# 2026 Medicare Physician Payment Schedule and Quality Payment Program Final Rule

## SUMMARY AND ANALYSIS

On October 31, 2025, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2026 Payment Policies under the Medicare Physician Payment Schedule (PFS) and Other Changes to Part B Payment and Coverage Policies final rule and associated fact sheet. The final rule, published in the November 5, 2025, issue of the Federal Register, includes several notable changes to Medicare physician payment and the Quality Payment Program (QPP). The American Medical Association (AMA) submitted detailed comments to CMS regarding these policies as proposed on Sept. 11, 2025. The finalized changes will take effect on January 1, 2026, unless otherwise noted.

Attached is the CMS specialty impact table. The AMA hopes to share more granular impact tables with the Federation in the near future after receiving additional information from CMS.

## EXECUTIVE SUMMARY

All physicians will benefit from the positive conversion factor updates for 2026, including a 3.77 percent increase for advanced alternative payment model (APM) qualifying participants (QPs) and a 3.26 percent increase for all other physicians. The conversion factor increases reflect:

- A temporary 2.5 percent pay bump passed by Congress in H.R. 1;
- Small, permanent updates to the baseline as required under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2025, including a 0.75 percent increase for QPs and a 0.25 percent increase for all other physicians; and
- A positive 0.49 percent budget neutrality adjustment.

The budget neutrality adjustment results from misvalued code changes and a -2.5 percent “efficiency adjustment.” Although AMA comments raised several questions about the efficiency adjustment and recommended alternative approaches to achieve CMS’ objectives, CMS will apply the negative adjustment to work relative value units (RVUs) and the corresponding intra-service portion of physician time of existing, non-time-based services that CMS believes accrue gains in efficiency over time.

The AMA is disappointed that CMS did not factor in the Physician Practice Information (PPI) Survey information in updating 2026 practice expense relative values to adjust Medicare Economic Index (MEI) weights impacting the distribution of RVU components. Independent from the PPI Survey, CMS chose to finalize its proposed modification to the indirect practice expense methodology, redistributing indirect practice costs from facility-based services to non-facility-based services. This change in practice expense methodology, only recognizing 50 percent of the physician’s work of facility-based services in the indirect cost method, results in a significant shift of payment between sites-of-service. Payment for physician services performed in facilities will decrease overall by -7 percent while payment for physician services performed in non-facility settings will increase by 4 percent, but reductions for specific physician practices will be even steeper.

The final rule summary and analysis which follows provides additional detail about these changes, discusses other Medicare physician payment policies finalized for 2026, and describes the positive and negative impacts on the physicians affected by these policies, which include:

- Telehealth;
- Individual code changes and valuations;
- Skin substitutes;
- Geographic Practice Cost Indices (GPCIs);
- Medicare Diabetes Prevention Program (MDPP);
- Medicare Shared Savings Program (MSSP)
- Merit-based Incentive Payment System (MIPS);
- MIPS Value Pathways;
- Advanced alternative payment models; and
- Ambulatory Specialty Model.

## PAYMENT UPDATES AND POLICIES

### CY 2026 Medicare Conversion Factors

- **Positive impact**: All physicians will receive a positive update that exceeds the growth in inflation in practice costs.
- **Negative impact**: For many physicians, the benefits of the positive update will be at least partially offset by the finalized practice expense and efficiency adjustment cuts, explained below.

After a 2025 reduction, the AMA is pleased CMS implemented positive conversion factor updates for 2026, including a 3.77 percent increase for advanced alternative payment model (APM) qualifying participants (QPs) and a 3.26 percent increase for all other physicians. In the final rule, CMS announced 528,827 eligible clinicians achieved QP status in 2024, making them eligible for the 3.77 percent payment increase in 2026, along with a 1.88 APM lump sum bonus payment in 2026. The conversion factor increases reflect:

- A temporary 2.5 percent pay bump passed by Congress in H.R. 1;
- Small, permanent updates to the baseline as required under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2025, including a 0.75 percent increase for QPs and a 0.25 percent increase for all other physicians; and
- A positive 0.49 percent budget neutrality adjustment.

The budget neutrality adjustment results from misvalued code changes and a -2.5 percent “efficiency adjustment.” Although AMA comments raised several questions about the efficiency adjustment and recommended alternative approaches to achieve CMS’ objectives, CMS will apply the negative adjustment to work relative value units (RVUs) and the corresponding intra-service portion of physician time of existing, non-time-based services that CMS believes accrue gains in efficiency over time. More information about the efficiency adjustment is below.

| 2026 Medicare Conversion Factors (CFs) | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **2025 CFs** | **APM or Non APM Update Factor (1.0075 or 1.0025)** | **CY 2026 RVU Budget Neutrality Adjust-ment** | **CY 2026 2.50 Percent Increase (1.025)** | **Anes-thesia Only PE and PLI Adjust-ment** | **2026 CFs** | **Percentage Changes** |
| **APM QP** | $32.3465 | $32.5891 | $32.7588 | $33.5675 | N/A | $33.5675 | **3.77%** |
| **Non-APM QP** | $32.3465 | $32.4274 | $32.5863 | $33.4009 | N/A | $33.4009 | **3.26%** |
| **Anesthesia APM QP** | $20.3178 | $20.4702 | $20.5705 | $21.0847 | $20.5998 | $20.5998 | **1.39%** |
| **Anesthesia Non-APM QP** | $20.3178 | $20.3686 | $20.4684 | $20.9801 | $20.4976 | $20.4976 | **0.88%** |

The AMA continues to strongly advocate for permanent baseline updates to the conversion factors that account for the growth in physician practice costs, which CMS projects will be 2.7 percent as measured by the (MEI. In their June 2025 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) expressed concerns about the growing gap between physicians' input costs and Medicare payment, warning: "[t]his larger gap could create incentives for clinicians to reduce the number of Medicare beneficiaries they treat, stop participating in Medicare entirely, or vertically consolidate with hospitals, which could increase spending for beneficiaries and the Medicare program." MedPAC therefore recommended Congress repeal current law updates and replace them with annual updates tied to MEI for all future years. The 2025 Medicare Trustees Report reiterated similar concerns about patient access to care, stating that under current law, "the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term."

