Medicare physician payment adequacy: Budget neutrality

Background

As one of the few Medicare providers without a payment update tied to inflation, physicians have watched their inflation-adjusted payments decline 29% from 2001 to 2024. Physician payments are further eroded by frequent and large payment redistributions caused by budget neutrality adjustments, as explained below.

Medicare has paid for physicians' services under the Medicare Physician Fee Schedule (MFS) since 1992. To determine payment for a particular service, the MFS geographically adjusts relative value units (RVUs), which reflect the physician work and costs of providing that service, and then multiplies those RVUs by a dollar amount known as the Medicare conversion factor, which is set by the Centers for Medicare & Medicaid Services (CMS) annually. Every year, CMS makes changes in RVUs for some services because the billing codes used to describe a set of services have changed, technological advances cause new services to be added to the fee schedule, or more recently collected data indicate that services are either undervalued or overvalued.

Current statute requires any changes made in fee schedule payments be implemented in a budget neutral manner. So, if CMS projects that net pricing changes for existing services across the MFS will increase (or decrease) total Medicare spending by more than $20 million, the agency must reduce (or increase) all Medicare physician services by that excess amount, typically by adjusting the Medicare conversion factor.

Recent actions by Congress to ease the impact of COVID-19 on physician practices focused primarily on transitioning a sizeable conversion factor cut due to the budget neutrality adjustments that were required when coding and documentation policies for office and other visit services, the most commonly billed physician services, were implemented and caused large payment redistributions.

It is not uncommon for CMS to overestimate utilization in its budget neutrality estimates. The most prominent example of this was when transitional care management (TCM) services were added to the MFS in 2013. CMS estimated 5.6 million new claims would be submitted for these services. Actual utilization turned out to be just under 300,000 claims for the first year; it was still less than one million claims after three years. As a result of this overestimation for TCM services alone, Medicare physician payments were reduced by more than $5.2 billion from 2013 to 2021. Once these redistributions are made through the conversion factor, they are not added back, even when utilization is lower than expected. The net result in these circumstances is not budget neutrality, but rather a permanent reduction in Medicare physician payments across-the-board.

Legislative solutions (included in H.R. 6371, the Provider Reimbursement Stability Act)

1. **Provide a lookback period to reconcile overestimates and underestimates of pricing adjustments for individual services.** This solution would allow for the Medicare conversion factor to be prospectively adjusted based on actual utilization data after a full year's worth of claims data become available.
2. **Require the direct inputs for practice expense relative value units to be updated at least every five years.** Direct inputs include clinical wages, prices of medical supplies and prices of equipment, which in the past have been reviewed by CMS only after many years and, because they also were not reviewed concurrently, led to significant payment redistribution.

3. **Increase the budget neutrality trigger from $20 million to $53 million.** This $20 million threshold was established in 1992 and has not been updated since. Increasing the threshold to $53 million would recognize inflation and allow for greater flexibility in making necessary pricing adjustments for individual services without triggering automatic, across-the-board Medicare cuts.
4. **Limit year-to-year conversion factor variance.** Starting in 2025 require the secretary of Health and Human Services to limit positive or negative increases to the MFS conversion factor to no greater than 2.5% each year. The policy goal is to provide stability for the MFS by removing relatively large and abrupt changes in the conversion factor calculations. The intent is for any policy that increases or decreases the conversion factor by 2.5% to continue in subsequent years. Of note, payment increases established by legislation would be exempt from this cap on the conversion factor. In other words, the statutorily mandated 0.25% increase for participants in the Merit-based Incentive Payment System (MIPS) and 0.75% increase for participants in Advanced Alternative Payment Models scheduled to begin in 2026, as well as any potential, forthcoming increase associated with an inflationary update tied to the Medicare Economic Index (MEI), would be excluded from the cap.