2026 Medicare Physician Payment Schedule and Quality Payment Program Proposed Rule Summary

On July 14, 2025, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2026 Revisions to Payment Policies under the Medicare Physician Payment Schedule (PFS) and Other Changes to Part B Payment and Coverage Policies proposed rule and associated fact sheet. The proposed rule, published in the July 16, 2025, issue of the Federal Register, includes several proposals related to Medicare physician payment and the Quality Payment Program (QPP). If finalized, these policies will take effect on January 1, 2026, unless otherwise noted. Interested parties have until September 12, 2025, to provide comments on the proposed rule. The American Medical Association (AMA) will continue analyzing the rule and share a draft comment letter with the Federation in advance of this submission deadline.

The attached impact tables (*CMS Granular Specialty Impact Analysis*), provided by CMS on their website, relate to the proposed efficiency adjustment and practice expense changes. They do not include the 2026 conversion factor increases. Note the first table includes all physicians and other qualified health care professionals, even low volume practitioners, while the second is weighted by relative value units (RVUs).

Payment Updates and Proposals

CY 2026 Medicare Conversion Factors

For the first time this century, CMS proposes four conversion factors. The conversion factors reflect two different, small permanent updates to the baseline beginning January 1, 2026, as required under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. Under MACRA, physicians who are qualifying participants (QPs) in advanced alternative payment models (APMs) will receive a slightly higher conversion factor update and, thus, slightly higher Medicare payments in 2026 compared to physicians who are not QPs. Each conversion factor also reflects the temporary, one-year 2.5 percent update enacted in H.R. 1 recently signed into law. These conversion factors are outlined in the table below.

Proposed 2026 Medicare Conversion Factors (CFs)							
	2025 CFs	**APM or Non APM Update Factor (1.0075 or 1.0025)**	**CY 2026 RVU Budget Neutrality Adjustment (1.0055)**	**CY 2026 2.50 Percent Increase (1.025)**	**Anesthesia Only PE and PLI Adjustment**	**Proposed 2026 CFs**	**Percentage Changes**
APM QP	$32.3465	$32.5891	$32.7683	$33.5875	N/A	$33.5875	**3.84%**
Non-APM QP	$32.3465	$32.4274	$32.6057	$33.4209	N/A	$33.4209	**3.32%**

Anesthesia APM QP	$20.3178	$20.4702	$20.5828	$21.0973	$20.6754	$20.6754	**1.76%**
Anesthesia Non-APM QP	$20.3178	$20.3686	$20.4806	$20.9926	$20.5728	$20.5728	**1.26%**

Additionally, the conversion factors are affected by a positive 0.55 percent budget neutrality adjustment resulting from proposed misvalued code changes and a -2.5 percent efficiency adjustment, which CMS proposes to apply to work RVUs and the corresponding intra-service portion of physician time of non-time-based services that CMS believes accrue gains in efficiency over time. This new efficiency adjustment impacts most surgical specialties, radiology, and pathology by reducing overall payment by one percent. More information about the efficiency adjustment is below.

The AMA continues to strongly advocate for permanent baseline updates to the conversion factors that account for the growth in physician practice costs, 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

Development of Strategies for Updates to Practice Expense 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 discusses the PPI Survey in the proposed rule, 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 criticizes occupational therapy and the independent diagnostic testing facilities (IDTFs) for not sharing their collected data. CMS states the intention to work with the AMA to understand whether and how such data should be used in rate setting in future rulemaking. CMS shares numerous alternatives, and their specialty impacts, for use of the PPI data in determining the MEI weights for physician work, practice expense and professional liability insurance.

Updates to Practice Expense (PE) Methodology – Site of Service Payment Differential

CMS proposes an arbitrary reduction in indirect practice expense 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 proposal. CMS believes that physicians who provide services in the facility no longer maintain a separate office and receive "duplicative payments" under the MPFS and the facility fees under the outpatient or the ASC payment schedules. While CMS proposes no exceptions, it seeks comment on the impact of this proposal on maternity care.