**Practice Expense (PE)**

- **Positive impact:** While the impact will vary even within specialties, specialists who primarily see patients in an office, including family medicine physicians, allergists, and rheumatologists, will see a pay increase.
- **Negative impact:** Many physicians who see patients in hospitals, ambulatory surgery centers, and nursing homes, such as infectious disease physicians, hospitalists, cardiothoracic surgeons, ophthalmologists, and gastroenterologists, will face cuts due to the redistribution of PE RVUs from physician services performed in facilities to physician services performed in non-facilities.

*Development of Strategies for Updates to PE Data Collection and Methodology*

The AMA contracted with Mathematica to conduct a technical and comprehensive survey of physician practice costs, termed the Physician Practice Information (PPI) Survey. This project began with interviews and pilot surveys in 2020, ultimately leading to a delay of a broader launch until practices had time to recover from the COVID-19 public health emergency. Mathematica pre-tested and piloted the survey again in 2023 before a launch in summer 2023. More than 170 organizations signed a letter of support to share with all potential survey respondents, including all state medical associations, more than 100 national medical specialty societies and other health care professional associations, the American Group Medical Association, the Medical Group Management Association and the Association of American Medical Colleges.

The PPI survey data collection effort was completed in September 2024. The PPI Survey concluded with 380 practices providing usable data for 831 departments, which encompassed 18,086 physicians, resulting in a 6.8 percent response rate. As part of this effort, 5,690 physicians responded to the survey of physician hours. In parallel, a non-MD/DO survey concluded with 317 practices providing usable data and included 2,548 other health care professionals. The response rate was 9.1 percent. These data were shared with CMS in January 2025.

CMS declined to use the PPI Survey in the 2026 Medicare Physician Payment Schedule, noting concerns about low response rates, representativeness, and variance in the number of specialties with sufficient responses, as compared to the previous 2007/2008 PPI Survey. CMS also criticized occupational therapy and the independent diagnostic testing facilities for not sharing their collected data. CMS stated the intention to work with the AMA to understand whether and how such data should be used in rate setting in future rulemaking. CMS shared numerous alternatives, and their specialty impacts, for use of the PPI data in determining the MEI weights for physician work, PE, and professional liability insurance (PLI). CMS also declined to change MEI weights in 2026, stating that further information and data is welcomed to inform future rulemaking on these cost shares.

*Updates to PE Methodology – Site of Service Payment Differential*

CMS finalized a reduction in indirect PE RVUs for all services provided in the facility setting. The mechanism for the reduction is highly technical as CMS would reduce the portion of facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs. CMS cites AMA and MedPAC studies showing the growing number of employed physicians and physicians in hospital-owned practices and the shrinking number of private practices as its rationale for this policy change. CMS believes that physicians who provide services in the facility no longer maintain a separate office and receive "duplicative payments" under the PFS and the facility fees under the outpatient or the ASC payment schedules.

Payment for physician services performed in facilities will decrease overall by -7 percent while payment for physician services performed in non-facility settings will increase by 4 percent. The results to individual physicians and specialties are proposed to be substantial and these *Specialty Impacts by Practitioner* are available on CMS website. While the impact will vary even within specialties, many specialists who see patients in hospitals, ambulatory surgery centers, and nursing homes, such as infectious disease physicians, ophthalmologists, and gastroenterologists, will face cuts. On the other hand, specialists who primarily see patients in an office, including family medicine physicians, allergists, and rheumatologists, will see a pay increase.

As the AMA explained in detail in our comments, this policy is likely to result in unintended consequences, including further incentivizing consolidation. When a private practice physician performs a service or procedure in the facility setting, their physician practice still must handle coding and billing for the physicians' claim and scheduling as well. Physician practices would still have administrative staff, and their clinical staff often perform some work supporting services that are performed in the facility. The results from the 2024 PPI survey data showed $57 in indirect expenses per hour of direct patient care for hospital-based medicine and $62 for hospital-based surgery. For surgical global codes performed in the facility setting, the bundled post-operative office visits are often performed in a physician office even though the major surgery was performed in the facility setting.

*Use of the Relationship Between Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classification (APC) Relative Weights to Establish PE RVUs for Radiation Oncology Treatment Delivery, Superficial Radiation Treatment, Proton Beam Treatment Delivery, Remote Physiologic Monitoring and Remote Therapeutic Monitoring*

In lieu of utilizing PE RVUs using the standard methodology, CMS has set the RVUs for these services by using the relative weights and cost data from the hospital OPPS APCs for the PE only codes from several radiation treatment delivery and remote monitoring code families. The services impacted are revised radiation oncology treatment delivery codes 77402, 77407 and 77412, new superficial radiation treatment codes 77436, 77437 and 77438, new/revised remote physiologic monitoring codes 99445 and 99454 and new/revised remote therapeutic monitoring

codes 98985 and 98977. Separately, CMS is also considering a similar approach for the proton beam treatment delivery code family in the future, but it will remain as carrier priced for 2026.

*Direct PE Adjustments*

CMS made several improvements to the direct PE inputs, resulting from the AMA/Specialty Society RVS Update Committee (RUC) recommendations and the comment process. CMS implemented a RUC recommendation to correct the pricing of medical supply packages and will transition to these new prices over three years. While not proposing to address the concern expressed by the Current Procedural Terminology (CPT) Editorial Panel and RUC to ensure accuracy in payment of high-cost supplies, CMS states that they are open to further discussion regarding whether G-codes should be created to describe the use of these supplies. CMS is also interested in potentially using OPPS data to price these high-cost supplies.

