SGR Reform: Questions for Feedback

Questions for Comment on Phase I:

1. What is an appropriate period of payment stability in order to develop and vet measures and build the necessary quality infrastructure?

2. Considering the different levels of provider readiness, how do we balance the need for a stable period enabling providers to build and test the necessary quality infrastructure, while still incentivizing early innovators to move to Phase II, with opportunities for quality-based payment updates?

3. What does a meaningful, timely feedback process look like for providers? What are adequate performance feedback intervals?

4. How should Peer Provider Cohorts be defined to ensure adequate specificity while preserving adequate comparison group size and ability to develop appropriate measurement sets? For example, is using the American Board of Medical Specialties (ABMS) list adequate?

5. Should the list of Peer Provider Cohorts also include patient, procedural, or disease-specific cohorts in addition to the traditionally-defined specialty groupings? Pros of this approach are that it would offer a more relevant basis for measure development and comparison between physicians, since many physicians perform outside of or in a narrow range of the "stereotype" description of their primary specialty. Cons are that it may create too vast of an array of cohorts. This may dilute the ability to develop meaningful quality measurement sets and comparison groups and impose excessive financial and administrative burden on the physician group as well as upon CMS. In addition to answering, please provide rationale.

6. Under the proposed revision of SGR which emphasizes best quality practices, non-physician providers who are currently paid under the Medicare payment system are also expected to be rated on quality measures. Do these non-physician providers need unique measurement sets compared to physician providers?

Questions for Comment on Phase II

1. Understanding that the proposed payment system relies on reporting, how should existing programs such as, but not limited to PQRS, EHR/Meaningful Use, VBM be transitioned into the new system? Are there aspects of the current systems that should be retained, modified, or discarded?

2. How do we align and integrate quality measurement and reporting with existing and developing specialty registries? How can registries support provider feedback and streamline provider reporting burden?

3. What Clinical Improvement Activities best promote high quality clinical care and should those activities be required as an integral part of a quality-based payment system?