Facility-based payment to physicians will decrease overall by -7 percent while non-facility-based payment to physicians will increase by 4 percent. The results to individual physicians and specialties are proposed to be substantial.

As the AMA explained in detail in our letter to MedPAC when the Commissioners were debating this issue of so-called "duplicative payments," 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 physician's 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 proposing PE RVUs using the standard methodology, CMS proposes to 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 77X05, 77X07 and 77X08, new/revised remote physiologic monitoring codes 99XX4 and 99454 and new/revised remote therapeutic monitoring codes 98XX5 and 98977. Separately, CMS also seeks comment about using a similar approach for the proton beam treatment delivery code family in the future but will retain as carrier priced for 2026.

Direct Practice Expense Adjustments

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 CPT Editorial Panel and RUC to ensure accuracy in payment of high-cost supplies, CMS does call for comment on whether G-codes should be created to describe the use of these supplies. CMS also seeks comment on whether additional information should be considered, such as the Hospital OPPS mean unit cost data.

Payment for Services in Urgent Care Centers

CMS seeks comments regarding whether separate coding and payment is needed for evaluation and management (E/M) visits furnished at urgent care centers, such as an add-on code or a new set of visit codes. The agency also seeks to understand how practice costs, including but not limited to indirect costs, may vary among different nonfacility settings of care, including urgent care centers.

Potentially Misvalued Services

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.

Telehealth

CMS proposes several policy changes for Medicare telehealth services. Consistent with AMA advocacy, CMS proposes to permanently lift the frequency limits on providing subsequent hospital inpatient and nursing facility visits and critical care consultations furnished via telehealth and to permanently allow virtual direct supervision. However, CMS proposes 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.

In terms of coverage, five services are proposed to be added to the 2026 Medicare Telehealth List, but CMS is not proposing to add the Current Procedural Terminology (CPT®) codes for telemedicine E/M services., As a result, both audio-only and audio-video E/M visits will need to continue being reported with the CPT codes for in-person E/M and the appropriate audio-only or audio-video modifier.

Finally, CMS proposes to simplify the process for requesting additions to the Medicare Telehealth List by reducing it from the current five to a three-step process. Under this proposal, services on the Medicare Telehealth Services List would no longer be designated "permanent" or "provisional." All services listed or added on the Medicare Telehealth Services List would be considered included on a permanent basis.

Valuation of Specific Codes

CMS proposes to accept 89 percent of the AMA/Specialty Society RVS Update Committee (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 CMS typically publishes values for codes that are not used for Medicare purposes, the agency proposes not to publish the RUC recommendations for three new immunization counseling codes.

Efficiency Adjustment

CMS proposes applying an arbitrary 2.5 percent decrease to the work RVUs and physician intra-service time of most services in the MPFS on the assumption that physicians have gained efficiency in providing them. This includes brand new services, surveyed for physician time and work within the past year. The decrease would be applied to 8,961 physician services. 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).

CMS states that it will exempt time-based services, such as E/M, care management, maternity care, and services on the telehealth list. Only 393 services will be exempted from the decrease. Of note, although CMS states that they will exempt time-based services and services on telehealth list from the efficiency adjustment, several of these codes remain on the pending cut list.

The adjustment impacts most specialties by reducing overall payment by one percent. The only specialties or professions to gain at least one percent from this proposal are clinical psychology (three percent), clinical social

work (four percent), geriatric medicine (one percent), and psychiatry (one percent), the individuals who perform a more significant amount of telehealth services, which CMS has exempted from efficiency adjustments. This proposal, combined with the AMA/Specialty Society RVS Update Committee's recommendations on individual CPT codes, results in a 0.55 percent budget neutrality adjustment to the conversion factor.

