

110TH CONGRESS
1ST SESSION

H. R. 2749

To amend title XVIII of the Social Security Act to provide for a transition to a new voluntary quality reporting program for physicians and other health professionals.

IN THE HOUSE OF REPRESENTATIVES

JUNE 15, 2007

Mr. GORDON of Tennessee (for himself and Mr. SHADEGG) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XVIII of the Social Security Act to provide for a transition to a new voluntary quality reporting program for physicians and other health professionals.

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 “Voluntary Medicare
5 Quality Reporting Act of 2007”.

1 **SEC. 2. FINDINGS.**2 (a) FINDINGS.—Congress makes the following find-
3 ings:4 (1) The health care system of the United States
5 is the world's most advanced health care system and
6 delivers health care according to the highest quality
7 standards. Physicians and other health professionals
8 are committed to providing the highest quality of
9 health care to beneficiaries under the Medicare pro-
10 gram.11 (2) Physicians have been actively engaged with
12 the American Medical Association's Physician Con-
13 sortium for Performance Improvement in the devel-
14 opment of evidence-based and clinically valid meas-
15 ures in order to improve the quality of health care
16 and have also worked closely with the Centers for
17 Medicare & Medicaid Services ("CMS") in assuring
18 the successful implementation of the Physician Vol-
19 untry Reporting Program ("PVRP") developed to
20 measure and evaluate quality of health care.21 (3) Physicians are actively collaborating with
22 consensus organizations in their efforts to—23 (A) improve the quality of health care
24 through the specification of quality measures
25 for services; and

1 (B) develop a rational system for collecting, aggregating, and reporting data across
2 numerous public and private insurance programs in the least burdensome way.

9 (A) evidence-based and clinically valid;
10 (B) regularly updated to reflect current
11 medical practice;

12 (C) specialty specific; and

(D) developed by relevant medical and other health professional specialty societies with expertise in the area of health care involved.

16 (5) All quality measures for covered profes-
17 sional services (as so defined) should be pilot-tested
18 in a variety of practice settings and across all rel-
19 evant medical and other health professional special-
20 ties before they are included in a value-based pur-
21 chasing system for such services.

22 (6) Physicians must be actively engaged in all
23 aspects of the development and implementation of
24 an effective quality reporting and value-based pur-
25 chasing system for covered professional services (as

1 so defined). The development process for such sys-
2 tem must be transparent to all physicians and ad-
3 here to a consistent set of rules.

4 (7) Any effective quality reporting system for
5 covered professional services (as so defined) must
6 recognize the actual health information technology
7 and administrative costs physicians and other health
8 professionals incur for participating in the system.

9 (8) Any quality reporting program for covered
10 professional services (as so defined) should focus on
11 meaningful improvements in patient care rather
12 than requiring physicians to report for the sake of
13 reporting.

14 (9) Most physicians and other health profes-
15 sionals have not had any experience in quality re-
16 porting and lack the necessary health information
17 technology and administrative infrastructures to par-
18 ticipate in a value-based purchasing system for phy-
19 sicians' services.

20 (10) The 6-month program under section
21 1848(k) of the Social Security Act (42 U.S.C.
22 1395w-4(k)), as added by section 101(b) of division
23 B of the Tax Relief and Health Care Act of 2006
24 (Public Law 109-432; 120 Stat. 2975), the 2007
25 Physician Quality Reporting Initiative ("PQRI"),

1 does not provide a sufficient amount of time to test
2 and evaluate the appropriateness and effectiveness
3 of this new reporting system. Therefore, it is pre-
4 mature to implement a permanent Medicare quality
5 reporting system for physicians in 2008.

6 **SEC. 3. TRANSITION TO NEW VOLUNTARY MEDICARE QUAL-
7 ITY REPORTING PROGRAM.**

8 (a) EVALUATING THE TRANSITIONAL QUALITY RE-
9 PORTING SYSTEM ESTABLISHED FOR 2007.—

10 (1) EVALUATION.—The Secretary of Health
11 and Human Services shall evaluate the quality re-
12 porting system under paragraph (1) of section
13 1848(k) of the Social Security Act (42 U.S.C.
14 1395w-4(k)) (as added by section 101(b) of division
15 B of the Tax Relief and Health Care Act of 2006
16 (Public Law 109-432)), as applied for 2007 using
17 the quality measures described in paragraph (2)(A)
18 of such section to determine the following:

19 (A) The extent to which such quality meas-
20 ures were valid, clinically relevant, practicable,
21 and not overly burdensome.

