Advancing High Performance Health

One Prince Street
Alexandria, VA 22314-3318
O 703.838.0033
F 703.548.1890

Medicare Physician Fee Schedule Conversion Factor: Pursue Comprehensive Reform

Overview

The Medicare Physician Fee Schedule (PFS) conversion factor has declined substantially in real terms for more than two decades, undermining physician practice sustainability and threatening beneficiary access to care. This erosion directly conflicts with federal policy goals to strengthen primary care, expand accountable care models, and promote high-quality, cost-effective care delivery. Despite repeated short-term congressional patches, the underlying structural flaws in physician payment remain unaddressed.

At the core of the problem are two interrelated defects: (1) the absence of predictable, inflation-adjusted annual updates to the conversion factor, and (2) a rigid budget neutrality framework that redistributes inadequate payment levels rather than modernizing them. Together, these features have systematically undervalued physician services, destabilized practices, untethered payment from the actual cost of providing care, and weakened the financial foundation necessary for participation in Advanced Alternative Payment Models (APMs) and the Medicare Shared Savings Program (MSSP).

Since 2001, inflation-adjusted physician payment has declined by more than 30% in real terms, according to analyses drawing on Medicare Trustees' Reports, Bureau of Labor Statistics data, and Congressional Budget Office projections. Over the same period, practice expenses—captured by the Medicare Economic Index (MEI)—have consistently grown by approximately 2%–4% annually. This widening gap has required continual productivity gains merely to maintain financial neutrality, a dynamic that is increasingly untenable.

The consequences are particularly acute for primary care and cognitive specialties that deliver longitudinal, team-based care and lack the procedural volume to offset declining margins. Independent, rural, and safety-net practices are disproportionately affected.

AMGA urges Congress and the Department of Health and Human Services (HHS) to pursue

durable, structural reform to restore payment stability, align incentives with federal high-value care objectives, and protect beneficiary access to care.

AMGA's Policy Recommendations

AMGA urges Congress and HHS to pursue comprehensive reform of the physician payment system by:

1. **Establishing Automatic Inflation-Based Updates:** Amend 42 U.S.C. § 1395w-4 to provide annual updates to the conversion factor tied to the MEI or a comparable measure of practice cost inflation.

2. **Reforming Budget Neutrality Requirements:** Exempt targeted adjustments intended to correct undervaluation, improve payment accuracy, or support new care delivery models from strict budget neutrality.

3. **Creating a Transitional Stabilization Mechanism:** Establish time-limited funding to stabilize physician payment during the transition to inflation-indexed updates and prevent access disruptions.

4. **Strengthening Payment for Primary Care and Cognitive Services:** Provide targeted increases for evaluation and management, care coordination, and chronic disease management services that reinforce accountable care.

5. **Aligning Payment Policy with High-Value Care Goals:** Ensure that conversion factor reforms support participation in Advanced APMs and MSSP through stable, adequate base payments that justify necessary investments in organizational infrastructure.

Background

Short-Term Patches Fail to Address Structural Deficiencies

Since 2003, Congress has enacted more than a dozen temporary payment patches to avert scheduled conversion factor reductions. While these actions have prevented immediate disruptions, they have created ongoing uncertainty, discouraged long-term investment, and failed to resolve the structural inadequacy of physician payment. Temporary fixes are not a substitute for the certainty of a predictable payment framework.

Budget Neutrality Creates a Zero-Sum Trap

Current budget neutrality requirements force increases in payment for certain services to be offset by reductions elsewhere, creating artificial conflicts among specialties and care modalities. This zero-sum structure prevents the payment system from adapting to clinical innovation, evolving care models, and improved valuation without penalizing other clinicians. Reforming budget neutrality would allow payment accuracy to improve without arbitrary redistribution.

Any meaningful reform of physician payment, however, must also address the structural link

between Part B spending and Part B premiums. Under current law, Medicare Part B premiums are set as a percentage of total program expenditures, meaning that correcting chronically inadequate physician reimbursement rates would, absent legislative intervention, increase beneficiary premiums. This coupling creates a perverse dynamic in which improving payment accuracy for clinicians is effectively penalized through cost-shifting to seniors and people with disabilities who depend on Medicare Part B. Congress should explore decoupling the premium-setting formula from aggregate Part B expenditures or otherwise establishing a financing mechanism that allows reimbursement to reflect actual costs of care without burdening beneficiaries with premium increases that are result from the lack of long-overdue payment corrections.

Payment Adequacy Is Foundational to Value-Based Care

CMS increasingly expects clinicians to assume financial risk, manage total cost of care, and invest in team-based, technology-enabled care delivery. Participation in Advanced APMs and MSSP requires significant upfront and ongoing investment in data infrastructure, care management, quality measurement, and care coordination. These investments are only feasible if base fee-for-service payments adequately cover operating costs and support reinvestment. Continued erosion of the conversion factor undermines the financial viability of high-value care participation, particularly for independent, rural, and safety-net practices.

Access to Care Is at Risk

AMGA member organizations consistently report that inadequate Medicare payment is influencing decisions to limit Medicare patient panels, reduce appointment availability, or exit Medicare participation altogether. Primary care practices, which operate on narrow margins and rely heavily on Medicare revenue, are especially vulnerable. Cognitive specialties face similar pressures due to persistent undervaluation of non-procedural services. Without reform, beneficiary access to timely, high-quality care is likely to deteriorate, particularly in rural and underserved communities.

Precedent Exists for Inflation-Adjusted Payment

Congress has long recognized the necessity of inflation-based updates in Medicare payment systems, including the hospital inpatient prospective payment system (42 U.S.C. § 1395ww) and hospital outpatient prospective payment system (42 U.S.C. § 1395l(t)). The absence of a comparable mechanism in the PFS is an omission that has been compounded over time. Applying the same principle to physician payment is essential for systemwide sustainability across provider types.

Conclusion

Temporary statutory patches cannot resolve the structural inadequacy of the Medicare Physician Fee Schedule. Without durable reform, continued erosion of physician payment will accelerate consolidation, reduce beneficiary access, and undermine the infrastructure required for the national transition to high-value care.

AMGA urges Congress and the administration to act now to establish a sustainable physician payment foundation—one that is predictable, inflation-responsive, and capable of supporting high-quality, accessible care for Medicare beneficiaries.