This proposal is based on the premise that physician time in the RBRVS is inflated, with criticism of utilizing physician surveys to estimate physician time. The following statement was prepared related to this unfair criticism:

> Bobby Mukkamala, MD
> President, American Medical Association
>
> > "The American Medical Association believes that proposals to exclude or limit the input of expert practicing physicians and health care professionals in the development of Medicare payment policy would ultimately harm patients and represents a radical departure from the time-tested CMS decision-making process. This proposal 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.
> >
> > Academic researchers and federal officials established survey protocols that are currently used to gather information from practicing physicians. They did this because they knew Medicare depended on expert physician insight to create Medicare payment policy that mirrors the evolution of science, technology, and innovations in patient care.
> >
> > There is no substitute for relying on experienced practicing physicians when creating Medicare payment policy. No one knows more about what is involved in providing services to Medicare patients than the physicians who care for them. The valuable expertise of physicians makes them an indispensable source of survey information that Medicare can count on to create payment policy. By substituting arbitrary and flawed proposals in place of front-line, real-world knowledge from expert physicians, Medicare is proposing to cut itself off from the most credible insights into the complexities of patient care, which will ultimately lead to lower quality care, inferior health outcomes and a less sustainable Medicare system."

E/M Visit Complexity Add-On Code (HCPCS code G2211)

The AMA is deeply disappointed that CMS did not respond to AMA advocacy and did not propose 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.

Additionally, CMS proposes to allow the E/M add-on code, G2211, to be billed as an add-on code with the home or residence E/M visits code family, including visits to beneficiaries in nursing facilities, assisted living facilities, and the beneficiary's home.

Enhanced Care Management

CMS proposes to create optional add-on codes for Advanced Primary Care Management (APCM) 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.

CMS also seeks comments about the application of cost sharing for APCM services, particularly if the agency were to include preventive services within the APCM bundles, and how to drive an increase in participation of primary care physicians in accountable care organizations, such as through prospective monthly APCM payments.

Policies to Improve Care for Chronic Illness and Behavioral Health Needs

Updates to Payment for Digital Mental Health Treatment (DMHT) and Comment Solicitation on Payment Policy for Software as a Service (SaaS)

Beginning in 2025, CMS established coding and payment for DMHT devices furnished incident to behavioral health services used in conjunction with ongoing behavioral health care treatment (HCPCS codes G0552, G0553, and G0554). CMS proposes expanding payment for DMHT for FDA cleared or authorized devices for treating attention deficit hyperactivity disorder. The agency seeks comments about expanding payment for other devices used for treating gastrointestinal conditions, fibromyalgia, and reducing sleep disturbance for psychiatric conditions. CMS is not proposing changes to the existing contractor-priced status for HCPCS code G0552. CMS continues to welcome information, including from the CPT Editorial Panel, and may consider national pricing for devices through future rulemaking.

CMS seeks comments on the possibility of establishing separate coding and payment beginning in 2026 for a broader set of services describing digital tools used by physicians and qualified healthcare professionals intended for maintaining or encouraging a healthy lifestyle as part of a mental health treatment plan of care but where a physician does not furnish the digital tool. The agency seeks comments on other related digital device policies for consideration in future rulemaking.

Additionally, CMS notes there has been rapid development in the use of software-based technologies to support clinical decision-making in the outpatient and physician office settings, some of which may be devices requiring FDA clearance, approval, or authorization, and CMS refers to these software-based technologies as SaaS. CMS seeks comments regarding how CMS should consider paying for SaaS and augmented intelligence (AI) devices in the MPFS. CMS notes that stakeholders have requested the development of a payment policy for these devices that is stable and consistent across settings of care, payment systems, and types of services incorporating SaaS and AI devices. Additionally, CMS is seeking to understand how the use of SaaS and AI technology affects the management of chronic disease and primary care services, such as Advanced Primary Care Management and risk-based payment arrangements generally.

Prevention and Management of Chronic Disease – Request for Information

CMS notes that six in 10 Americans have at least one chronic disease and 4 in 10 have two or more chronic diseases. The agency seeks feedback about how to better support the prevention and management of chronic disease, including whether to create separate coding and payment for services addressing social isolation and loneliness, intensive lifestyle interventions, medically tailored meals as an incident-to service, FDA-cleared digital therapeutics that treat or manage the symptoms of chronic diseases, and motivational interviewing. CMS also requests ideas to increase the uptake of Annual Wellness Visits (AWVs).