**Potentially Misvalued Services**

- **Positive impact**: All physicians benefit from RUC's work to ensure valuation remains appropriate, and medicine provides the clinical input into this review. The positive budget neutrality adjustment resulting from the RUC's review of potentially misvalued services impacts all physicians.

The positive budget neutrality RVU adjustment is partially due to the savings produced from the RUC's identification and review of potentially misvalued services. For 2026, CMS received several comments identifying potentially misvalued services for review. CMS reviewed these comments and concluded that these services do not qualify as potentially misvalued, but CMS welcomes additional comments and review by the RUC. The RUC will review the following issues in 2026 resulting from these comments: final needle aspiration and maxillofacial prosthodontic services.

**Telehealth**

- **Positive impact**: Physicians who treat hospital inpatients and nursing facility patients through telehealth, those who provide services requiring direct supervision, and teaching physicians who virtually supervise residents in the delivery of telehealth services will all benefit.
- **Negative impact**: The lapse in telehealth coverage during the government shutdown has prevented payment for many telehealth claims and led some physicians to stop offering these services.

Following five years of AMA advocacy, the 2026 final rule permanently allows virtual direct supervision and lifts the frequency limits on providing subsequent hospital inpatient and nursing facility visits and critical care consultations furnished via telehealth. CMS will now permanently allow physicians to be immediately available via audio-video telecommunications for all services that require direct supervision except those with a 10- or 90-day global period.

In a win for teaching physicians, CMS reversed its proposal to limit virtual teaching physician supervision of residents providing telehealth services to non-metropolitan areas and no longer allow virtual supervision of residents in metropolitan areas. As the AMA advocated, the final policy permanently allows virtual supervision of residents providing telehealth services in all training settings.

CMS also discusses concerns raised by the AMA and others regarding expiration of flexibility at the end of 2025 that allowed physicians providing telehealth services from their homes to use their currently enrolled practice location instead of listing their home address in the Medicare enrollment database. The Agency clarifies that, although it is not further extending this flexibility, subregulatory guidance states that physicians who mark the address as "Home office for administrative/telehealth use only" will suppress their street address details in the Medicare database.

CMS is finalizing its proposal to simplify the process for requesting additions to the Medicare Telehealth List, reducing it from five to three steps, and it has finalized the addition of the five services that it proposed to add to the 2026 Medicare Telehealth List. CMS also maintains its view that the CPT® codes for telemedicine evaluation and management (E/M) services are not eligible under the current Medicare statute to be added to the Telehealth List.

**Valuation of Specific Codes**

- **Positive impact**: Practicing physicians and other health care professionals who advise Medicare based on their experience persuaded CMS to adopt nearly all of the RUC recommendations.

CMS was persuaded by comments on individual codes and will now accept and implement 91 percent of the RUC recommendations for new/revised CPT® codes and codes identified via the RUC's potentially misvalued services process. CPT 2026 will include a major restructuring of lower extremity revascularization (LER) represented by 46 new codes. CMS accepted 100 percent of the RUC recommendations for LER. Although not recognized for Medicare payment purposes, AMA and RUC comments persuaded CMS to publish relative values for the immunization counseling codes to be utilized by other payors and physician productivity systems.

**Efficiency Adjustment**

- **Positive impact:** Physicians who primarily provide services excluded from the efficiency adjustment, including family medicine physicians and psychiatrists, will avoid the cut.
- **Negative impact:** The 2.5 percent cut to work RVUs and physician intraservice time impacts most specialties by reducing overall payment by one percent.

CMS finalized its proposal to apply a 2.5 percent decrease to the work RVUs and physician intra-service time of most services in the PFS on the assumption that physicians have gained efficiency in providing them. In response to feedback from the AMA, the Agency will exempt brand new services but will apply the reduction to services surveyed for physician time and work within the past year. The decrease will be applied to 91 percent of physician services. CMS will apply the efficiency adjustment to the intraservice portion of physician time and work RVUs every 3 years.

CMS arrives at a 2.5 percent efficiency adjustment by tallying the last five years' productivity adjustments in the MEI. Despite organized medicine's advocacy, physicians do not receive MEI-based updates, and other Medicare providers receive a productivity adjustment applied to their annual baseline updates (e.g., hospital market basket minus productivity). In the AMA comments, CMS was urged to provide greater transparency regarding the source data for the 2.5 percent efficiency adjustment. CMS responded to these comments and provided greater detail in the final rule. The 2.5 percent remains difficult to replicate as CMS and Bureau of Labor Statistics overwrites their data with revised data every few months, and the CMS data selection is from a moment in time that is no longer publicly available. CMS' response also raises new questions about the appropriateness of the economy-wide productivity adjustment factor currently used in the efficiency adjustment and MEI. The AMA is conducting additional analyses in response to the final rule and will share any helpful findings with the Federation.

CMS states that it will exempt new 2026 codes; time-based services (such as E/M and care management), maternity care, and services on the telehealth list. Only 656 services will be exempted from the decrease. Of note, the AMA comments ensured that CMS had an accurate accounting of all time-based services and services on telehealth list to exempt from the efficiency adjustment.

The adjustment impacts most specialties by reducing overall payment by one percent. Physicians who primarily provide excluded services, including family medicine physicians and psychiatrists, will avoid the cut. This policy, combined with the AMA/Specialty Society RVS Update Committee's recommendations on individual CPT® codes, results in a 0.49 percent budget neutrality adjustment to the conversion factor. As mentioned above, CMS released

*Specialty Impacts by Practitioner* tables, which show the combined impact of the efficiency adjustment and indirect PE changes.

The AMA continues to oppose this policy and explore alternative approaches to accomplish CMS' goals of ensuring that the time data used in work RVUs is accurate, that high-volume services are frequently reviewed to account for efficiencies, and that primary care payment is adequate.

