Reform Medicare's Physician Payment System

Medicare payment policy plays a uniquely important role in the U.S. healthcare system, serving as the standard setter for *reimbursement* across both public and private payers. However, even with congressional relief, Medicare payments to physicians have not kept up with inflation. Ensuring that physician payments accurately reflect the real cost of delivering care is essential for the stability of practices and continued access to essential services, including urogynecologic care.

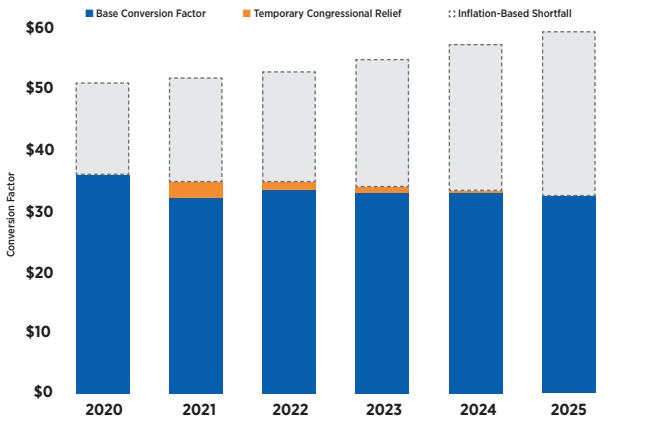

FIGURE 1. From 2020–2025, the Medicare physician payment conversion factor has steadily fallen behind inflation. The blue represents the "base" conversion factor set by CMS, while the orange bar shows temporary increases passed by Congress. The gray indicates the inflation-based shortfall, or what the conversion factor would be if adjusted each year to keep pace with rising practice costs. This shortfall translates into real, inflation-driven cuts for physician practices and ultimately threatens patients' access to care.

Congress has an opportunity to strengthen and modernize Medicare's physician payment system to better support high-quality care, sustain practice viability, and protect patient access.

HOW CONGRESS CAN HELP

We are advocating for Congress to take three steps to fix Medicare physician payment:

- **Establish a permanent annual inflationary update for physician payments.** After adjusting for inflation in practice costs, Medicare physician payment declined 33% from 2001 to 2025. AUGS is lobbying Medicare to establish a permanent physician payment update tied to inflation which would provide stable, predictable increases that reflect the real cost of care and support long-term practice viability and ensure patient access to care. It would also mirror inflationary updates given to hospitals and other facility-based providers.

- **Modernize outdated budget neutrality requirements.** Under Medicare's Physician Fee Schedule, whenever policy changes are expected to increase overall spending by more than $20 million in a year, CMS must make offsetting cuts elsewhere in physician payments. This "budget neutrality" threshold—set in 1992 and never adjusted for inflation—is now unrealistically low. As a result, even modest policy updates can trigger across-the-board cuts that destabilize physician practices and threaten patient access. Raising the threshold would reduce these unintended cuts and create a more sustainable payment system.

- **Strengthen support for chronic disease management.** Many urogynecologic conditions, such as pelvic floor disorders, are chronic in nature and require ongoing, longitudinal care. Unlike other specialties that may address these conditions episodically or in conjunction with broader medical issues, urogynecologists are uniquely trained to manage the full continuum of pelvic floor health across the lifespan. Medicare policy should more fully recognize the specialized role of urogynecology—including the distinct clinical expertise and practice resources required to delivery longitudinal urogynecologic care—in order to ensuring patients, and particularly those in rural and underserved communities, have access to this subspecialty expertise to improve outcomes and promote whole-person health.

By creating a more sustainable and predictable framework that reflects the true cost of care and the vital role of urogynecologists, we can protect practice stability and ensure timely and equitable access to high-quality care nationwide.