of its failure to meet such
6 applicable additional requirement before the first
7 day of the first calendar quarter beginning after the
8 close of the first regular session of the State legisla-
9 ture that begins after the date of enactment of this
10 Act. For purposes of the previous sentence, in the
11 case of a State that has a 2-year legislative session,
12 each year of the session is considered to be a sepa-
13 rate regular session of the State legislature.

14 (3) OPTION TO IMPLEMENT 12-MONTH CONTIN-
15 UOUS ELIGIBILITY PRIOR TO EFFECTIVE DATE.—A
16 State may elect through a State plan amendment
17 under title XIX or XXI of the Social Security Act
18 (42 U.S.C. 1396 et seq., 42 U.S.C. 1397aa et seq.)
19 to apply the amendment made by subsection (a) or
20 (b), respectively, on any date prior to the 18-month
21 date specified in paragraph (1), but not sooner than
22 the date of the enactment of this Act.

1 **SEC. 4. PREVENTING THE APPLICATION UNDER CHIP OF**
2 **COVERAGE WAITING PERIODS.**

3 (a) **IN GENERAL.**—Section 2102(b)(1)(B) of the So-
4 cial Security Act (42 U.S.C. 1397bb(b)(1)(B)) is amend-
5 ed—

6 (1) in clause (iii)—

7 (A) by striking “in the case of” and insert-
8 ing “in the case of a targeted low-income child
9 (including a child provided dental-only supple-
10 mental coverage under section 2110(b)(5)) or in
11 the case of”; and

12 (B) by adding “and” after the semicolon;

13 (2) by striking clause (iv); and

14 (3) by redesignating clause (v) as clause (iv).

15 (b) **CONFORMING AMENDMENTS.**—Section
16 2105(c)(10) of the Social Security Act (42 U.S.C.
17 1397ee(c)(10)) is amended by striking subparagraph (F)
18 and redesignating subparagraphs (G) through (M) as sub-
19 paragraphs (F) through (L), respectively.

20 (c) **EFFECTIVE DATE.**—The amendments made by
21 this section shall take effect on the date of enactment of
22 this Act.

1 **SEC. 5. PERFORMANCE BONUSES FOR ENROLLMENT AND**
 2 **RETENTION IMPROVEMENTS FOR CERTAIN**
 3 **INDIVIDUALS.**

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

7 “(aa) PERFORMANCE BONUSES FOR ENROLLMENT
 8 AND RETENTION OF LOW-INCOME INDIVIDUALS.—

9 “(1) IN GENERAL.—In addition to performance
 10 bonuses for enrollment and retention described in
 11 section 2105(a) (related to children), a State may
 12 qualify for 1 or more performance bonuses related to
 13 the enrollment and retention of individuals described
 14 in section 1902(e)(12)(C)(iii)(III). For purposes of
 15 this paragraph, a State meets the condition of this
 16 paragraph for such individuals if, for each category
 17 of individuals specified in section
 18 1902(e)(12)(C)(iii)(III) and selected by the State for
 19 additional enrollment and retention provisions, the
 20 State is implementing at least 3 of the following en-
 21 rollment and retention provisions (treating each sub-
 22 paragraph as a separate enrollment and retention
 23 provision) throughout the entire fiscal year:

24 “(A) ALIGNING TREATMENT OF INCOME
 25 UNDER MEDICAID WITH THAT OF OTHER IN-
 26 SURANCE AFFORDABILITY PROGRAMS.—The

1 State implements policies, including prorating
2 income over annual periods, so as to align its
3 treatment of income for purposes of a deter-
4 mination of eligibility for medical assistance
5 with that of other affordability insurance pro-
6 grams with the goal of eliminating inconsistent
7 determinations among these programs.

8 “(B) MAINTAINING COVERAGE FOR INDI-
9 VIDUALS DURING PERIODS OF TRANSITION.—

10 “(i) IN GENERAL.—Upon determina-
11 tion that an individual is no longer eligible
12 for medical assistance, the State imple-
13 ments policies to maintain eligibility for
14 medical assistance, including enrollment in
15 the managed care organization in which
16 the individual was enrolled at the time of
17 the determination of ineligibility, during
18 the period of time in which—

19 “(I) eligibility-related information
20 is transmitted to the other insurance
21 affordability programs;

22 “(II) a determination is made as
23 to for which other insurance afford-
24 ability program the individual is eligi-
25 ble; and

1 “(III) coverage in such program
2 and any related managed care organi-
3 zation becomes effective.