**E/M Visit Complexity Add-On Code (Healthcare Common Procedure Coding System [HCPCS] code G2211)**

- **Positive impact**: Physicians who provide care to Medicare patients in their homes and residences will be able to bill G2211 beginning in 2026.
- **Negative impact**: All physicians' payment rates were reduced by over one percent starting in 2024 due to CMS' overestimate of G2211 utilization and the agency declined to prospectively correct this misestimate.

The AMA is deeply disappointed that CMS did not make an upward budget neutrality adjustment to the 2026 conversion factors to correct a misestimate made by CMS when it projected utilization of the new office visit add-on code, G2211, which contributed to a substantial cut to the 2024 conversion factor due to budget neutrality requirements. In the final rule, CMS stated that it "would not compare actual claims reported for new coding against the utilization estimates made in the PFS final rule for the year in which such coding began." The Agency also continues to believe that utilization of the add-on code will increase over time.

CMS finalized, as proposed, to allow HCPCS code G2211 to be billed as an add-on code with the home or residence E/M visits code family. CMS also notes that the add-on code is intended to address the lack of distinction between E/M codes used to describe visits that involve a longitudinal relationship between the physician and patient and visits that do not. The Agency hints that it is looking at improved approaches to recognize those differences more holistically without use of an add-on code and that "there continues to be an imbalance in payment for E/M visits that are part of ongoing care."

**Enhanced Care Management**

- **Positive impact**: Certain primary care physicians no longer have to document time when integrating behavioral health into their practice, potentially improving access to mental health care for Medicare patients.
- **Negative impact**: Billing requirements and patient cost-sharing concerns continue to limit uptake of Advanced Primary Care Management codes. CMS implemented these services by establishing G-codes, which limits their use to Medicare patients only, rather than working with the CPT Editorial Panel to develop comprehensive coding that reduces administrative burden.

CMS finalized its proposal to create optional add-on codes for Advanced Primary Care Management services (HCPCS codes G0556, G0557, G0558) that would facilitate providing complementary behavioral health integration (BHI) services by removing the time-based requirements of the existing BHI and Collaborative Care Model (CoCM) codes. CMS believes that removing the time-based requirements will reduce burden by reducing the documentation requirements for billing, which CMS expects will make primary care physicians more likely to furnish BHI and CoCM services.

**Policies to Improve Care for Chronic Illness and Behavioral Health Needs**

- **Positive impact**: Physicians who screen their Medicare patients for diet and exercise may bill separately for that service beginning in 2026.
- **Negative impact**: Physicians who screen their Medicare patients for social drivers of health will no longer be able to bill separately for this service. However, the AMA expects the impact to be limited as the revised E/M coding guidelines implemented in 2021 facilitate capturing social drivers of health as it relates to the complexity level or visit length.

*Social Determinants of Health (SDOH) Risk Assessment (HCPCS code G0136)*

Although CMS proposed to stop covering and paying separately for an SDOH risk assessment, to delete HCPCS code G0136, and to remove this code from the Medicare Telehealth Services List, the Agency instead finalized retaining HCPCS code G0136 and revising the code descriptor to read "Administration of a standardized, evidence-based assessment of physical activity and nutrition, 5-15 minutes, not more often than every 6 months." CMS states that all billing rules for HCPCS code G0136 will remain the same, and G0136 will remain on the telehealth list.

**Payment of Skin Substitutes**

- **Positive impact:** Physicians in accountable care organizations or measured on Total Per Capita Cost in the Merit-based Incentive Payment System (MIPS) will no longer be unfairly penalized for the drastic increases in payment and utilization of skin substitutes.
- **Negative impact**: The AMA raised concerns that incorporating these high-cost products into the RBRVS will likely trigger budget neutrality and shift practice expense values and could reduce payment rates for other physician services, creating long-term instability in the overall Medicare Physician Fee Schedule.

CMS finalized its policy to establish a single payment methodology for skin substitute products furnished in both non-facility and hospital outpatient settings, effective January 1, 2026. Under this policy, skin substitutes will be paid as incident-to supplies and grouped into three categories based on their FDA regulatory pathway: Premarket Approval, 510(k) clearance, and Section 361 HCT/P (Human Cells, Tissues, and Cellular and Tissue-Based Products). Products licensed under section 351 of the Public Health Service Act will continue to be separately reimbursed under section 1847A.

For CY 2026, CMS finalized a single payment rate based on hospital outpatient utilization patterns. The Agency will maintain existing HCPCS codes and apply the applicable rate to each. CMS projects approximately $9.4 billion in annual savings, asserting that grouped valuation and market competition will lead to lower product prices over time. While the AMA supports CMS' objective to address excessive markups in the skin substitute market and appreciates the decision to treat supply codes as add-on codes without PLI RVUs, the AMA remains deeply concerned about the budget neutrality implications of this policy.

Incorporating these high-cost supply codes into the RBRVS structure risks destabilizing the PE RVU pool for all other physician services in future years. As CMS itself acknowledged, once claims data from 2026 are used in rate setting for CY 2027 and beyond, changes in skin substitute pricing will affect the distribution of PE RVUs across the PFS. Upward adjustment in the price of these supplies would require offsetting reductions in the practice expense methodology under budget neutrality rules.

**Global Surgery Payment Accuracy**

- **Impact:** CMS continues to express skepticism about the valuation of global surgical packages, soliciting comments about the division of work between surgeons and physicians and other health care professionals who provide post-operative care.

Beginning in 2025, CMS expanded the use of the transfer of care modifier (modifier -54) to include instances when the surgeon anticipates performing only the operative portion of a global surgical code, and another physician or qualified health care professional (QHP) provides the post-operative care even if there is no formal transfer of care agreement in place. In that case, CMS currently pays the surgeon the assigned percentage share of the procedure, which is usually around 80 percent for 90-day global periods and 90 percent for 10-day global periods.