22 (B) The percentage of eligible professionals
23 (as defined in paragraph (3)(B) of such section)
24 in each category of eligible professionals de-

1 scribed in such paragraph that had such quality
2 measures to report for such year.

3 (C) The rate of participation in such qual-
4 ity reporting system of eligible professionals de-
5 scribed in subparagraph (B) in each such cat-
6 egory.

7 (D) The average administrative costs of
8 medical practices of such eligible professionals
9 for reporting such quality measures, as it re-
10 lates to the size of such practices.

11 (2) REPORT.—Not later than June 1, 2008, the
12 Secretary of Health and Human Services shall sub-
13 mit to Congress a report containing the findings of
14 the evaluation under paragraph (1).

15 (b) TRANSITIONAL QUALITY REPORTING AFTER DE-
16 CEMBER 31, 2007, AND BEFORE IMPLEMENTATION OF
17 NEW VOLUNTARY MEDICARE QUALITY REPORTING PRO-
18 GRAM.—

19 (1) IN GENERAL.—Section 1848(k)(2)(B) of
20 the Social Security Act (42 U.S.C. 1395w-
21 4(k)(3)(B)) is amended to read as follows:

22 “(B) FOR 2008 AND 2009.—Eligible profes-
23 sionals may continue to report to the Secretary
24 quality measures specified under subparagraph
25 (A) after December 31, 2007, and before De-

3 (2) PROHIBITING USE OF PHYSICIAN ASSIST-
4 ANCE AND QUALITY INITIATIVE FUND FOR QUALITY
5 REPORTING BONUS PAYMENTS IN 2008.—Section
6 1848(l)(2)(B) of the Social Security Act (42 U.S.C.
7 1395w-4(l)(2)(B)), as added by section 101(d) of di-
8 vision B of the Tax Relief and Health Care Act of
9 2006 (Public Law 109-432), is amended by adding
10 at the end the following new sentence: “The Sec-
11 retary shall not expend from the Fund any amounts
12 for bonus incentive payments for quality reporting of
13 data on quality measures with respect to services
14 furnished during 2008.”.

15 SEC. 4. THE VOLUNTARY MEDICARE QUALITY REPORTING 16 PROGRAM.

17 (a) IN GENERAL.—Section 1848(k)(2) of the Social
18 Security Act (42 U.S.C. 1395w-4(k)(2)) as added by sec-
19 tion 101(b) of Division B of the Tax Relief and Health
20 Care Act of 2006 (Public Law 109-432; 120 Stat. 2975),
21 is amended by adding at the end the following new sub-
22 paragraph:

1 “(iii) FAIRNESS.—The selection of
2 quality measures under this subparagraph
3 shall be conducted (and such quality meas-
4 ures shall be applied) in a manner that—
5 “(I) takes into account dif-
6 ferences in individual health status;
7 “(II) takes into account an indi-
8 vidual’s compliance with health care
9 orders;
10 “(III) does not directly or indi-
11 rectly encourage patient selection or
12 deselection;
13 “(IV) does not penalize eligible
14 professionals who furnish services to
15 individuals entitled to benefits under
16 part A or enrolled under this part who
17 are frail, low-income, of racial or eth-
18 nic minority groups, or of limited
19 English language proficiency;
20 “(V) reduces health disparities
21 across groups and areas;
22 “(VI) uses appropriate statistical
23 techniques to ensure valid results; and
24 “(VII) assures that the Secretary
25 is able to process data for the quality

1 measures as written by the individual
2 or organization that developed the
3 measure.

