

AAO-HNS Summary of March 2014 Medpac Meeting

1) MEASURING QUALITY ACROSS MEDICARE'S DELIVERY SYSTEMS

During this session discussion centered on how best to refocus quality strategy so as to provide a useful comparison between the different delivery models: Fee For Service (FFS) Medicare, Medicare Advantage (MA), and Accountable Care Organizations (ACOs). The main focus of the session was Measuring Potentially Inappropriate Use Measures. The current quality strategy in FFS includes the use of process measures, which according to the Commission reinforces FFS incentives for volumes of services and adds unnecessary complexity and burden to providers. An alternative strategy was presented, which emphasized outcome measures and measures to monitor possible responses to incentives in each system, such as measuring potentially inappropriate use (a concept which includes overuse and underuse).

For illustrative purposes, the Commission highlighted CMS's measures of appropriate use of imaging in outpatient departments. Specifically, it looked at three of CMS's imaging measures, including: patients with low back pain who had an MRI without trying conservative treatments first; CT scans of the chest that were combination (double) scans; and patients who received cardiac imaging stress tests before low-risk outpatient surgery. In addition, when measuring potentially inappropriate use, focus rested on repeat testing. According to MedPAC, repeat testing is common and has a high degree of geographic variation. The following six services were studied: echocardiography; imaging stress tests; chest CT; upper GI endoscopy; pulmonary function tests; and cystoscopy. It was found that one-third to one-half of these services were repeated within three years.

Issues for Commission discussion:

- Strengths and challenges of measuring inappropriate use?
- Should overuse and underuse measures be applied in all three payment systems or should each system's incentives be targeted?
- Should overuse and underuse measures be applied at population level, provider level, or both?
- Do overuse and underuse measures fit into the potential quality strategy?

The Chairman emphasized that Medpac's role with its recommendations to Congress should remain at a high-level, which does not include the development of measures. Developing measures should be addressed, according to the Chairman, by other entities such as specialty societies. Most commissioners felt that the application of overuse and underuse measures should be applied in all three payment systems (FFS, MA, and ACOs) and that there should be fewer measures or a broader set that are applicable across programs. In addition, most Commissioners were split on whether or not overuse and underuse measures should be applied at the population or provider level.

2) DEVELOPING PAYMENT POLICY TO PROMOTE USE OF SERVICES BASED ON CLINICAL EVIDENCE

During this session the Commission discussed Developing Payment Policy to Promote Use of Services Based on Clinical Evidence, specifically focusing Medicare's quality strategy on incentives to improve outcomes and reduce potentially inappropriate use. Emphasis was placed on the following subjects:

- Setting the payment rate of Part B drugs based on comparative clinical evidence;
- Setting the payment rate of new services based on comparative clinical evidence;
- Two case studies on differences between Medicare's payment policies and other groups' decisions.

AAO-HNS Summary of March 2014 Medpac Meeting

When discussing setting payment rates of new services based on comparative clinical evidence it was noted that Medicare's payment systems generally do not consider whether a new service results in better outcomes than alternatives. Further, there are instances when the payment rate for a new service is higher than that of alternatives, even when evidence is lacking that the new service results in better outcomes. In order to set payment rates of new services based on comparative clinical evidence, Medicare would need legislative authority. According to the Commission this should include a requirement of transparency. Issues that may need to be addressed regarding this notion, include: establishing a time period to generate clinical evidence, developing a process for generating and considering clinical evidence, and application to existing services.

Two case studies were presented to demonstrate that Medicare's payment policies do not always align with other groups' evidence-based decisions. Overall, it was determined that because Medicare has limited comparative clinical effectiveness information on which to base its payment policies, its payment policies are not always based on clinical evidence. Because of this, it was suggested that Medicare payment policy be better aligned with evidence-based decisions through cost sharing for low-value services.

To view the presentation, click [here](#).