CMS sought comments about three alternative approaches to dividing payment shares among pre-operative, operative, and post-operative care. As its rationale, CMS believes many post-operative visits considered during the

valuation of global surgical packages are not provided as part of these packages based on its internal findings and RAND's flawed analyses of CPT® code 99024 reporting. CMS wants to use information from claims-based reporting of postoperative visits to develop procedure shares. The AMA has previously detailed the problems with RAND's analyses, beginning on page 31 of our comment letter on the 2022 PFS proposed rule. These options are available in the file titled "Estimated Procedure Shares" on the CMS website under downloads for the proposed rule. In the final rule, CMS noted that "we received public comments on this comment solicitation. After consideration of public comments, we express appreciation for the feedback from commenters and will take the comments into consideration for possible future rulemaking."

**Professional Liability RVUs**

- **Impact:** The updated premium data also lead to relatively small changes in PLI RVUs, with only Emergency Medicine estimated to receive at least a one percent payment increase.

CMS will implement a standard update to the specialty liability insurance risk premiums that are the main input in the PLI RVU formula, a standard maintenance process conducted once every three years. CMS and its contractor (the Actuarial Research Corporation) described the data collection process for this CY 2026 update as generally following the process used for the CY 2023 update, with further success in collecting specialty-specific data. Most physician specialties have moderate increases for their assigned risk premiums for the PLI RVU formula.

**Geographic Practice Cost Indices (GPCIs)**

- **Positive impact**: GPCI changes are budget neutral, but use of updated data leads to increased payment rates of less than one percent in most western localities, Illinois, parts of Florida, and more than one percent in Atlanta.
- **Negative impact**: States that would normally be subject to the work GPCI floor face cuts unless the floor is extended through 2026.

CMS is required to update the GPCIs every three years and to phase them in over two years. As the GPCIs were last updated in 2023, CMS finalized its proposal to update the GPCIs for 2026 and phase them in over 2026 and 2027. The update relies on the same general data sources as the previous update, primarily the Bureau of Labor Statistics Occupational Employment and Wage Statistics, but with more recent data. Because the most recent extension of the 1.00 work GPCI floor expired on September 30, 2025, the 2026 GPCIs do not include the 1.00 floor, so if Congress passes legislation extending the floor for 2026 then the GPCIs will need to be modified accordingly. Aside from the geographic areas affected by expiration of the GPCI floor, the payment impact to most geographic areas from the GPCI update is less than one percent.

CMS also finalized its decision to keep the weights assigned to the GPCI cost categories the same in 2026 as they are currently. In response to AMA comments recommending use of the PPI and CPI Survey data to update the work, PE, and PLI cost share weights in the GPCIs with more recent data, CMS states that it will consider this feedback in possible future rulemaking.

**Medicare Diabetes Prevention Program (MDPP)**

- **Positive impact**: Allowing MDPP to be delivered through asynchronous and synchronous online and virtual modalities should expand Medicare beneficiary access to MDPP.

CMS finalized several AMA-supported policies to expand access, flexibility, and participation in the MDPP. The Agency will now allow MDPP suppliers to deliver services asynchronously online during a four-year test period from January 1, 2026, through December 31, 2029, without requiring them to maintain in-person delivery capability. To qualify, suppliers must adhere to the CDC Diabetes Prevention Recognition Program (DPRP) Standards and

continue to provide live coach interaction during weeks when participants engage with content. This interaction may occur through bi-directional communication such as email or text messaging but not through AI-driven platforms. The AMA has long supported expanded digital delivery options to increase beneficiary participation, particularly for individuals in rural and underserved communities, emphasizing that asynchronous delivery can improve program reach while maintaining quality and accountability.

CMS also created a new HCPCS code (G9871) and corresponding payment rate for online MDPP sessions to evaluate the effectiveness of asynchronous delivery compared with synchronous in-person and distance learning modalities. The AMA supported these changes as a step toward modernizing MDPP delivery and aligning with evolving digital health models.

Additionally, CMS finalized new flexibilities to reduce administrative burden and improve beneficiary safety, including allowing weight documentation within five days of completing an MDPP session and permitting beneficiaries to self-report weight from reasonable locations outside of their homes or MDPP sites such as gyms, medical offices, or community centers. The AMA supported these updates, which promote flexibility while maintaining program integrity and consistent quality standards.

**Medicare Shared Savings Program (MSSP)**

- **Positive impact**: Quality reporting changes should ease the administrative burden on accountable care organizations (ACOs).
- **Negative impacts**:
    - CMS shortened the on-ramp to two-sided financial risk, potentially increasing the number of ACOs that exit the program.
    - Removing the health equity adjustment from ACOs' quality scores will hurt ACOs that disproportionately treat patients who are dually eligible for Medicare and Medicaid.

Beginning with 2027 agreement periods, CMS finalized its proposal to reduce the maximum time that an Accountable Care Organization (ACO) can be in an upside-only risk track from seven to five years. Also for 2027, CMS will offer more flexibility in its requirement that ACOs have a minimum of 5,000 assigned patients. To reduce patient matching burden and at the urging of the AMA, CMS finalized policy to revise the definition of a beneficiary eligible for Medicare Clinical Quality Measures (CQMs) for ACOs for performance year 2025 and subsequent years so that the population identified for reporting within the Medicare CQM collection type would have greater overlap with the ACO's assigned beneficiary population. Despite AMA opposition, CMS also finalized policy to remove the health equity adjustment applied to an ACO's quality score beginning in performance year 2025.

CMS also expanded the extreme and uncontrollable circumstances policy for ACOs to obtain relief from performance requirements to include a cyberattack. The Agency makes a handful of updates to the list of primary care service codes used for beneficiary assignment. Lastly, CMS will require ACOs to make mid-performance year participant list changes in change-of-ownership scenarios.

CMS notes there are 477 MSSP ACOs with more than 15,000 participant TINs and 650,000 ACO providers and suppliers as of January 1, 2025. CMS anticipates its finalized policies will reduce program spending by $20 million in total through the end of the 10-year period 2026 through 2035.