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

CMS proposes 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. CMS believes HCPCS code G0136 is already accounted for in existing codes, such as E/M visits.

Payment of Skin Substitutes

CMS proposes to establish a single payment methodology for skin substitute products furnished in both non-facility and hospital outpatient settings, effective January 1, 2026. Under the proposal, skin substitutes would be paid as incident-to supplies and grouped into three payment categories based on their FDA regulatory pathway: Premarket Approval (PMA), 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 would remain separately reimbursed under section 1847A.

For CY 2026, CMS proposes to calculate a single payment rate across all three categories based on hospital outpatient utilization patterns. CMS would maintain existing HCPCS codes and apply the applicable rate to each. The proposed 2026 payment rate is $125.38 per square centimeter, geographically adjusted, and is estimated to save $9.4 billion per year. Future payment rates, beginning in 2027, would impact practice expense RVUs for other services. However, CMS anticipates that market pressure will result in price reductions in these skin substitute products.

To establish payment rates, CMS proposes to use the volume-weighted Average Sales Price (ASP) for each category, when available. CMS also proposes to update these rates annually through rulemaking based on the most recent calendar quarter of ASP data and is soliciting comments on whether using a single quarter is advisable.

CMS also seeks input on how to incorporate these payment data into future PE RVUs and whether scaling factors should be applied to improve relativity with other services and supplies. The agency will continue reviewing complete HCPCS Level II applications for skin substitutes through its existing biannual process. Finally, CMS proposes to codify the definition of a “biological” for Medicare payment purposes as a product licensed under section 351 of the Public Health Service Act at 42 CFR §§ 414.802 and 414.902.

Global Surgical Payment Accuracy

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 seeks 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 MPFS proposed rule. These options are available in the file titled “Estimated Procedure Shares” on the CMS website under downloads for the proposed rule.

Professional Liability RVUs

CMS proposes a standard update to the specialty liability insurance risk premiums that are the main input in the Professional Liability Insurance (PLI) RVU formula in this proposed rule, 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 are proposed to have moderate increases for their assigned risk premiums for the PLI RVU formula. 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.

Geographic Practice Cost Indices (GPCIs)

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 is proposing updated GPCIs for 2026 to be phased in over 2026 and 2027. The update relies on the same general data sources as the previous update, such as the Bureau of Labor Statistics, but with more recent data. CMS notes that because the most recent extension of the 1.00 work GPCI floor is set to expire on September 30, 2025, under current law, the 2026 proposed GPCIs do not include the 1.00 floor. The impacts to most geographic areas from the updated GPCIs are less than one percent in payment, with only Atlanta with a positive impact greater than one percent. The following geographic areas are proposed to have negative impacts greater than one percent, largely due to the expiration of the 1.00 work GPCI floor: Arkansas, Iowa, Kansas, Southern Maine, Detroit, Mississippi, Missouri, and North Dakota.

Medicare Diabetes Prevention Program (MDPP)

CMS proposes several changes aimed at increasing beneficiary access and uptake of this program. Most significantly, CMS proposes, in response to previous calls from the AMA and other stakeholders, to allow MDPP suppliers to deliver MDPP services asynchronously online and not requiring suppliers to maintain in-person delivery capabilities through CY 2029 provided they meet existing standards including interaction with a live coach, which may be satisfied via email or text messages. CMS would also introduce a separate new G-code and payment for online sessions to collect additional data about the effectiveness of online versus other modalities of delivering MDPP sessions. The agency further proposes defining several key terms and allowing certain additional flexibilities for satisfying weight measurement requirements, including allowing weight documented in the beneficiary's medical record within two days of completing the MDPP session (rather than same day) and allowing beneficiaries to self-report weight from a reasonable location outside of an MDPP in-person delivery site or the beneficiary's home, such as a gym.

