MedPAC Releases Report to Congress

On March 15, 2022, the Medicare Payment Advisory Commission (MedPAC) released its biannual report to Congress, recommending no pay increases for physicians in 2023. MedPAC advises Congress on issues affecting the Medicare program, including payments to providers operating under the Medicare Physician Fee Schedule (MPFS). Despite recent declines in MPFS payment rates across the house of medicine, including significant cuts to radiation oncology, MedPAC is not recommending any payment increases for physicians under the Fee Schedule for 2023. The March report recommends continued shifts in resources from specialty to primary care, which will continue to erode payments for radiation oncology services. In addition to the rate update recommendation, there are several sections of the report of interest to the Radiation Oncology community, including recommendations involving site-neutral payments and incentivizing population-based outcomes.

No Rate Update Recommendation for 2023

To determine a rate update, MedPAC looks at the adequacy of Medicare payments in the current year (access to care, quality of care, and providers' access to capital) and compares it to providers' costs. The Commission then considers how those costs are expected to change in the next year and recommends an update to payments accordingly. Due to data lags caused by the COVID-19 public health emergency (PHE), the most recent complete data used by MedPAC was from 2020. MedPAC recognizes that COVID-19 had a tremendous impact on the entirety of health care and has caused major financial disruptions to many providers. However, they believe the actions taken by Congress and CMS to counteract those financial hardships, such as "tens of billions of dollars in relief funds to clinicians" in Provider Relief Funding, largely offset the short-term effects of the PHE for many providers.

Increasing Payment to Primary Care Providers

In 2021, CMS increased the MPFS payment rates for E&M office visits, which began "to rebalance the fee schedule toward primary care." MedPAC believes more needs to be done to increase payments to primary care providers and recommends improving the accuracy of MPFS payments.

The Commission stated that some services, like procedures, imaging, and tests, increase in efficiency over time because of better technology and technique, but E&M office visits do not have these efficiency gains because they are largely based on activities requiring a physician's time. They note that if the work for a particular service decreases, but the relative value units (RVUs) for it remain the same, the service is overvalued. Due to budget-neutrality rules for RVUs, decreasing the payment rates for overvalued services increases the money available for E&M visits. It is MedPAC's belief that this "tends not to occur," and E&M visits have become devalued over time.

In its June 2018 report, MedPAC recommended rebalancing the MPFS in a budget-neutral way to increase payment rates for ambulatory E&M services while reducing rates for other services. They estimated that a 10% increase would raise spending for ambulatory E&M services by $2.4 billion, and to maintain budget neutrality, all other MPFS services would be reduced by 3.8%.

Even with reduced rates for non-E&M services, MedPAC found that physician compensation continued to rise. In 2020, median compensation across all specialties grew by 1.0% (pre-PHE, compensation grew

at an average annual rate of 2.5%). However, primary care physicians saw a much lower median compensation, "underscoring concerns about the mispricing of physician fee schedule services and its impact on the number of physicians who choose to practice primary care." It is clear the Commission remains concerned about the difference in rates between specialists and primary care providers and that erosion of reimbursement rates is a problem for the entire House of Medicine. We can see the impact of these types of policy recommendations in recent rules promulgated by CMS, such as this year's clinical labor price update to the MPFS, which caused large rate cuts to specialties that use expensive equipment, like radiation oncology, and 2021's shift of payments from procedural to non-procedural physician services.

Push for Alternative Payment Models

One issue that the Commission has with traditional fee for service (FFS) payment systems is that "providers are paid more when they deliver more services, often without regard to the value of those additional services, and that these payment systems seldom include incentives for providers to coordinate care over time and across care settings." Therefore, it is not surprising that one of MedPAC's recommendations is to incentivize population-based outcomes based on meaningful outcome, patient experience, and value measures, in addition to streamlining CMS's existing advanced alternative payment models (APMs). This is in-line with the Commission's recommendations in prior years.

Access to Care

Even with the ongoing PHE, beneficiary access to care was comparable to prior years, and 93% of beneficiaries reported being satisfied with the quality of care they received; only 10% reported forgoing care. It appears a large portion of those patients who sought care were able to maintain access due to telehealth visits, and in the report, MedPAC recommends requiring clinicians to use a claims modifier to distinguish between audio-only and audio-video telehealth visits to assess the impact of audio-only on access, quality, and cost.

Hospital Inpatient and Outpatient Services

According to the report, some hospital payment adequacy indicators improved in 2020, but some declined; MedPAC believes this variation is due mainly to the PHE rather than changes in overall adequacy of Medicare payments to hospitals. COVID-19 did cause disruptions in access to hospital care, but fewer hospitals closed in 2020 and 2021 compared to previous years, and they found that overall, hospitals maintained excess inpatient capacity.

MedPAC reports that in 2020, Medicare's payments to hospitals continued to be below hospitals' costs. IPPS payments per stay grew 8.7%, but costs per stay grew even faster at 12.6%. OPPS payments per service were up 13.5%, but costs per service were up even higher at 24.4%. They believe the faster growth in costs than payments was due to a combination of the PHE, higher wages, and PHE-related protocols and supplies. Because they expect the PHE-related changes to be temporary, they do not recommend an increase to the OPPS update in 2023.

Site-Neutral Payments

Currently, Medicare pays higher prices in some care settings than in others for the same service. MedPAC believes this incentivizes providers to shift care to the more profitable setting, which leads to

an increase in spending without an increase in quality. Their recommendation is to make payments for the same services delivered in different settings equal, or “site-neutral.”

Scrutinize Claims More Closely

One challenge that Medicare faces, as stated in the report, is that it is required to pay providers’ claims, regardless of clinical appropriateness. Traditional Medicare does not have the authority to implement provider networks or provider credentialing, which are methods private payers (and Medicare Advantage plans) use to reduce the potential for overutilization. The Commission’s recommendation is to scrutinize claims more closely to reduce overutilization, fraud, and abuse. In prior years, the Commission has recommended implementing prior authorization in various ways. For example, in 2011, they suggested creating a prior authorization program for practitioners who order substantially more advanced imaging services than their peers. They continue to reference it as an effective utilization management tool for private payers and MA plans.

As the push for Medicare payment reform moves forward, it is important to keep in mind that the contents of the MedPAC report are, at this time, just recommendations. However, the report is influential with members of Congress and can provide some insight into where the debate will head. Meanwhile, ASTRO continues to advocate with legislators and regulators for meaningful reforms to the Fee Schedule.