RADIATION ONCOLOGY
POLICY UPDATE

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Committee Examines the Medicare Physician Fee Schedule, MACRA, and Payment Reforms

The Energy and Commerce Health Subcommittee dug into the Medicare payment formula at a hearing on May 20 and came to a bipartisan agreement that pay cuts for doctors should come to an end.

Rep. John Joyce (R-Pa.), a dermatologist, said he and other members of the GOP Doctors Caucus are working on a bill that would change the payment formula to tie doctors' expenses to cost data shared by hospital outpatient departments and give independent physicians' practices and hospitals "similar accounting of their practice costs."

"After adjusting for inflation, Medicare physician reimbursement has declined 33% since 2001," testified Rick Snyder, MD, the President of HeartPlace, who criticized Medicare's budget neutrality requirements and warned that payment instability is accelerating consolidation and threatening independent physician practices. "There is something fundamentally broken about a payment system in which the cost of a service more than quadruples when a beneficiary takes a "magic elevator ride" from my office down one floor to a hospital outpatient department in the same building for the very same service. If we fail to act, we will continue moving toward a healthcare system dominated by larger and more expensive institutional providers," he said.

- Watch the hearing.
- Read testimonies from Dana Smetherman, Rick Snyder, Farzad Mostashari, William Fox, and Steven Furr.

Ways and Means Advances Legislations that Would Reduce Medicare Physician Payment Year-to-Year Volatility

The Ways & Means Committee unanimously advanced bipartisan legislation on May 21 aimed at stabilizing Medicare physician reimbursement and reducing the payment volatility.

The amended version of the Provider Reimbursement Stability Act (H.R. 8163) would raise Medicare's budget neutrality trigger threshold from $20 million to $57.64 million beginning in 2028 and place guardrails on year-to-year physician payment fluctuations tied to budget neutrality adjustments.

Rep. Greg Murphy (R-NC), the bill's lead sponsor, said during the markup the legislation is "critical" to helping independent physician practices stay afloat by reducing reimbursement instability and giving CMS more flexibility before budget neutrality adjustments trigger cuts to physician payments.

The legislation would also create a reconciliation process for correcting inaccurate CMS utilization estimates tied to budget neutrality calculations, require CMS to periodically update practice expense cost inputs used in physician payment formulas, and cap annual conversion factor fluctuations caused by budget neutrality adjustments.

The unanimous committee vote shows that Medicare physician pay reform is a top concern for lawmakers on both sides of the aisle, improving the bill's chances of advancing through the full House.

But even though the legislation has support from both parties, the American Medical Association (AMA), and both primary care and specialty groups, the bill could still face scrutiny and potential hurdles to passage over its cost. A committee staffer said during the markup that it has "a direct spending impact of just under $5 billion."

 Watch the hearing.

 Review the bill.

HealthAffairs Article Criticizes Primary Care Scarcity Claim

A recent proposal from the Urban Institute argues that the Physician Fee Schedule is structurally biased against primary care—failing to adequately account for uncompensated care—and that prior reforms have not meaningfully shifted resources from specialists to primary care.

Their proposed solution is a separate conversion factor to increase payments for primary care services. The conversion factor is a dollar value that is multiplied by the resources that go into a particular service to determine the reimbursement for that service under the PFS.

In an article published in *HealthAffairs* in May, Drs. Senkowski, Selzer, Mabry, Sutherland, and Tsai argue that the March 2026 report to Congress from MedPAC shows excellent access to primary care in both urban and rural environments, while focus groups and survey studies show declining specialty-care access.

The authors write, "We must understand the consequences of sacrificing specialty care in an era when patients have more complex medical conditions that demand the expertise, skill, and innovation of our specialists. When procedural wRVUs depreciate or reimbursement declines, what occurs? Are the recent declines in patient-reported access to specialists a direct result of years of cost shifting from specialists to primary care? These outcomes are measurable and merit investigation before introducing further policy changes.

A more measured approach grounded in rigorous evaluation would better serve both the profession and patients. What the US needs is not a choice between primary and specialty care—we need both. Prevention addresses the health crises of tomorrow; specialty care treats the burden of disease today. What we cannot afford is to restrict access to the cutting-edge, lifesaving treatments that specialists provide."

Review the Urban Institute proposal.

Read the HealthAffairs article.

New Bill Proposes Default Enrollment to MA

A new bill, introduced in May, would automatically enroll beneficiaries into either Medicare Advantage plans -- in which private insurers contract with CMS to serve Medicare beneficiaries -- or ACOs, such as those that participate in the Medicare Shared Savings Program. The bill would mandate that once enrolled in an MA plan, enrollees would be unable to disenroll or switch plans for three years.