Medicare Shared Savings Program

Beginning with 2027 agreement periods, CMS proposes 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 proposes to offer more flexibility in its requirement that ACOs have a minimum of 5,000 assigned patients. To reduce patient matching burden, CMS proposes to revise the definition of a beneficiary eligible for Medicare Clinical Quality Measures (CQM) 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. CMS also proposes to remove the health equity adjustment applied to an ACO's quality score beginning in performance year 2025. Furthermore, CMS proposes expanding the extreme and uncontrollable circumstance policies 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 proposes to allow ACOs to make mid-performance year participant list changes in change-of-ownership scenarios.

Quality Payment Program (QPP) Updates and Proposals

Merit-based Incentive Payment System (MIPS) Performance Threshold

CMS is proposing 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 and stability to program participants.

MIPS Value Pathways (MVPs)

CMS is proposing six new MVPs to be available for reporting in the CY 2026 performance period:

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

CMS is also proposing modifications to all 21 existing MVPs, in alignment with proposals to update the quality measure and improvement activity inventories. In addition, CMS is proposing that Qualified Clinical Data Registries would have one year after a new MVP is finalized before they are required to fully support that MVP.

MVP Subgroup Reporting

As previously finalized, beginning with the 2026 performance period, multispecialty groups will no longer be able to report MVPs as a single group. This will mean 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 proposes allowing them to continue to have the option of group reporting. They may still choose to divide and report as subgroups to be scored on MVPs. CMS acknowledges 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 proposes allowing 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 (APM) Performance Pathway

CMS is proposing to update the APP Plus quality measure set under the APP, in alignment with proposals for the MIPS quality measure inventory. If finalized for removal from the MIPS quality measure inventory, *the Screening for Social Drivers of Health* measure would be removed from the APP Plus quality measure set as well. Therefore, as previously finalized for the 2026 Performance Period, CMS plan to incrementally incorporate additional measures in the APP Plus quality measure set and the following two measures will be added, in addition to the six 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

CMS is proposing a total of 190 quality measures for the CY 2026 performance period. Note that QCDR measures are approved outside the rulemaking process and are excluded from this total.

These proposals reflect:

- Addition of five quality measures, including two 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.
- Substantive changs to 32 existing quality measures.

CMS is also proposing that 19 quality measures receive topped out measure status and have the alternative benchmark methodology (flat benchmark methodology) 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.

In addition, CMS is proposing to update the benchmarking methodology for administrative claims quality measures to align with the benchmarking methodology for cost measures beginning with the CY 2025 performance period/ 2027 MIPS payment year. Furthermore, CMS proposes to revise the definition of high priority measures so that the revised definition would be: *An outcome (including intermediate-outcome and patient-reported outcome), appropriate use, patient safety, efficiency, patient experience, care coordination, or opioid quality measure.*

Furthermore, CMS is proposing to add a web-based survey mode to the current CAHPS for MIPS Survey administration to increase participation in and responses to the survey and thus increase its usefulness to groups, subgroups, virtual groups, and APM entities (including MSSP ACOs).

Cost Performance Category

CMS does not propose adding or removing any cost measures to MIPS for 2026. The agency does propose much-needed refinements to the Total Per Capita Cost (TPCC) measure attribution methodology, which it outlines in Appendix 4 and in the measure specifications. CMS proposes to exclude qualified health care professionals (QHPs) who are part of a group comprised of excluded specialists to limit inappropriate attribution to highly specialized group practices.

Additionally, in response to a recommendation from the AMA and other stakeholders, CMS proposes adopting a two-year, informational-only feedback period for newly implemented 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 clarifies the feedback period would not apply when existing cost measures are revised.

Improvement Activities (IAs) Performance Category

CMS proposes to remove the Achieving Health Equity (AHE) subcategory and add a new subcategory entitled Advancing Health and Wellness. CMS would recategorize five existing IAs from the AHE subcategory to other subcategories. The agency proposes to add three new IAs, broaden one existing IA (Diabetes screening for people with schizophrenia or bipolar disease who are using antipsychotic medication), and remove eight IAs, many of which were in the AHE subcategory, citing obsoletion. Newly proposed IAs include: 1) Improving Detection of Cognitive

Impairment in Primary Care; 2) Integrating Oral Health Care in Primary Care; and 3) Patient Safety in Use of Artificial Intelligence (AI). A complete inventory of proposed changes to IAs for the 2026 reporting year can be found in Appendix 2.