4 “(ii) MANAGED CARE ORGANIZATION
5 CONTINUITY.—The State shall also imple-
6 ment policies to enroll the individual in the
7 managed care organization in which the in-
8 dividual was a member prior to the loss of
9 medical assistance eligibility, if such man-
10 aged care organization participates in the
11 other insurance affordability program, un-
12 less the individual voluntarily selects a sep-
13 arate managed care organization.

14 “(C) ENHANCED DATA-SHARING BETWEEN
15 AGENCIES.—The State utilizes findings from an
16 American Health Benefit Exchange, an Express
17 Lane Agency (as identified by the State and as
18 described in section 1902(e)(13)(F)) or the So-
19 cial Security Administration or other agencies
20 administering employment, educational, or so-
21 cial services programs as identified by the
22 State, to document income, assets, residency,
23 age or other relevant information in deter-
24 mining or renewing eligibility.

1 “(D) ELIGIBILITY BASED ON PENDING
2 STATUS.—The State maintains eligibility for
3 enrollees whose renewal status has not yet been
4 determined and for whom eligibility based on
5 alternative eligibility criteria has not yet been
6 ruled out.

7 “(E) DEFAULT REENROLLMENT IN MAN-
8 AGED CARE ORGANIZATION.—In the case of in-
9 dividuals who are determined to be eligible for
10 medical assistance under this title after the loss
11 of eligibility for fewer than 6 months, and who
12 previously had been members of a managed
13 care organization, the State re-enrolls the indi-
14 vidual in the managed care organization in
15 which the individual was a member prior to the
16 loss of eligibility, unless the individual volun-
17 tarily selects a separate managed care organiza-
18 tion.

19 “(2) PERFORMANCE BONUS PAYMENT TO OFF-
20 SET COSTS RESULTING FROM 12-MONTH CONTIN-
21 UOUS ENROLLMENT FOR MEDICAID ENROLLEES.—

22 “(A) AUTHORITY TO MAKE BONUS PAY-
23 MENTS.—

24 “(i) IN GENERAL.—In addition to the
25 payments provided under section 2105(a)

1 of the Social Security Act, subject to sub-
2 paragraph (C) the Secretary shall make
3 payments to a State (beginning with fiscal
4 year 2016) that satisfies the requirements
5 of subparagraph (B).

6 “(ii) REGULATIONS.—Payments to
7 States shall be allocated annually among
8 States in accordance with regulations pro-
9 mulgated by the Secretary not later than
10 July 1, 2015.

11 “(iii) TIMING.—The payment under
12 this paragraph shall be made, to a State
13 for a fiscal year, as a single payment not
14 later than the last day of the first calendar
15 quarter of the following fiscal year to
16 which the performance payment applies.

17 “(B) STATE ELIGIBILITY FOR BONUS PAY-
18 MENTS.—A State shall be eligible for bonus
19 payments under this subsection if—

20 “(i) the State has adopted at least 3
21 of the 5 policies described in subpara-
22 graphs (A) through (E) of paragraph (1);
23 and

24 “(ii) the State is able to demonstrate
25 improvement in the continuity of enroll-

1 ment by aged, blind, and disabled and
2 adult populations, compared to its baseline
3 performance in fiscal year 2013.

4 “(C) AMOUNTS AVAILABLE FOR PAY-
5 MENTS.—

6 “(i) IN GENERAL.—The total amount
7 of payments under paragraphs (1) and (2)
8 of this section shall be equal to
9 \$500,000,000 for fiscal year 2016 for
10 making payments under this paragraph, to
11 be available until expended.

12 “(ii) BUDGET AUTHORITY.—This sub-
13 section constitutes budget authority in ad-
14 vance of appropriations Acts and rep-
15 resents the obligation of the Secretary to
16 provide for the payment of amounts pro-
17 vided under this subsection.

18 “(D) USES OF ENROLLMENT AND RETEN-
19 TION PERFORMANCE BONUSES.—Nothing in
20 this section shall prohibit a State from estab-
21 lishing criteria which would permit the State to
22 distribute a portion of the proceeds of any per-
23 formance bonuses received pursuant to this sec-
24 tion to financially support providers who have
25 contributed to improved enrollment and reten-

1 tion activities. For purposes of allocation of En-
2 rollment and Retention Performance Bonuses
3 the definition of provider shall have the mean-
4 ing given to it in a State Plan.”.