**Requests for Information (RFIs)**

CMS thanked interested parties for their feedback on numerous RFIs, including those listed below that the AMA commented on, and stated that the Agency will consider comments in future rulemaking.

- Payment for Services in Urgent Care Centers;
- Payment Policy for Software as a Service (SaaS); and
- Prevention and Management of Chronic Disease.

## QUALITY PAYMENT PROGRAM UPDATES AND POLICIES

Following ongoing advocacy by the AMA, CMS finalized several AMA recommended improvements to the 2026 MIPS program, keeping its focus on stability in the program. The AMA will continue to advocate that there is more red tape to be cut to make the program less burdensome and costly and not disproportionally hurt small practices.

**Merit-based Incentive Payment System Performance Threshold**

- **Positive impact:** Maintaining the performance threshold to avoid a penalty at 75 points for the next three years introduces much-needed stability and predictability into a program that costs $12,800 per physician per year to comply.
- **Negative impact:** Small practices and solo practitioners continue to be disproportionately impacted by MIPS penalties because they have fewer resources to comply with this complex program. While CMS projects the median final score for solo practitioners at 75 points, they are less likely to exceed the performance threshold and earn an incentive.

CMS finalized its proposal to set the performance threshold at 75 points for the next three years, starting with the CY 2026 performance period/2028 MIPS payment year through CY 2028 performance period/2030 payment year, to provide continuity to participants. CMS notes that 87.37 percent of MIPS eligible clinicians will receive a positive payment adjustment in 2026 based on their 2024 performance. The stability with the performance threshold should continue to provide physicians with an opportunity to earn a positive or neutral incentive.

**MIPS Value Pathways (MVPs)**

- **Positive impacts:**
  - CMS modifies MVPs to align with the AMA's recommendations on structuring MVPs by finalizing "clinical groupings" within MVPs.
  - MVP is maintained as an optional reporting pathway to satisfy MIPS.
- **Negative impact:** MVPs continue to ignore the variation in care provided by specialists, subspecialists, differences among patient populations, and the relevancy of cost measures.

CMS modified all 21 existing MVPs to align with the AMA's recommendations on an alternative framework for structuring MVPs by finalizing "clinical groupings" within MVPs. CMS also finalized six new MVPs for reporting starting with the CY 2026 performance period:

- Diagnostic Radiology
- Interventional Radiology
- Neuropsychology
- Pathology
- Podiatry
- Vascular Surgery

However, we continue to have concerns that even with the "clinical groupings," MVPs still ignore the variation in care provided by subspecialists, differences among patient populations, and the relevancy of the cost measures.

In addition, CMS finalized that QCDR would have one year after a new MVP is finalized before they are required to fully support that MVP. The flexibility should provide specialty societies with additional time to implement MVPs within their registries.

**MVP Subgroup Reporting**

- **Positive impact:** Small multispecialty practices still have the option to report an MVP as a group or to form and report through subgroups. Multispecialty groups may continue to participate in traditional MIPS.
- **Negative impact:** Large multispecialty groups who chose to report through MVP must participate as sub-groups or individuals, increasing their administrative burden.

As previously finalized, beginning with the 2026 performance period, multispecialty groups will no longer be able to report MVPs as a single group. This means that if a multispecialty group would like to report an MVP, they must divide into and report as subgroups or individuals. Alternatively, multispecialty groups may continue to participate in traditional MIPS.

To encourage small multispecialty practices to report MVPs, CMS finalized an AMA-supported policy to give multispecialty small practices the option to report an MVP as a group or to form and report through subgroups. CMS acknowledged that small practices are already resource constrained and requiring them to divide into subgroups would be too onerous. Additionally, subgroups of small multispecialty practices may not meet established case minimums, resulting in lower scores.

Additionally, in response to a recommendation from the AMA and other stakeholders, CMS finalized policy to allow group practices registering for MVP reporting to self-attest to being a single specialty group or a multi-specialty group that meets the definition of a small practice. CMS acknowledges it is unable to utilize claims data as intended for designating a group as either a single specialty group or a multispecialty group due to several factors, including specialization of QHPs, changes in composition of a group practice, and specialists who are providing similar patient care.

**Alternative Payment Model Performance Pathway (APP)**

- **Positive impact:** CMS removes the problematic *Screening for Social Drivers of Health* measure from the APP measure set.
- **Negative impact:** CMS moves forward with expanding the numbers of measures ACOs must report through the APP Plus quality measure set.

CMS finalized its proposal to update the APP Plus quality measure set under the APP, in alignment with the MIPS quality measure inventory. Since CMS removed from the MIPS quality measure inventory, *the Screening for Social Drivers of Health* measure, CMS has removed the same measure from the APP Plus quality measure set, which was supported by the AMA. Therefore, as previously finalized for the 2026 Performance Period, CMS plans to incrementally incorporate additional measures in the APP Plus quality measure set and the following two measures will be added, in addition to the 6 measures in the existing APP plus quality measure set:

- Quality measure #113: Colorectal Cancer Screening
- Quality #484: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions

**Quality Performance Category**

- **Positive impact:** Overall, physicians should receive higher quality scores because of CMS revising the methodology to score administrative claims quality measures and update to how CMS defines and scores “topped out” quality measures. CMS will now allow CAHPS for MIPS to be administered through a web-based survey mode, which should assist with increasing response rates.
- **Negative impact:** CMS maintains the decile-based methodology scoring approach for non-administrative claims quality measures. CMS only applies the alternative “topped out” benchmark methodology to a select number of quality measures, not all.

Due to positive policy improvements to the Quality Performance Category, specifically changes to the administrative claims-based quality measure scoring methodology to align with the cost measure methodology beginning with the CY 2025 performance period, as well as the updated "topped out" measure policy, CMS projects that 84.04 percent of MIPS eligible clinicians will receive a positive adjustment based on their 2026 performances. Updating the benchmarking methodology and revising how CMS classifies and scores "topped out" measures has been a long-standing AMA recommendation.

