

## Highlights of MedPAC March Report to Congress

On March 15, 2018, the Medicare Payment Advisory Commission (MedPAC) released its March 2018 Report to the Congress regarding Medicare payment policy. Among other things, the report includes MedPAC's recommendations for how Congress should update payment rates in fee-for-service (FFS) Medicare for 2019.

These "update" recommendations—which MedPAC is required by law to submit each year—are based on an assessment of payment adequacy that examines beneficiaries' access to and use of care, the quality of the care they receive, supply of providers, and providers' costs and Medicare's payments. For 2019, MedPAC is recommending that the payment rates for acute-care hospitals (inpatient and outpatient services) and for physicians and other healthcare professionals should be updated by the amount determined under current law, which are projected to be 1.25 percent and 0.25 percent, respectively.

In 2016, across all services, volume per beneficiary grew by 1.6 percent. Among broad service categories, growth rates were 1.1 percent for evaluation and management services, 1.4 percent for imaging services, 2.8 percent for major procedures, 2.5 percent for other procedures, and 1.7 percent for tests. In 2016, Medicare payment rates for physician and other health professional services were 75 percent of commercial rates for preferred provider organizations, compared with 78 percent in 2015.

Of particular note, MedPAC included stress tests and PCI for stable coronary disease as possible "low-value care," which is defined as either a service that has little or no clinical benefit or care in which the risk of harm from the service outweighs its potential benefit. In this section of the report, MedPAC highlighted measures with the highest volume and highest spending – stating that "those with the highest Medicare spending were percutaneous coronary intervention with balloon angioplasty or stent placement for stable coronary disease (\$1.3 billion), spinal injection for low back pain (\$1.3 billion), and stress testing for stable coronary disease (\$1.2 billion)"

One significant aspect of the March MedPAC report revolves around the Commission's recommendation to eliminate the Merit-based Incentive Payment System (MIPS), which measures individual clinicians in traditional Medicare on a set of measures that they choose. MedPAC's reasoning behind this recommendation was that "MIPS is premised on the assumption that Medicare can measure and pay for quality at the level of the individual clinician, but a system built on that assumption will be fundamentally inequitable for two reasons: (1) clinicians will be evaluated and compared on dissimilar measures, and (2) many clinicians will not be evaluated at all, because as individuals, they will not treat enough Medicare beneficiaries to produce statistically reliable scores."

Therefore, MedPAC is proposing a Voluntary Value Program (VVP), which would require providers to self-organize into groups that would be collectively responsible for patient outcomes and costs. The groups would be rewarded based on performance on population-based measures, measuring quality based on mortality and readmissions. In proposing the VVP, MedPAC offered a number of reasons why some healthcare professionals might embrace this approach. For example, the Commission states that "infrastructure requirements for a VVP are minimal; that is, clinicians would only need to elect to be measured as a voluntary group"... and that "Medicare would no longer require tools for reporting such as registries, EHRs, and other quality-data reporting methods", potentially diminishing the role of registries in assessing quality at the national level. A number of healthcare organizations are opposed to eliminating MIPS –including the Alliance of Specialty Medicine.