Medicare proposes ‘efficiency’ pay cuts that would hit highly paid specialists the most

The decision is a sign that Medicare, under RFK Jr., is more willing to neuter the AMA’s powerful physician panel

By Bob Herman and Tara Bannow – STAT News
July 16, 2025

Medicare is proposing across-the-board cuts to what Trump administration officials believe are overpriced medical procedures, scans, and tests — a consequential decision designed to even the score between highly paid specialists and primary care doctors.

The federal Medicare agency justified its action by saying that more than half of the 10,000 billing codes used by physicians have never been reevaluated in the 30-plus years of this payment system. Medicare also criticized the way these services are currently priced — through surveys of physician practices that have unreliably low response rates — and wants to exclude that input going forward.

Doctors for decades have been paid using rates developed largely under the advice of the industry’s main lobbying group, the American Medical Association. Experts have railed against the system for decades, calling it complex and filled with self-interested factions that ultimately favor surgeons and higher-priced specialists over primary care clinicians.

Medicare’s proposal for 2026 would create a so-called “efficiency adjustment” that would reduce payment by 2.5% for thousands of procedures and diminish some of the influence held by the AMA’s advisers, known as the Relative Value Scale Update Committee, or the RUC.

“This is probably one of the most controversial components of this rule,” said Shari Erickson, a top official with the American College of Physicians, which mostly lobbies for primary care doctors. “It is sort of continuing to chip away at some of the concerns that many have raised about the RUC and the power that they’re viewed as having.”

The result is that family medicine doctors and other primary care physicians would see the highest average increases in their payments, per Medicare’s estimates. Dermatologists, gastroenterologists, general

surgeons, neurosurgeons, ophthalmologists, orthopedic surgeons, pathologists, and radiologists would experience some of the biggest net decreases to their Medicare pay.

Importantly, the agency would exempt services that are based on time — for example, routine 15- and 30-minute visits performed by primary care physicians. More broadly, Medicare is using the savings from these cuts to bump up the "conversion factor" that dictates the payment rates for all physician services.

Michael Abrams, managing partner of health care strategy firm Numerof & Associates, said this would help fix what's been a "very serious issue" for decades: the pay imbalance between primary and specialty care.

"People used to talk about the primary care physician being sort of the quarterback of the team," Abrams said. "But what team do you know where the quarterback is the lowest-paid member?"

This is Medicare's first physician payment rule under Robert F. Kennedy Jr., who had been exploring a way to upend this payment system even before he was confirmed as the Health and Human Services secretary. He's had a rocky relationship with the AMA, especially because of his views on vaccines. Calley Means, an adviser to Kennedy, has criticized the way Medicare pays physicians, calling it "a system that waits for Americans to get sick and profits."

The AMA slammed Medicare's proposal. AMA President Bobby Mukkamala, a head and neck surgeon, said in a statement to STAT that limiting the use of the RUC's surveys "would have negative repercussions for appropriately determining the resources required for effective patient care."

"To label practicing physicians conflicted when all they are doing is sharing their real-world patient experiences where empirical data often do not exist is biased, unfair, and a skeptical opinion of community-based physicians," Mukkamala said in the statement.

Medicare's physician payment system is expected to dish out $90.5 billion in 2026, boosted in part by a one-time 2.5% bump that was written into Republicans' tax bill. Public comments are due by Sept. 12, giving lobbying groups two months to push for changes. A final rule usually comes out in November.

Congress has required the system to be "budget-neutral," meaning any spending increase must be offset with a decrease elsewhere.

“Because of budget neutrality, it kind of pits physicians against each other,” said Jeffrey Davis, a health policy director at the consulting firm McDermott+. “You do have clear winners and losers.”

He said analyzing what kinds of services physicians typically bill for will determine whether they actually get more money next year, but it’s not a foregone conclusion that all specialists will be getting less.

Major elements of the proposed rule take aim at the RUC. The group of doctors advises Medicare on how to value the codes for physician services by supplying information on how long it takes to perform certain procedures and the overhead costs involved.

Medicare agrees with most of the RUC’s recommendations, meaning doctors are setting their own pay for many types of care. Private insurers also tend to base their payment rates on Medicare’s. That inherent conflict of interest has been an open secret for decades, and the RUC does not let members of the public watch their meetings unless they sign a confidentiality agreement.

The Centers for Medicare & Medicaid Services is taking a chisel to some of that power by saying that the RUC’s physician surveys do not provide good enough data on the actual time spent and intensity of work involved with each service.

Several analyses, including one by the Urban Institute and other analytics firms, have shown the formulas for paying for physicians are “distorted” across numerous medical codes. For example, Medicare currently pays for skin lesion removals based on data that says the procedure takes more than 20 minutes, when in reality, the procedure just takes seconds.

“Procedures, radiology services, and diagnostic tests should become more efficient as they become more common,” Medicare officials wrote in the regulation. “As expertise develops, learning leads to enhanced familiarity with the various aspects of a service, variations in the anatomy of each patient, and confidence in the practitioner’s own ability to handle unexpected challenges that arise.”

Groups that support primary care physicians have contended that they often get the short end of the stick in the current arrangement. It’s difficult to become more efficient in primary care settings when the majority of the services are investments of time — like taking an hour to evaluate someone’s dementia or chronic conditions.

“It’s a recognition that you just can’t treat these different kinds of services all the same,” said Ann Greiner, CEO of the Primary Care Collaborative.

Unsurprisingly, specialty physicians came out swinging against the rule’s efficiency adjustment.

Christian Shalgian, senior vice president of advocacy for the American College of Surgeons, said it’s important to analyze each service individually to determine how much doctors should get paid. This across-the-board 2.5% cut does the opposite, he said.

“This is very much different from what we expected to see under Oz,” Shalgian said, referring to CMS administrator Mehmet Oz. “This is not being done in a surgical way. This is being done with a blunt instrument across the entire spectrum. This is not how we think physician pay reform should be done.”

Gregory Nicola, chair of the American College of Radiology’s Commission on Economics, warned that the cuts could impact the availability of imaging exams, including to detect breast and lung cancers.

“Cutting payment for these lifesaving exams is not helpful,” Nicola said. “We look forward to working with regulators and those in Congress to arrive at more sensible imaging reimbursement policies that encourage widespread access to care for all Americans.”

Medicare’s argument — that procedures can be made more efficient using technology or simply by learning to perform them in a shorter amount of time — may be true for some specialties, but it doesn’t apply to anesthesiology, said Donald Arnold, president of the American Society of Anesthesiologists. Currently, Medicare pays anesthesiologists based on two factors: a procedure’s complexity and the amount of time involved.

“If there were efforts to reduce payments based on some efficiency argument, it is at best a stretch because it’s not applicable to the way our payments work,” Arnold said.