Republicans argue that Medicare Advantage, with its smaller physician networks and stricter prior authorization rules, can save the Medicare program money. However, a report by the Medicare Payment Advisory Commission (MedPAC) in March found that Medicare paid $76 billion more for MA patients in 2025 than it would have if those same patients had been enrolled in traditional Medicare.

Review the bill.

Review the MedPAC report.

Medicaid Advisors List Recommendations to Congress

Congress' Medicaid advisors voted on May 7 to recommend CMS develop a transparent plan for monitoring and evaluating how Medicaid work requirements will affect eligibility and enrollment as well as employment, health, and state and federal administrative and program spending.

The recommendations include the following:

- A baseline of what areas beyond eligibility and enrollment -- employment, health, and state and federal administrative and program spending -- CMS should focus on when evaluating Medicaid work requirements' impact.
- CMS' monitoring plan should build on existing state data reporting mechanisms in order to minimize state administrative burden.
- The HHS Secretary should direct CMS to issue guidance to state Medicaid agencies and Medicaid managed care plans clarifying that an individual with appropriate expertise should review and authorize all decisions to deny service authorizations or

to authorize a service. This guidance should also clarify that adverse determinations may not be made by automation tools alone.

- Congress should require HHS to develop and maintain a directory of youth residential treatment facilities
- The HHS Secretary should direct CMS to develop a transparent plan for monitoring and evaluating community engagement (CE) requirements in Medicaid.
- CMS to require states to send a notice to Children and Youth with Special Health Care Needs (CYSHCN) aging out of child Medicaid eligibility a minimum of 60 days in advance of the end of the eligibility period.



Review the MACPAC meeting agenda and transcripts.

States Take Steps on Medicaid Work Requirements

States have taken steps to implement Medicaid work requirements, but several key decisions are still contingent on guidance from CMS, including whether beneficiaries can self-attest to qualifying for a medically frail exemption, according to KFF and Georgetown University's Center for Children and Families, who surveyed 43 states and held focus groups with officials in eight states.

Among the survey findings:

- States are looking to use new data sources as part of their automated verification process -- including using claims data to check eligibility for a medically frail exemption.
- 29 states want to use self-attestation to verify medically frail exemptions if verification data is not available, but they are unsure as to whether this would be allowed under federal rules as CMS has yet to release guidance on what conditions count as medically frail.
- Most states plan on using existing Medicaid claims data to verify whether someone is medically frail, but states are in different phases of figuring out how to use this data. Ten states say they have identified specific ICD-10 and CPT service codes to confirm medical frailty.
- 25 states plan to use enrollment in a behavioral health managed care plan.
- 30 states say they will develop a process to obtain provider confirmation in cases where exemption status cannot be verified using Medicaid claims and other data.
- Most states are planning to verify work requirement compliance every six months at renewal, with a one-month lookback period to verify compliance at application and renewal.
- 14 states plan to take action to increase eligibility staff.



Review the report.

ACA Enrollment Falls And Healthcare Costs Remain a Top Concern

ACA enrollment could fall from 22.3 million in 2025 to around 17.5 million this year, according to a KFF report, which relied on federal and state data as well as findings from the actuarial firm Wakely Consulting Group.

A higher proportion of middle-income Americans dropped coverage compared to other groups, the report found. That group makes too much money to qualify for the remaining subsidies in the program that are reserved for low-income enrollees. But they don't make enough to comfortably afford their health coverage without the COVID-era enhanced subsidies that are now expired.

Drops in ACA sign-ups were seen across most states, KFF found, though states that had their own exchanges retained a larger percentage of enrollees than states that relied on the federal marketplace.

The cost of healthcare also dominated the conversations at Axios' second annual Future of Health Summit.

Key takeaways from the summit:

- 75% of respondents in the summit's live audience poll said the one thing they'd change about the health care system would be costs.
- Pharmaceutical leaders say high drug costs are being driven by complex legislation, FDA volatility and unfair international policy.
- Fraud is top of mind, as leaders point to wasteful and inaccurate spending.

Review the KFF report.

Watch the Axios Health Summit.

Reports Criticize Hospitals for High Healthcare Costs

Paragon Health Institute, a conservative think tank led by Brian Blase, a former Trump adviser, published a report in April blaming government policies for fostering hospital consolidation and price inflation. Two weeks later, left-leaning advocacy group Families USA released a report echoing similar concerns.