4 “(iv) SELECTION PROCESS FOR MEAS-
5 URES TO BE REPORTED.—The measures
6 selected under clause (i) for 2010 (and
7 each succeeding year) shall be measures
8 that have been published by the Secretary
9 in the Federal Register not later than No-
10 vember 1 before the year as endorsed qual-
11 ity measures that are applicable to covered
12 professional services during the year. For
13 purposes of this subparagraph, the Sec-
14 retary may publish quality measures for
15 2010 (or a succeeding year) in the Federal
16 Register only if such measures are selected
17 and endorsed as follows:

18 “(I) RECOMMENDATIONS FOR
19 CLINICAL AREAS.—Not later than Oc-
20 tober 1, 2008 (and each succeeding
21 October 1), the Secretary shall re-
22 quest, through notice in the Federal
23 Register (without comment period),
24 each physician specialty organization,
25 each other eligible professional organi-

1 zation, and each quality improvement
2 organization to submit to the Physi-
3 cian Consortium for Performance Im-
4 provement of the American Medical
5 Association (referred to in this sub-
6 paragraph as the ‘Consortium’) by not
7 later than December 31, 2008 (and
8 each succeeding December 31), rec-
9 commendations of clinical areas for the
10 development of quality measures for
11 purposes of this subparagraph. Not
12 later than December 31, 2008 (and
13 each succeeding December 31), the
14 Secretary shall also submit to the
15 Consortium recommendations of clin-
16 ical areas for the development of such
17 quality measures.

18 “(II) SELECTION OF CLINICAL
19 AREAS.—Not later than March 31,
20 2009 (and each subsequent March
21 31), the Consortium is requested to
22 submit to the Secretary the rec-
23 commendations described in subclause
24 (I).

“(IV) ENDORSEMENT OF QUALITY MEASURES.—Not later than June 15 of each year (beginning with 2009), the Consortium is requested to submit the proposed quality measures developed under subclause (III) to a consensus organization for endorsement. Not later than September 30 of each year (beginning with 2009), the consensus organization is requested to submit to the Secretary the quality measures that have been endorsed by the consensus organization.

1 “(v) DEFINITIONS FOR TYPES OF
2 MEASURES.—In this subparagraph:

3 “(I) STRUCTURAL MEASURE.—
4 The term ‘structural measure’ means
5 a measure that reflects the organiza-
6 tional, technological, and human re-
7 sources infrastructure of a system
8 necessary for the delivery of quality
9 health care (such as the use of health
10 information technology for submission
11 of measures).

12 “(II) PROCESS MEASURE.—The
13 term ‘process measure’ means a meas-
14 ure associated with the practice of
15 health care or the furnishing of a
16 service that is known to be effective.

17 “(III) OUTCOME MEASURE.—The
18 term ‘outcome measure’ means a
19 measure that provides information on
20 how health care affects patients.

21 “(vi) CONSENSUS ORGANIZATION DE-
22 FINED.—In this subparagraph, the term
23 ‘consensus organization’ means an organi-
24 zation, such as the National Quality
25 Forum, that the Secretary identifies as—

1 “(I) having experience in using a
2 process for reaching a group con-
3 sensus with respect to quality meas-
4 ures relating to the performance of
5 those providing health care services;
6 and

7 “(II) including in such process
8 practicing physicians, practitioners
9 with experience in the care of the frail
10 elderly and individuals with multiple
11 complex chronic conditions, organiza-
12 tions and individuals representative of
13 the specialty involved, individuals enti-
14 tled to benefits under part A or en-
15 rolled under this part, experts in
16 health care quality, individuals with
17 experience in the delivery of health
18 care in urban, rural, and frontier
19 areas and to underserved populations,
20 and representatives of the Secretary.”.

21 (b) USE OF REGISTRY-BASED REPORTING.—Section
22 1848(k) of the Social Security Act (42 U.S.C. 1395w-
23 4(k)) as added by section 101(b) of Division B of the Tax
24 Relief and Health Care Act of 2006 (Public Law 109-
25 432; 120 Stat. 2975) is amended to read as follows:

1 “(4) USE OF REGISTRY-BASED REPORTING.—
2 As part of the process for reporting quality meas-
3 ures under subparagraphs (B) and (C) of paragraph
4 (2), the Secretary shall address a mechanism where-
5 by an eligible professional may provide data on qual-
6 ity measures through an appropriate medical reg-
7 istry, as identified by the Secretary. The Secretary
8 shall require that any such mechanism be for pur-
9 poses of reporting data only to the Secretary. The
10 Secretary shall treat such data as confidential and
11 shall not make such data available to any other
12 party or person. Any data obtained by the Secretary
13 under this paragraph shall not be subject to dis-
14 covery or admitted into evidence in any Federal or
15 State civil judicial or administrative proceeding.”.

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