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MEDICARE FACT SHEET

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PHYSICIAN VOLUNTARY REPORTING PROGRAM

Overview

As part of its overall quality improvement efforts, CMS is launching the Physician Voluntary Reporting Program (PVRP). This new program builds on Medicare's comprehensive efforts to substantially improve the health and function of our beneficiaries by preventing chronic disease complications, avoiding preventable hospitalizations, and improving the quality of care delivered. Under the voluntary reporting program, physicians who choose to participate will help capture data about the quality of care provided to Medicare beneficiaries, in order to identify the most effective ways to use the quality measures in routine practice and to support physicians in their efforts to improve quality of care. Voluntary reporting of quality data through the PVRP will begin in January 2006.

Given the recognized need for evidence-based quality measures to help improve the quality of health care services, and the time required to implement processes to obtain and use such measures effectively, a voluntary program can help Medicare and physicians become better positioned to usher in a system that promotes higher quality and rewards better health care delivery.

Background

As noted by CMS Administrator Mark B. McClellan, M.D., Ph.D. in his testimony before the House Ways and Means Subcommittee on Health on September 29, 2005, CMS believes that an important component of delivering high quality care is the ability to measure and evaluate quality. Accordingly, CMS is committed to the development of reporting and payment systems that will support and reward quality.

Providing quality health care to Medicare beneficiaries is a high priority for President Bush and the Department of Health and Human Services. CMS is also committed to assuring quality of care for all Americans. To that end, CMS has developed several quality initiatives that provide information on the quality of care across different settings, including hospitals, skilled nursing facilities, home health agencies, and dialysis facilities for end stage renal disease. The quality initiatives aim to empower providers and consumers with information that would support the overall delivery and coordination of care, and ultimately to support new payment systems that provide more financial resources to provide better care, rather than simply paying based on the volume of services.

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The PVRP would initiate the process by which physicians who choose to participate would begin reporting quality data and be able to receive feedback on their performance, as well as to provide input on how quality reporting can be improved and made even less burdensome.

These steps are an important step in enabling CMS to provide better support for physicians' efforts to deliver high-quality care.

Reporting Infrastructure

CMS has developed the underlying infrastructure so that voluntary reporting of quality measures can begin by January 2006, using the existing administrative system for physician claims.

While the usual source of the clinical data for quality measures is retrospective chart abstraction, data collection through this process can be burdensome. Consequently, the voluntary reporting program will focus on ways to obtain valid quality measures as efficiently as possible.

Electronic health records (EHRs) will greatly facilitate clinical data reporting and performance improvement in the future but its adoption is not currently widespread. CMS is working with physicians to achieve the goal of adopting EHRs in their offices, building on reporting based on the pre-existing claims based system will be used for reporting data under the PVRP. The utilization of a pre-existing reporting system will minimize the burden on physicians.

Physicians can begin providing voluntary information for constructing evidence-based quality measures for the Medicare population through a defined set of HCPCS codes (called "G-codes"), which are reported on the pre-existing physician claim form. These new codes will supplement the usual claims data with clinical data that can be used to measure the quality of services rendered to beneficiaries.

The G-codes are an interim step until electronic submission of clinical data through EHRs replaces this process. Medicare expects to work with some physician groups that have already adopted EHRs to assist with this transition.

Medicare's contracted Quality Improvement Organizations (QIOs) are helping physicians move toward a more dynamic and evolving public reporting and pay-for-performance quality improvement environment. In specific, QIOs are providing assistance to help physicians create systems so that the measures can be more easily reported.

Development of Measures

Measuring and evaluating quality requires the development of clinically valid quality measures.

Effective measures for performance measurement, quality improvement, disease prevention, and public reporting should be valid, reliable, evidence-based, and relevant for consumers, clinicians and purchasers. In addition, such measures must be developed through open and transparent processes and implemented in a realistic manner with minimal burden on physicians so as not to discourage appropriate care.

The PVRP will begin to phase in quality performance measures that are consistent with these requirements. These 36 evidence-based clinically valid measures have been part of the guidelines endorsed by physicians and the medical specialty societies and are the result of extensive input and feedback from physicians and other quality care experts. Physicians recognize the importance of these measures for the management of their patients' care, providing CMS with a strong starting point for the voluntary program.

Additional quality measures are under development now and could be phased-in for reporting later in 2006.

Quality Measures

The 36 quality measures are arranged in sets of measures, with multiple G-codes in each set. The physician will report the appropriate G-code that represents the clinical services furnished with regard to a specific measure set.

Each measure set has a defined numerator (the appropriate G-code) and a denominator (specifically defined according to the appropriate services or condition), which will be used to calculate performance.

The objective of the PVRP is to help physicians obtain information they can use to improve quality and avoid unnecessary costs. Thus, CMS will provide feedback to physicians on their level of performance based upon the data submitted through this voluntary effort. This feedback may begin as early as summer 2006.

The quality measures for voluntary reporting through the PVRP are reflected in the following table:

Measure Description
Aspirin at arrival for acute myocardial infarction
Beta blocker at time of arrival for acute myocardial infarction
Antibiotic administration timing for patient hospitalized for pneumonia
Hemoglobin A1c control in patient with Type I or Type II diabetes mellitus, age 18-75
Low-density lipoprotein control in patient with Type I or Type II diabetes mellitus, age 18-75
High blood pressure control in patient with Type I or Type II diabetes mellitus, age 18-75
Angiotensin-converting enzyme inhibitor or angiotensin-receptor blocker therapy for left ventricular systolic dysfunction
Beta-blocker therapy for left ventricular systolic dysfunction
Beta-blocker therapy for patient with prior myocardial infarction
Antiplatelet therapy for patient with coronary artery disease
Low-density lipoprotein control in patient with coronary artery disease
Osteoporosis screening in elderly female patient
Screening of elderly patients for falls
Screening of hearing acuity in elderly patient
Screening for urinary incontinence in elderly patients

Measure Description
Dialysis dose in end stage renal disease patient
Hematocrit level in end stage renal disease patient
Receipt of autogenous ateriovenous fistula in end-stage renal disease patient requiring hemodialysis
Warfarin therapy in patient with heart failure and atrial fibrillation
Smoking cessation intervention in chronic obstructive pulmonary disease
Prescription of calcium and vitamin D supplements in osteoporosis
Antiresorptive therapy and/or parathyroid hormone treatment in newly diagnosed osteoporosis
Bone mineral density testing and osteoporosis treatment and prevention following osteoporosis associated nontraumatic fracture
Annual assessment of function and pain in symptomatic osteoarthritis
Influenza vaccination
Mammography
Pneumococcal vaccination
Antidepressant medication during acute phase for patient diagnosed with new episode of major depression
Antidepressant medication duration for patient diagnosed with new episode of major depression
Antibiotic prophylaxis in surgical patient
Thromboembolism prophylaxis in surgical patient
Use of internal mammary artery in coronary artery bypass graft surgery
Pre-operative beta blocker for patient with isolated coronary artery bypass graft
Prolonged intubation in isolated coronary artery bypass graft surgery
Surgical re-exploration in coronary artery bypass graft surgery
Aspirin or clopidogrel on discharge for isolated coronary artery bypass surgery patient

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