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A Physician's Perspective on Medicare Physician Payment Reform

Dr. Larry Bucshon, Senior Policy Advisor
Former Member of the U.S. House of Representatives (R-Ind.) | Vice Chair, GOP Doctors Caucus

A Cut Scheduled for January 1

Now that CMS has released the final 2027 Medicare Physician Fee Schedule, the numbers are locked in and, for physicians, they point in the wrong direction. There are two conversion factors for 2027: $32.9548 for qualifying alternative payment model participants, down 1.83 percent from $33.5675, and $32.6286 for everyone else, down 2.31 percent from $33.4009.

Before I ran for office, I spent years as a cardiothoracic surgeon in Evansville, Indiana, and I know exactly what a cut like this means on the ground. The one-year 2.5 percent increase the U.S. Congress provided for 2026 expires, and CMS is required to strip it out before applying this year's modest statutory updates of 0.75 percent and 0.25 percent and a further budget neutrality reduction. Physicians are once again staring down a cut just to keep their doors open to Medicare patients, even as practice costs keep climbing. CMS' measures of the increase in practice cost inflation, the Medicare Economic Index (MEI), shows input costs rising 2.6 percent for 2027. Any physician who has run a practice knows you can't keep paying staff, rent and malpractice premiums that go up every year on reimbursement that goes down. That's not sustainable, and it's not what Congress intends when it talks about protecting seniors' access to care.

None of this is new. In my 14 years in the U.S. House of Representatives, including on the Committee on Energy and Commerce Subcommittee on Health, I watched physicians absorb reductions to the conversion factor year after year, often softened only by temporary, one-year fixes from Congress that expire and leave practices right back where they started. Adjusted for inflation in practice costs, Medicare physician payment has been sliding for decades. The difference this year is the calendar. The midterm elections flipped both chambers. Democrats won at least 253 House seats, with 25 races still to be called, and will control at least 54 Senate seats, with Alaska and Mississippi still outstanding. The cut takes effect January 1, 2027, and the outgoing Congress has only a few weeks to stop it before a new majority takes the gavels.

The Lame-Duck Window

Congress has a track record of stepping in late in the year to blunt or delay these cuts, and the lame duck has often been where that happens. Government funding still needs to be resolved in this Congress, and that package may offer a vehicle for physician payment relief. Having served through more than one lame duck, I can tell you these sessions can be more productive than people expect. Members often want to wrap up unfinished business, and leaders on both sides may see value in resolving health care issues before the new year. I'd encourage physician and healthcare professional organizations to continue making the case for relief that offsets the 2027 reduction to give practices greater stability.

Keeping Up the Pressure in the New Congress

Whatever happens in the lame duck, a one-year fix is still a one-year fix. The goal for the 120th Congress has to be a permanent, inflation-based update tied to the MEI. This is an issue close to my heart. I was proud to sponsor H.R. 2474, the Strengthening Medicare for Patients and Providers Act, in the 118th Congress, a bill that would tie annual physician payment updates to the MEI, and I'm encouraged that the idea has since gained support from members on both sides of the aisle. This year's final rule makes the case on its own terms. CMS projects practice costs will rise 2.6 percent in 2027, while the statutory updates are just 0.75 percent and 0.25 percent. Physician payment won't be at the top of the new majority's health agenda, which is focused on reversing the 2025 Medicaid and Marketplace changes and lowering costs, so physicians will have to make room for it.

The final rule is another reminder that CMS can do only so much. Only Congress can replace the cycle of cuts and patches with a permanent update that keeps pace with inflation. That won't happen in one session, and it won't happen without sustained pressure from the physician community. As a surgeon, I learned that you don't stop treatment just because the patient is stable for the moment, and the same is true here. The lame duck is the near-term priority, but the work on a permanent fix needs to start the day the new Congress is sworn in.