Promoting Interoperability (PI) Performance Category

CMS continues to emphasize the central role of using certified electronic health record (EHR) technology (CEHRT) for earning a score for the PI Performance Category. In addition, the agency highlights that this technology must be certified under the Assistant Secretary for Technology Policy/Office of the National Coordinator (ASTP/ONC) Health Information Technology (IT) Certification Program and meet the Base EHR definition as well as be certified as meeting additional ASTP/ONC health IT certification criteria.

CMS is also proposing several changes, including adding 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. CMS wants eligible clinicians to 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 would be required to submit two affirmative ("Yes") attestations for this measure to be considered a meaningful EHR user and earn a score for this performance category.

There is also a proposal to modify the High Priority Practices Safety Assurance Factors for EHR Resilience (SAFER) Guide Measure, which 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.

Additionally, CMS is proposing the Public Health Reporting Using the Trusted Exchange Framework and Common Agreement (TEFCA) Measure as an optional bonus measure, adding to the optional bonus measures available under the Public Health and Clinical Data Exchange Objective. CMS is working with the Centers for Disease Control and Prevention, ASTP/ONC, public health agencies (PHAs), and other interested parties to expand the use of TEFCA for sharing health information for public health purposes. CMS firmly believes that facilitating standardized health information exchange with PHAs through the TEFCA Framework has the potential to reduce the reporting burden for MIPS eligible clinicians as well as PHAs. According to the Proposed Rule, MIPS eligible clinicians would be able to claim five bonus points under this objective if they are actively engaged with a PHA to submit data for one or more of this objective's four optional measures, including the Public Health Reporting Using TEFCA Measure.

Projected 2026 MIPS Participation and 2028 Payment Adjustments

CMS estimates there will be 607,419 MIPS eligible clinicians in the 2026 performance period, the median final score will be 89.47, and 84 percent of MIPS eligible clinicians will receive a positive payment adjustment in 2028 as a result of the 2026 performance period. Solo practitioners and small practices remain more likely to be penalized. CMS estimates 49 percent of solo practitioners and 21 percent of small practices will receive a penalty of up to -9 percent compared to 12 percent of MIPS eligible clinicians overall. This is also true for solo practitioners and small practices that qualify as safety net physicians, and those in rural areas. See the table below.

	Estimated 2026 median final score	Estimated percent receiving a penalty
All MIPS eligible clinicians	89.47	12%
All solo practitioners	75.00	49%
All small practices	87.53	21%
All rural practitioners	87.80	13%
Rural solo practitioners	75.00	47%

Rural small practices	89.11	20%
All safety net practitioners	92.43	13%
Safety net solo practitioners	57.76	55%
Safety net small practices	85.90	29%

CMS projects the median positive payment adjustment in the 2028 payment year based on 2026 performance will be 1.30 percent while the median penalty will be -1.88 percent. However, CMS expects the median penalty will be -6.55 percent for solo practitioners and -6.08 percent for small practices because more solo practitioners and small groups are expected to receive the maximum -9 percent MIPS penalty.

Advanced APM Proposals

CMS reintroduces several proposals concerning Advanced APMs in response to previous AMA advocacy. First, CMS proposes to add an individual level calculation to Qualifying APM Participant (QP) determinations such that each eligible clinician would 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 would apply to the Medicare Option and All-Payer Combination Option, as well as to QP and partial QP thresholds.