5 (b) EXTENSION OF CHIP PERFORMANCE BONUS TO
6 ALIGN WITH REAUTHORIZATION OF STATE ALLOT-
7 MENTS.—Section 2105(a)(3) of the Social Security Act
8 (42 U.S.C. 1397ee(a)(3)) is amended—

9 (1) in subparagraph (A), by striking “2013”
10 and inserting “2015”;

11 (2) in subparagraph (E)(ii)—

12 (A) in the heading for subclause (I)(aa), by
13 striking “2012” and inserting “2014”;

14 (B) in subclause (I)(aa)—

15 (i) by striking “2012” and inserting
16 “2014”;

17 (ii) by striking “subsection (a)” and
18 inserting “section 2104(a)”; and

19 (iii) by striking “subsection (m)” and
20 inserting “section 2104(m)”;

21 (C) in the heading for subclause (I)(bb),
22 by striking “2013” and inserting “2015”;

23 (D) in subclause (I)(bb)—

24 (i) by striking “fiscal year 2013” and
25 inserting “fiscal year 2015”;

1 (ii) by striking “subsection
2 (a)(16)(A)” and inserting “section
3 2104(a)(18)(A)”;

4 (iii) by striking “October 1, 2012, and
5 ending on March 31, 2013” and inserting
6 “October 1, 2014, and ending on March
7 31, 2015”;

8 (iv) by striking “subsection (m)” and
9 inserting “section 2104(m)”; and

10 (v) by striking “or set aside under
11 subsection (b)(2) of section 2111 for such
12 fiscal year”;

13 (E) in the heading for subclause (I)(cc), by
14 striking “2013” and inserting “2015”;

15 (F) in subclause (I)(cc)—

16 (i) by striking “2013” each place it
17 appears and inserting “2015”;

18 (ii) by striking “subsection
19 (a)(16)(B)” and inserting “section
20 2104(a)(18)(B)”;

21 (iii) by striking “subsection (m)” and
22 inserting “section 2104(m)”; and

23 (iv) by striking “or set aside under
24 subsection (b)(2) of section 2111 for such
25 fiscal year”;

1 (G) in subclause (II), by striking “2013”
 2 and inserting “2015”; and
 3 (H) in subclause (III), by striking “2013”
 4 and inserting “2015”; and
 5 (3) in subparagraph (F)(iii), by striking
 6 “2013” and inserting “2015”.

7 **SEC. 6. MEASURING AND REPORTING ON COMPARABLE**
 8 **HEALTH CARE QUALITY MEASURES FOR ALL**
 9 **PERSONS ENROLLED IN MEDICAID.**

10 (a) **QUALITY ASSURANCE STANDARDS.**—Section
 11 1932(c)(1) of the Social Security Act (42 U.S.C. 1396u–
 12 2(c)(1)) is amended in subparagraph (A), by inserting
 13 after “1903(m)” the following: “or comparable primary
 14 care case management services providers described in sec-
 15 tion 1905(t) as well as health care services furnished in
 16 fee-for-service settings”.

17 (b) **ADULT HEALTH QUALITY MEASURES.**—Title XI
 18 of the Social Security Act (42 U.S.C. 1301 et seq.), as
 19 amended by section 2701 of the Patient Protection and
 20 Affordable Care Act (Public Law 111–148), is amended
 21 at section 1139B (42 U.S.C. 1320b–9b)—

22 (1) by adding after (b)(3) the following:

23 “(4) **QUALITY REPORTING FOR MEDICAID ELI-**
 24 **GIBLE ADULTS.**—Beginning January 1, 2016, the
 25 Secretary shall require States to use the measures

1 and approaches identified in paragraph (3) of this
2 subsection to report on the initial core set of quality
3 measures for Medicaid eligible adults identified in
4 paragraph (2), subject to revisions made by (5)(B)
5 of this subsection.”;

6 (2) by redesignating subsection (b)(4) as (b)(5)
7 and (b)(5) as (b)(6);

8 (3) in subsection (d)(1)(B) inserting after “Sec-
9 tion 1937 of this title” the following: “or comparable
10 primary care case management services providers
11 described in section 1905(t) as well as health care
12 services furnished in fee-for-service settings”; and

13 (4) in subsection (d)(2) by inserting after “(1)”
14 the following: “including analysis of comparable
15 quality measures for Medicaid eligible adults who re-
16 ceive their health services through managed care,
17 primary care case management, and fee-for-service
18 settings”.

