MEDPAC Medicare Payment Advisory Commission

MEETING BRIEF

March 6–7, 2014

Next steps in measuring quality across Medicare's delivery systems

ISSUE: The Commission has been discussing and making recommendations concerning quality measurement in Medicare since 2003. Over the last ten years, the Congress has authorized and CMS has implemented several quality reporting and pay-for-performance (value-based purchasing) initiatives for health care providers and plans under the three main components of the Medicare program: fee-for-service (FFS) Medicare, Medicare Advantage (MA) plans, and Medicare Accountable Care Organizations (ACOs).

Recently, the Commission and other experts have become concerned about the rapid growth in the size, cost, complexity, and potential unintended consequences of Medicare's quality measurement enterprise, particularly in FFS Medicare. At the Commission's November 2013 meeting, Commissioners discussed these concerns and the feasibility of using a small set of population-based quality measures to compare quality across the three main components of Medicare.

KEY POINTS: In response to Commissioners' discussions and requests for further analysis, staff will present 1) a revised description of a potential population-based outcomes approach for measuring quality across FFS Medicare, MA, and ACOs, and 2) results of analyses of potentially inappropriate use of outpatient imaging services and repeat testing.

ACTION: Commissioners are requested to discuss the potential population-based outcomes approach and the analyses of potentially inappropriate use of outpatient imaging services and repeat testing. Commissioners also are requested to provide guidance to staff for further research on these topics.

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