Regarding "topped out" measures, CMS will now also consider MVP impact, not just specialty measure set impact. As a result, in CY 2026, 19 quality measures receive topped out measure status and have the alternative benchmark methodology, which is more favorable, applied to them. These measures belong to specialty sets and MVPs with limited measure choice and a high proportion of topped out measures, in areas that lack measure development, which precludes meaningful participation in MIPS.

CMS also finalized a total of 190 quality measures for the CY 2026 performance period. For all 2026 measure specifications, CMS added clarifying language stating that if telehealth encounters are permitted for denominator eligibility, this applies regardless of any future changes to coding or billing practices. QCDR measures, which are approved outside the rulemaking process, are not included in this total.

The updates to the CY 2026 measure inventory reflect:

- Addition of 5 quality measures, including 2 electronic clinical quality measure (eCQMs). One of the eCQMs, *Screening for abnormal glucose metabolism in patients at risk of developing diabetes* was stewarded by the AMA. The measure focuses on diabetes prevention and supports the AMA's ongoing efforts to aid physicians and care teams in improving hypertension control and heart failure;
- Removal of 10 quality measures from the MIPS quality measure inventory; and
- Substantive changes to 30 existing quality measures. The AMA flagged concerns with proposed revisions to the Breast Cancer Screening and Colorectal Cancer Screening measures due to concern the changes would have potentially encouraged overuse of services to satisfy the measure and were not directly tied to improving patient care. The proposed changes were specifically problematic for ACOs because they are required to report the measures as part of the MSSP. As a result, CMS did not finalize its proposal.

CMS finalized revisions to the definition of a high-priority measure to clarify that such measures include outcome (including intermediate-outcome and patient-reported outcome), appropriate use, patient safety, efficiency, patient experience, care coordination, and opioid-related quality measures. This update aligns with CMS' intent to improve measure consistency and encourage greater use of clinically meaningful performance indicators.

In addition, CMS finalized the addition of a web-based survey mode for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey to expand participation and improve response rates. This change is intended to enhance the representativeness and usefulness of CAHPS data for groups, subgroups, virtual groups, and APM entities, including MSSP ACOs. The AMA had recommended this update to make the survey more accessible and to better capture patient experience data in diverse care settings.

**Cost Performance Category**

- **Positive impacts**:
    - Improvements to the Total Per Capita Cost (TPCC) measure should prevent specialists who do not manage patients' primary care, such as radiologists and hospitalists, from being wrongfully scored on this measure.
    - The two-year informational-only feedback period for new cost measures will benefit physicians who are scored on future cost measures by giving them extra time to prepare before the score impacts their Medicare payment.
- **Negative impact**: TPCC continues to be fundamentally flawed as it holds physicians accountable for costs outside of their control, and the AMA continues to advocate for its removal from MIPS.

In response to AMA advocacy, CMS finalized crucial changes to the Total Per Capita Cost (TPCC) measure attribution methodology. CMS will exclude qualified health care professionals who are part of a group comprised of excluded specialists to limit inappropriate attribution to highly specialized group practices. The AMA previously sounded the alarm on the inappropriate attribution of TPCC to radiologists and hospitalists, among others, due to flaws in the attribution methodology.

Additionally, CMS adopted an AMA recommendation to provide a two-year, informational-only feedback period for new MIPS cost measures. If a physician is attributed a cost measure during its informational-only feedback period, CMS would calculate a measure score and confidentially provide the score, as well as MIPS performance feedback. Importantly, however, scores on new cost measures in the informational-only feedback period would not count toward a physician's MIPS score or adjust their Medicare payment. CMS clarified that the feedback period would not apply when existing cost measures are revised.

**Improvement Activities (IAs) Performance Category**

- **Positive impact:** Adding IAs gives physicians more options to report based on their clinical practice improvement efforts.
- **Negative impact:** Removing IAs creates administrative complexity as physicians must pivot to fulfill and report different IAs, potentially requiring increases in limited resources.

CMS added three new IAs that align with evolving clinical and technological priorities: Improving Detection of Cognitive Impairment in Primary Care, Integrating Oral Health Care in Primary Care, and Patient Safety in Use of Artificial Intelligence. CMS also finalized modifications to seven existing IAs to improve clarity and consistency and restructured the subcategory framework by eliminating the Achieving Health Equity subcategory and creating a new Advancing Health and Wellness subcategory.

The AMA had urged CMS to refine existing activities rather than remove them, cautioning that abrupt deletions can disrupt reporting continuity for physicians who depend on stable IAs. Despite this feedback, CMS moved forward with the removal of eight existing activities, most of which were focused on addressing social drivers of health, stating that these were obsolete.

**Promoting Interoperability (PI) Performance Category**

- **Positive impact**: CMS will review and sunset specific PI measures it finds burdensome or unnecessary. This reduces the number of measures physicians must meet in PI, allowing for greater success in MIPS.
- **Negative impact**: CMS added a new security assessment attestation under the Security Risk Analysis measure in PI. Physicians are already required to perform a security risk assessment to comply with HIPAA. This is a duplicative and a check-the-box exercise.

CMS added a second attestation to the existing Security Risk Analysis measure that requires MIPS eligible clinicians to attest "Yes" to having implemented security measures to demonstrate compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 Security Rule implementation specification for risk management. Eligible clinicians must attest to having implemented security measures to manage their security risk. This second attestation is in addition to the current requirement to attest "Yes" to having conducted or reviewed a security risk analysis. MIPS eligible clinicians will be required to submit two affirmative ("Yes") attestations for this measure to be considered a meaningful employee health record user and earn a score for this performance category.

