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EDITORIAL – GLOBAL HEALTH SERVICES RESEARCH

# Decreasing Medicare Reimbursements for Surgical Oncology Procedures: Future Implications

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Medicare was established in 1965 by President Lyndon B. Johnson as a measure to provide health insurance for the uninsured. In 1972, it was expanded to include people 65 years and older. In the USA, the number of adults 65 years and older is estimated to outnumber children 18 years or younger by 2034 (77 million adults 65 years and older versus 76.5 million children).[1] This may lead to a significant increase in older Medicare beneficiaries. As increasing age is also an important risk factor for malignancies, surgical oncologists will provide surgical care to many Medicare patients. Therefore, surgical oncologists need to understand the trends in Medicare reimbursements.

The current study by Hydrick et al. enhances our understanding of Medicare reimbursement trends for surgical oncology procedures.[2] The authors queried the Center for Medicare Services (CMS) fee schedule look-up tool for 23 common current procedural terminology (CPT) codes for breast, foregut, hepatobiliary, and thyroid surgery. The authors highlight the current Medicare reimbursement process, which is important to understand. Each CPT code is assigned certain relative value units (RVUs) based on the amount of work, practice expense, and malpractice costs. The individual RVUs are multiplied by the geographic practice cost index (GPCI) to adjust RVUs per the local market conditions. The adjusted RVUs are then multiplied by a conversion factor to arrive at a payment amount in dollars. The authors included data from 2007 to 2021 and normalized all GPCIs to one to eliminate regional variations. The raw change in reimbursement was then compared against the change in consumer price index (CPI) over the same interval. All values were converted to 2021 dollars.

The authors noted that overall reimbursement increased by an average of 21.6%, with the greatest increase for breast procedures (45%), followed by hepatobiliary procedures (20.8%), foregut procedures (15.8%), and thyroid procedures (10.6%). During the same time, CPI increased by 33%. This suggests that the average reimbursement rate for the index surgical oncology procedures decreased by 8.6% from 2007 to 2021. Although thyroid (–16.9%), hepatopancreatobiliary (HPB; –13%), and foregut surgery (–9.1%) experienced a decline, breast surgery experienced an increase in adjusted reimbursement rates of 9%, driven mainly by a 39.3% increase in reimbursements for partial mastectomy. In the last 5 years, the average inflation-adjusted decline in reimbursement was 2.47% for all procedures.

The study is not without limitations. Only a limited number of CPT codes were examined. Colorectal procedures, which could be part of surgical oncology practice, were not included. Only the physician reimbursements were examined, and hospitals and facility fees were not analyzed. Additionally, the regional variations and other trends based on workload, practice expense, and liability were not analyzed. Despite the limitations, the study provides important insight into the payment trends for the analyzed procedures. The results of the study are similar to other studies suggesting a decline in payments for many surgical specialties, including orthopedic surgery,[3] spine surgery(1.9% decline per year from 2000 to 2021),[4] and neurosurgery (1.59% decline per year from 2000 to 2018).[5]

Declining reimbursements for surgical care are likely to continue under current law. Similar to previous years, in 2022, the Medicare Trustees report raised significant



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concerns about the increasing gap between the growth in Medicare expenditures and gross domestic product (GDP).[6] Constraining the increases in Medicare expenditures has been the focus of legislative action and CMS policy for decades. During this time, Congress has consistently intervened to prevent statutorily mandated cuts to physician reimbursement. Current laws reducing Medicare expenditures include the Budget Control Act of 2011, which has resulted in the current 2% Medicare sequester, and the 2010 Pay-As-You-Go Act (PAYGO), which is scheduled to reduce Medicare funding by 4% in 2023. In addition, CMS has proposed an additional 4.5% reduction in the conversion factor for 2023.

