SGR FRAMEWORK FAQS

Why are there no updates to physician payments through the budget window?

The last few years of SGR patches have had zero percent updates – and have come with the annual uncertainty as to whether Congress would enact them. Do physicians really want to continue under the status quo? While this policy does not provide guaranteed updates, it does provide stability. It also allows individual providers to earn more based on their performance.

Updates of one percent for fee-for-service providers and two percent for APM providers would occur starting in 2024, once the new system is fully implemented and stabilized.

Why is such a large amount of payment at risk under this policy?

The payment at risk in the value-based performance (VBP) payment program is comparable to the amount at risk under current law through PQRS, VBM, and EHR meaningful use. But, rather than disparate programs, this policy combines them into one comprehensive program. The benefit of using the current law programs is that providers are already familiar with them. This saves providers from the burden of learning a brand-new quality program.

The payment at risk under the VBP program is also comparable to that at risk under the E&C legislation. Remember that the E&C legislation continues the current law incentive programs (and corresponding penalties) while also introducing an additional program (the Update Incentive Program (UIP)) with a +/- one percent payment consequence.

The misvalued codes policy is unnecessary; the RUC has already identified and corrected a number of these codes.

There is significant Congressional interest in the RUC process – particularly concerns about whether it is an effective process for determining values for physician services. Rather than marginalizing the RUC, this proposal engages the RUC as partners in identifying and correcting misvalued codes. If the target amount is met, then the money remains in the payment system and is redistributed to other codes. If the target amount is not met, then the difference between the target and the identified amount is removed from the payment system.

MedPAC has expressed concerns that the RUC hasn’t gone far enough in revaluing some codes. For example, the Commission recently noted that while the time estimates for revalued services decreased by an average of 20.4 percent, the work RVUs for those services decreased by only 7.3 percent. This suggests that the RUC is recommending reductions in “time,” but offsetting those reductions by increasing “intensity.”

Why is there a payment penalty for providers who do not submit resource use data requested by CMS?

This policy directs CMS to collect information from providers in order to better value physician services. Providers who submit the requested information may be compensated for their efforts. Providers who do not submit the information would receive a ten percent payment reduction. CMS currently offers payments to
providers in exchange for information and has a very low take-up rate. The payment penalty is there to encourage providers to participate.

In order to limit the burden on providers, small practices (ten or fewer providers) and those that submitted data the previous year can opt out of reporting.

Isn’t it possible that this emphasis on improving the valuation of physician services could result in a large downward adjustment for some services?

The policy framework would include a two-year transition period (as opposed to all in one year) for any downward adjustments greater than 20 percent.

How does this policy framework advance primary care and/or care provided by cognitive specialists?

There are a number of policies that are beneficial to primary care and cognitive providers. First, the focus on misvalued codes will mean redistributing values within the physician payment system and should increase the value of the evaluation and management (E&M) codes frequently billed by these providers. Second, the care coordination codes would provide a payment for providers who are truly responsible for managing care for patients with extra needs. These codes could be billed by physicians, NPs, PAs, and CNSs practicing in patient-centered medical homes (PCMHs) or comparable specialty practice models. Third, providers who receive a significant portion of their revenue through a PCMH model expanded by CMMI would be eligible to receive the five percent APM bonus. The PCMHs are not required to take on two-sided payment risk.

The appropriate use criteria (AUC) policy is far too aggressive and untested.

This policy grew out of proposals by the American College of Cardiology and the American College of Radiology – and AUC tools are currently being tested in Medicare and in the private sector. The AUC policy focuses on physician-developed and/or endorsed AUC tools that help physicians select the best imaging service for their patient as opposed to a blanket prior authorization program like those frequently used in the private sector. The private sector experience with AUC tools has shown that most providers respond to the tools and have corresponding decreases in ordering for unnecessary imaging services. This experience suggests that only a few providers – the true outliers – would be subject to prior authorization.

This proposal seems too focused on physicians. What about other providers?

This framework is inclusive of non-physician providers. While the VBP program starts with physicians in 2017, PAs, NPs, and CNSSs are included a year later in 2018, and other providers can be included at the Secretary’s discretion starting in 2019. PAs, NPs, and CNSSs are also eligible to receive payment for the new care coordination codes.

What about small practices that often find it difficult to comply with performance programs?

Cognizant of the pressure on small practices in particular, this framework includes a number of provisions aimed at assisting these providers. First, providers who treat few Medicare patients would be excluded from the VBP program. Second, special consideration would be given to rural practices or those located in HPSAs when establishing the clinical practice improvement activities. Third, small practices could elect to
participate in virtual groups for purposes of their performance assessment under the VBP program. This encourages coordination among providers and would allow small providers to band together in order to have a larger sample size for their quality and resource use measurements. Finally, assistance would be provided to small practices located in rural areas of HPSAs to help them improve their performance and transition to APMs.

**Will a measurement-based reimbursement program incentivize providers to avoid high-cost, high-risk patients?**

A key priority for the Committee is identifying and mitigating potential behavioral responses to a performance-based payment system. Perverse incentives currently exist for providers in the current FFS system (e.g., the incentive to over-treat and provide unnecessary services), but Members are also concerned about incentives in the opposite direction (e.g., the incentive to stint on care in a capitated system or cherry-pick only “good” patients in a measurement system). The Committee has a rich history in addressing these issues in its policies, and will continue to do so. The goal is to review current efforts, identify areas for improvement, and ensure the development of measures that accurately incorporate underlying patient risk factors (including health status, socioeconomic status, demographics, etc.). Ultimately, measures of quality, resource use, and other clinical indicators need to ensure that providers are compared on how they treat similar patients with similar risk profiles rather than comparing providers who treat a relatively healthy and wealthy population against those who treat a relatively unhealthy and poor population.

**If a larger amount of physician payments would be at risk through quality performance programs, should there be further investments in measure development?**

The framework would provide funding for measure development, especially physician measures. There is certainly a desire to advance quality measurement by focusing on outcomes measures, patient experience measures, as well as measures that capture the work of multiple physicians across settings.

**Why is so much information going to be posted on the Physician Compare website? The public will just be confused by this information.**

The Physician Compare website is already tasked with posting quality data, and this policy expands that to also include utilization and payment information. While the website is a work in progress, the goal is to have a user-friendly site where a beneficiary could click on a provider’s name and see his quality scores, as well as a listing of the top five or ten services he performs. This information will assist beneficiaries in selecting their providers.

**What is the purpose of the non-public analyses conducted by the qualified entities (QEs)?**

Currently, CMS-approved QEs are permitted to purchase CMS claims data and must then combine it with private payer data to publicly report on quality measures. This provision would allow QEs to perform additional, personalized, and non-public analyses for providers, health insurers, and employers and charge for those services. As these analyses would include data from multiple (if not all) payers in a state, providers could use them for performance improvement, while insurers and employers could use them to help select an efficient health care network for their subscribers and employees.