“Paragon and Families USA are aligned on not a long list of issues but on hospital prices and consolidation…it’s one of the few issues on which we are aligned on,” said Sophia Tripoli, senior director of health policy at Families USA, which receives funding from a number of philanthropic foundations.

Review the Paragon Institute report.

Review the analysis from Families USA.

Influencers' and Podcasters' Opinions Ahead of Scientists', Finds Survey

A report by SachsHEALTH, a newly launched nonpartisan healthcare policy and communications division of Sachs Media, found that only 50% of Americans trust the U.S. healthcare system to act in patients' best interests, and more than a third actively distrust it.

The findings are based on a national survey of 2,500 American adults conducted in February. The report aimed to understand the disconnect between who Americans consider influential in healthcare and who they wish had greater influence.

More findings:

- 50% of respondents identified their personal doctor or clinician as the source most likely to change their mind about a new health policy proposal.
- 42% deliberately act against their clinician's recommendations, like skipping treatment or stopping medication early.
- 50% believe payers have influence, but only 15% think they should have it.
- When asked to name the three groups with the most influence, 20% of respondents chose influencers and podcasters in their top three, ahead of journalists (14%) and independent scientists (11%). When asked to narrow it to a single most influential group, public health agencies barely edged influencers and podcasters, 9% to 8%.
- 63% said they regularly encounter confusing or conflicting health information.
- 71% of those who distrust the system say they have encountered conflicting or confusing health information, compared to 58% of those who trust it.
- Among those who distrust the healthcare system, the ability to check evidence is a top driver of whether they trust a health message (54%). Overall, the most trusted sources of information are providers (48%) and the ability to verify evidence independently (48%).
- The most trustworthy groups when a serious problem happens in healthcare: providers (34%), hospitals (28%), patient advocacy groups (27%), and public health agencies (22%).
- Top health concerns: affordability (54%), insurance denials and coverage gaps (33%), Medicare and Medicaid sustainability (29%), and mental health access (28%).
- About 44% trust clinicians to use AI for imaging or lab interpretation; 45% distrust the use case. Men were nearly 20 percentage points more likely to trust a clinician using AI than women. Generational differences were minimal.
- 47% are willing to use AI chatbots for general health questions, with those willing skewing younger, while 45% are not.



Review the survey.

Politicians on Both Sides Blamed for Healthcare Challenges, Says Report

After conducting 3 online focus groups with people who have either experienced healthcare premium increases or have gone uninsured, GBAO published the following findings.

- Affording healthcare is challenging, with many doing research or going without in order to minimize costs.
- Most see the country's system as deeply flawed, and hope for universal healthcare.
- Knowledge of "public option," "single payer," or "Medicare for All" is very thin, even among providers.
- Many have noticed a recent change in coverage, but not all can articulate why or who is to blame.
- More blame "politicians" writ-large, even if some acknowledge Democrats are more likely to fight for more accessible coverage.



Review the report.

AMA Publishes Policies to Combat AI Deepfake Physician Impersonations

The American Medical Association (AMA) rolled out a framework to protect physicians from unauthorized artificial intelligence-generated deepfakes. The framework is based on seven policy principles: physician identity as a protected right; prohibition on deceptive medical impersonation; informed, opt-in and revocable consent; mandatory transparency and labeling; shared responsibility to prevent impersonation; enforcement and practical remedies and minimizing administrative burden.

Recommended AMA safeguards include strict data protection standards, transparency standards and penalization of deceptive practices.



Review the AMA framework

Democrats Plan Health Care Affordability Offensive

Finance Committee ranking Democrat Ron Wyden (OR) and a group of Senate Democrats unveiled an affordability-focused initiative centered on reversing the Medicaid and Affordable ACA cuts in Republicans' reconciliation bill, simplifying health care, and taking on "corporate greed."

They argue that Republicans "have used their majority to increase Americans' health care costs and put new barriers between families and the care they need," while Democrats can instead pursue reforms that "put patients over profits and consumers over complexity."

“It is no surprise that Americans are increasingly questioning whether a system that incentivizes and rewards profit-seeking behavior is compatible with one that places the health and financial well-being of patients and families first,” the senators wrote.

Forty-two percent of “Make America Healthy Again” (MAHA) supporters say lowering health care costs is the issue they care most about, and significantly many said the issue could determine which party they back, according to a KFF poll released last week. More than half said health care costs would heavily influence both how they vote and which party they support in the midterms.

- Review the Democrats’ press release.
- Review the KFF poll.