The High Priority Practices Safety Assurance Factors for EHR Resilience Guide Measure has been modified. CMS requires MIPS eligible clinicians to attest "Yes" to completing an annual self-assessment to the newer 2025 version

of the guide, instead of the current 2016 version. Reviewing the new 2025 guides in the context of a practice's current technology setup will help physicians more effectively align with and meet HIPAA Security Rule obligations.

CMS established a new optional Public Health Reporting Using the Trusted Exchange Framework and Common Agreement (TEFCA) measure adding to the optional bonus measures available under the Public Health and Clinical Data Exchange Objective. CMS has expanded TEFCA for sharing health information for public health purposes. Eligible clinicians are able to claim five bonus points under this objective if they are actively engaged with a public health agency to submit data for one or more of this objective's four optional measures, including the Public Health Reporting Using TEFCA Measure.

CMS adopted a PI measure suppression policy at the urging of the AMA, giving the Agency authority to pause or retire PI measures that would create undue burden or risk negative consequences for physicians. CMS is now appropriately applying that policy by pausing the Electronic Case Reporting measure for the CY 2025 performance period, citing insufficient CDC support that would have prevented physicians from successfully meeting the requirement.

**Advanced Alternative Payment Model (APM) Policies**

- **Positive impact**: Per CMS, 528,827 clinicians have attained QP status for 2026 based on 2024 participation in advanced APMs, so they will receive a higher 3.77 percent update plus a 1.88 percent lump sum bonus payment in 2026.
- **Negative impact:** There is considerable uncertainty among physicians in advanced APMs about reaching QP thresholds in the coming year due to significant increases in the criteria under current law.

CMS made several Advanced APM policy changes in response to AMA advocacy. First, CMS added an individual level calculation to Qualifying APM Participant (QP) determinations such that each eligible clinician will receive *both* an APM Entity-level calculation *and* an individual-level calculation and could qualify as a QP under either beginning with the 2026 QP performance period, which the AMA previously recommended. This dual threshold calculation will apply to the Medicare Option and All-Payer Combination Option, as well as to QP and partial QP thresholds. CMS also added a QP determination step using all Covered Professional Services, in addition to a QP determination using E/M services, which is the current approach.

These policy changes come at an important time as QP thresholds to qualify for exemption from MIPS and a higher conversion factor update have increased substantially under current law. Advanced APM lump sum bonuses are also set to expire at the end of the 2026 payment year, which are based on participation in 2024. In the final rule, CMS announced 528,827 eligible clinicians earned QP status in 2024 and will receive the higher update in 2026, a 1.88 percent bonus in 2026, and were exempt from MIPS. The AMA continues to press Congress to extend the Advanced APM bonus and allow more flexibility in setting QP thresholds before the end of the year to ensure continued growth in APM participation.

The Agency also lifted the 50-clinician limit on Medical Home Model participants in response to previous AMA advocacy. Lastly, CMS clarified that the timing for the QP targeted review process is aligned with the MIPS targeted review process.

**Ambulatory Specialty Model (ASM)**

- **Positive impacts**: Cardiologists, orthopaedic surgeons, neurosurgeons, anesthesiologists, physiatrists, and other physicians who perform well enough in ASM to achieve positive payment adjustments.
- **Negative impacts**: The majority of physicians who are required to participate in ASM will face negative payment adjustments even if they perform well on the model's measures.

As outlined in the final rule, key features of ASM are the same as what CMS proposed. ASM will take effect in 2027 and will focus on two conditions, heart failure, and lower back pain. The initial model test is planned to run for five years and requires participation by physicians in seven specialties that treat patients with these conditions.

The AMA appreciates that ASM focuses on care of patients with specific conditions that are primarily managed in ambulatory settings, instead of either applying to all services across a broadly defined specialty or involving hospital episodes. AMA comments on ASM included important recommended changes, however, that were not adopted by CMS. As a result, the final model design will:

- Cut payments for the majority of physicians who are required to participate in ASM;
- Mandate participation by the specialties included in the model instead of allowing for voluntary participation;
- Lead to pay cuts as steep as -9 percent in 2029 based on the first year of ASM performance in 2027, growing to as much as -12 percent by 2033, with no ramp-up period at the front end before physicians face downside financial risk;
- Impose new administrative burdens on participants; and,
- Because there is no performance threshold set in advance, ASM provides no ability for physicians to have any sense of whether their performance on the ASM measures will qualify for a positive or negative payment adjustment until the year following the performance year, after CMS has assessed all participants' scores.

One of the CMS Innovation Center's current aims is designing models to "level the playing field for providers practicing independently and outside of health system or health plan ownership to increase competition in markets." The AMA and CMS are aligned in this goal, but we are concerned that the model design finalized in this rule will not provide better support for independent practices and may lead them to look for help from larger organizations to maintain their financial sustainability. For example, data from the AMA's 2024 Physician Practice Benchmark Survey identified "ease participation in risk-based payment models" as a key reason that physicians left private practice. As ASM does not take effect until 2027, the AMA will continue to work with the specialties included in ASM to secure improvements in the model.

**QPP Requests for Information**

CMS thanked interested parties for their feedback on numerous RFIs related to QPP, including those listed below that the AMA commented on, and stated that the Agency will consider comments in future rulemaking.

- Core Elements in an MVP–CMS is considering proposing the Core Elements policy in the CY 2027 PFS proposed rule and proposing the policy for implementation prior to sunsetting traditional MIPS.
- Well-being and Nutrition Measures
- Procedural Codes for MVP Assignment
- Transition Toward Digital Quality Measurement
- Query of Prescription Drug Monitoring Program Measure
- Performance-Based Measures in the Public Health and Clinical Data Exchange Objective
- Data Quality

## HELPFUL LINKS

- CMS Press Release
- Physician Payment Schedule Fact Sheet
- Medicare Shared Savings Program Fact Sheet
- QPP Fact Sheet
- Ambulatory Specialty Model Website