The American College of Surgeons (ACS) and other members of the Surgical Care Coalition continue to advocate for short-term relief from significant cuts and long-term reform in Medicare payments. In addition to supporting the advocacy efforts of the ACS, surgical oncology practices have options in reimbursement based on the Quality Payment Program (QPP) established by the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015.[7] The QPP was established to incentivize the transition from volume-based fee-for-service to value-based payment models. In the QPP, physician services are reimbursed under one of two programs: the Merit-based Incentive Payment System (MIPS) or through participation in Alternative Payment Models (APMs). In MIPS, physician reimbursements could theoretically increase (or decrease) by up to 9% depending on performance in four categories related to quality and cost. This payment structure would seem to create an opportunity for high-performing physicians to offset the reductions in the conversion factor. Full implementation, however, was delayed during the pandemic, and positive payment adjustments have been modest. For the 2022 performance year (2024 payment year), however, CMS has instituted a number of changes that will increase discrimination in performance. These changes, along with a higher threshold for positive adjustments, are intended to increase the magnitude of the payment adjustments, both upside and downside. MIPS is a budget-neutral program, and competition for positive payment adjustments will increase over time. For 2023, CMS has proposed a MIPS Value Pathway (MVP) for Advancing Cancer Care that may be of interest to surgical oncologists who work closely with medical oncologists.

CMS remains clear in its intention to increase participation in APMs and transition to value-based payment models with shared risk. Surgical oncologists facing declining reimbursement under MIPS may benefit from participation in an APM. A number of care models and reimbursement qualify as APMs, but all include sharing financial risk and achieving quality objectives. Physicians and groups of physicians who qualify as an APM Participant are reimbursed through the APM rather than through MIPS. In the first years of the QPP, the reimbursement model for participation in APMs included a 5% increase in Medicare payments to Qualified Participants (QP). This incentive expires in 2022. There will be no incentives for APM participation in the 2023 performance year/2025 payment year. For 2024, CMS has proposed a 0.75% increase in the Physician Fee Schedule for physicians that qualify as QPs in an APM. Additional financial incentives are available based on the lower cost of care and quality incentives. Importantly, incentives for APM participation are not required to be budget neutral.

Challenges with Medicare financing and budget neutrality will continue to exert negative pressure on reimbursement for physicians. As CMS transitions to value-based reimbursement models, specialists will be challenged to adapt and successfully participate in novel structures. Five approaches for surgeons were described by Dr. Michael Porter, the renowned Harvard Business School economist, in the John J. Conley Ethics and Philosophy Lecture, Value-Based Health Care Delivery: The Strategic Agenda at the 2018 Clinical Congress.[8]

"(1) Think beyond the operating room: Move away from surgical silos and partner with caregivers in preventive care, perioperative care, rehabilitation, short-term follow-up, and surveillance;
(2) Institute universal outcome measurement and public reporting to drive improvement and demonstrate high-value care;
(3) Utilize time-driven, activity-based costing methodology covering the full cycle of care to demonstrate overall impact on efficiency and value;
(4) Actively engage in bundled payments with employers, government payers, and private payers, and advocate for broader implementation;
(5) Reorganize care within a region to optimize resources
a. Aggregate volume by a condition in fewer sites
b. Perform lower acuity surgery in community hospital settings
c. Higher acuity/complexity surgery in tertiary care hospitals."

Following this lecture, ACS initiated the Transforming Healthcare Resources to Increase Value and Efficiency program (ACS THRIVE), a joint program with Harvard Business School's Institute for Strategy and Competitiveness to support surgeons and hospitals in the transition from fee-for-service to value-based care.[9] Surgical oncologists with experience in multidisciplinary, multi-institutional care and complex care coordination will be

able to capitalize on opportunities to convene and contribute to value-based models that reward high quality and low cost.

The biggest question remains; what is the true value of the care we provide, and how can surgeons meaningfully participate in shared risk, value-based payment arrangements? Understanding the true cost of surgical care episodes across the continuum of care is essential. Transitioning from charge-based to activity-based cost accounting systems is an important first step that is being supported by initiatives such as ACS-THRIVE. By combining accurate cost data with increasingly specific quality data and risk adjustment methodologies, surgeons will be able to understand the drivers of value. Once understood, value can be improved, and risk can be shared with payors. The efforts of our surgical societies should be supported as they seek to mitigate annual financial threats and support the transition to value-based surgical care. In 2022, less than 800 of the 84,000 members of the ACS contributed to the Political Action Committee (ACSPA-Surgeons PAC). Increased participation and support for the activities of the American College of Surgeons, the ACSPA-Surgeons PAC, and the Surgical Care Coalition are urgently needed. With our experience in continuous quality improvement and multidisciplinary care, surgical oncologists have the opportunity to create care models that optimize cancer care and contribute to the sustainability of our health care system.

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