19 (c) PEDIATRIC HEALTH CARE MEASURES.—

20 (1) IN GENERAL.—Title XI of the Social Secu-
21 rity Act, is amended at section 1139A(a) (42 U.S.C.
22 1320b–9a(a)) by—

23 (A) inserting after paragraph (4) as if it
24 were included upon enactment:

1 “(5) REPORTING OF PEDIATRIC HEALTH CARE
 2 MEASURES.—Not later than five years after the date
 3 of enactment of the Medicaid Continuous Quality
 4 Act of 2012, States shall use the procedures and ap-
 5 proaches identified in paragraph (4) to report infor-
 6 mation on the initial core measurement set regard-
 7 ing the quality of pediatric health care under titles
 8 XIX and XXI.”;

9 (B) redesignating paragraphs (5), (6), (7)
 10 and (8) as (6), (7), (8) and (9), respectively;
 11 and

12 (C) in subsection (c)(1)(B), inserting after
 13 “section 2103 of such Act” the following: “or
 14 comparable primary care case management
 15 services providers described in section 1905(t)
 16 as well as health care services furnished in fee-
 17 for-service settings”.

18 **SEC. 7. PERFORMANCE BONUSES FOR SIGNIFICANT**
 19 **ACHIEVEMENT IN MEDICAID QUALITY PER-**
 20 **FORMANCE.**

21 Section 1932(c)(1) of the Social Security Act (42
 22 U.S.C. 1396u–2(c)(1)) is amended by adding at the end
 23 the following new subparagraph:

24 “(F) PERFORMANCE BONUS FOR QUALITY
 25 PERFORMANCE ACHIEVEMENT.—

1 “(i) IN GENERAL.—The Secretary
2 shall establish a Medicaid Quality Perform-
3 ance Bonus fund for awarding perform-
4 ance bonuses to States for high attainment
5 and improvement on a core set of quality
6 measures related to the goals and purposes
7 of the Medicaid program.

8 “(ii) QUALITY PERFORMANCE BONUS
9 METHODOLOGY.—Not later than three
10 years after the date of enactment of this
11 Act, the Secretary shall establish a meth-
12 odology for awarding Medicaid Quality
13 Performance bonuses to States not less
14 than annually which will be based on the
15 annual State reports required under sec-
16 tion 1138B of title XI of the Social Secu-
17 rity Act, in accordance with regulations
18 promulgated by the Secretary.

19 “(iii) QUALITY PERFORMANCE MEAS-
20 UREMENT BONUSES.—Medicaid Quality
21 Performance Bonus funds will be awarded
22 to up to 10 States that meet thresholds es-
23 tablished by the Secretary for—

1 “(I) the top five States achieving
2 the designation of superior quality
3 performing State; or

4 “(II) five States demonstrating
5 the greatest relative level of annual
6 improvement in quality performance.

7 “(iv) INITIAL APPROPRIATION.—The
8 total amount of payments under this sub-
9 paragraph shall be equal to \$500,000,000
10 for making payments under this subpara-
11 graph, to be available until expended.

12 This subparagraph constitutes budget authority
13 in advance of appropriations Acts and rep-
14 resents the obligation of the Secretary to pro-
15 vide for the payment of amounts provided
16 under this subparagraph.

17 “(v) USES OF QUALITY PERFORMANCE
18 BONUS FUNDS.—

19 “(I) DESIGNATION FOR QUALITY
20 IMPROVEMENT ACTIVITIES.—As a
21 condition of receiving a bonus fund
22 award under clause (iii), a State shall
23 agree to designate at least 75 percent
24 of the performance bonus funds for
25 the development and operation of

1 quality-related initiatives that will di-
2 rectly benefit providers, including—

3 “(aa) provider pay-for-per-
4 formance programs;

5 “(bb) provider collaboration
6 initiatives that have been dem-
7 onstrated to improve performance
8 on quality;

9 “(cc) provider quality im-
10 provement initiatives, including
11 those aimed at improving care
12 for special and hard-to-reach
13 populations; and

14 “(dd) Secretary-approved
15 activities and initiatives that a
16 State may pursue to encourage
17 quality improvement and patient-
18 focused high value care.

19 Nothing in this subparagraph shall pro-
20 hibit a State from establishing criteria for
21 the State provider performance program
22 that limits the award to a particular pro-
23 vider type(s), that limits application to a
24 specific geographic area, or that directs in-
25 centive programs for quality-related activi-

1 ties for specific populations, including indi-
2 viduals eligible under this title and title
3 XVIII of the Social Security Act, hard-to-
4 reach populations.

5 “(II) REMAINING BONUS

6 FUNDS.—States may designate up to
7 25 percent of the quality performance
8 bonus award for activities related to
9 the goals and purposes of the pro-
10 gram.

11 “(vi) DEFINITION OF PROVIDERS.—

12 For purposes of allocation of Medicaid
13 Quality Performance Bonuses the defini-
14 tion of provider shall have the meaning
15 given to it in a State Plan. Nothing in this
16 section shall prohibit a State from invest-
17 ing bonus funds into quality improvement
18 activities for managed care entities.”.

○