

Joint E&C/W&M SGR Proposal

Request for Feedback

1. After the period of stability, physician fee schedule payment updates will be based on performance of meaningful, physician-endorsed measures of care quality and participation in clinical improvement activities.
 - How should a system of performance take into account differences among specialties?
 - Should such a system reward individual specialty society advancements in care quality and clinical improvement activities?
2. Medical specialty societies will develop meaningful quality measures and clinical improvement activities using a standard process.
 - How should such a method account for local variances?
 - What role do you envision state and local medical societies playing in the development of a standard development process to take into account local variances?
 - How would such a structure, once established, account for changes or advancements in quality and improvement activities?
 - Once established, what steps should be taken to help educate local physicians on the benefits of such quality measures and clinical improvement activities?
3. Performance will be based on both risk-adjusted relative rankings amongst physician specialty peer groups and improvement on quality over time.
 - Do you believe that some form of risk and reward system should be tied to performance? If so, what?
 - How would you recommend addressing outliers once risk-adjusted relative rankings amongst physician specialty peer groups have been conducted?
 - What other considerations should be taken into account with regards to medical professionals accessing and appealing such rankings?
4. This proposal will reduce the reporting burden on physician practices, override the current CMS quality measurement programs, and align Medicare payment initiatives with private payer initiatives.
 - What reporting requirements, among those your members must currently comply with, offer examples of how a more efficient reporting system might work?
 - What current reporting requirements offer examples of how a more efficient reporting system should not work?
 - How should such a system be designed to take into account improvements in current private payer initiatives or the introduction of new initiatives?