This proposal comes at an important time as under statute, QP thresholds substantially increased for the 2025 performance year from 50 to 75 percent of payments and 35 to 50 percent of patients. Partial QP thresholds similarly increased from 40 to 50 percent of payments and 25 to 35 percent of patients. Advanced APM lump sum bonuses are also set to expire at the end of the 2026 payment year (which is based on participation in 2024). The AMA continues to press Congress to extend the Advanced APM bonus and allow more flexibility in setting QP payment thresholds before the end of the year to ensure continued growth in APM participation. These policy changes would also help avert a potential cliff amongst clinicians suddenly not qualifying for QP status despite participating in advanced APMs, especially those participating in specialty models which inherently have a more challenging time meeting QP thresholds based on model design.

The agency reintroduces another proposal that was proposed, but not finalized, in the 2025 MPFS rule to expand the scope of the services used for attribution to all Medicare covered professional services (rather than E/M services, with limited exceptions for certain APMs that focus on specific episodes of care). The AMA previously supported the spirit of this proposal based on the reasoning that it affords a more consistent, predictable, and accurate methodology across models moving forward and could help counter perverse incentives for APM Entities to drop specialists from their participation lists, but sought more information concerning the unintended consequences before such a policy was finalized. In response, CMS opted not to finalize the proposal last year and reintroduces the concept in this year's proposed rule.

CMS also proposes to no longer limit Medical Home Model participants to 50 clinicians, again, in response to previous AMA advocacy. Lastly, CMS proposes to clarify that the timing for the QP targeted review process is intended to align with the MIPS targeted review process.

Ambulatory Specialty Model (ASM)

CMS is proposing to implement a new payment model in 2027 in select geographic areas that would be mandatory for physicians who treat patients with heart failure or low back pain. ASM is intended to encourage better collaboration between specialists and primary care physicians in order to prevent exacerbations and avoidable surgical procedures and hospital admissions. ASM has been structured like two MVPs except that the required performance measures have been selected specifically for physicians who treat patients with heart failure or low back pain instead of entire specialties. Performance scores on the measures would be based on comparisons to other ASM physicians instead of all physicians who report these measures in MIPS. Like MIPS, ASM performance

could generate payment adjustments starting in 2029 based on 2027 performance of up to +/- 9 percent for the physicians who would be mandated to participate in it. By the end of the five-year model, payment adjustments would grow to +/- 12 percent.

QPP Requests for Information (RFIs)

Core Elements in an MVP RFI

CMS seeks comments on how to encourage MVP reporting on key quality measures that reflect the essential components of an MVP. More specifically, seeking comments on a potential Core Elements MVP reporting requirement, which would identify a subset of quality measures in each MVP to comprise the MVP's Core Elements; the intended goals and ideal number of Core Elements in an MVP; and the role of measure collection types, the limitations of measure applicability for some clinicians, the policy implementation timeline, and any anticipated impacts on clinicians' transition to MVP reporting.

Well-being and Nutrition Measures RFI

CMS is also seeking feedback on well-being and nutrition measures in QPP, with the goal to provide a more comprehensive approach to disease prevention and health promotion. In addition, seeking comment on tools and measures that assess overall health, happiness, and satisfaction in life that could include aspects of emotional well-being, social connections, purpose, and fulfillment.

Procedural Codes for MVP Assignment RFI

CMS also includes an RFI to solicit feedback on the use of claims data to assign clinicians to an MVP to help facilitate specialty reporting of MVPs most relevant to their scope of care, including seeking comments on the data sources CMS should consider to utilize to assign clinicians to an MVP and the eligibility determination period to establish procedural code utilizations and relevant volume threshold.

Transition Toward Digital Quality Measurement RFI

CMS is seeking information on the transition toward digital quality measurement and the use of HL7 FHIR standard. Specifically, CMS is seeking comment on the anticipated approaches to FHIR-based eCQM reporting in quality reporting programs and ACOs experience with the transition to FHIR-based reporting of eCQMs and opportunities to mitigate reporting burden.

Query of Prescription Drug Monitoring Program (PDMP) Measure RFI

CMS is seeking public feedback on potentially modifying the Query of PDMP measure in the Promoting Interoperability performance category from an attestation measure to a performance-based measure. Initially finalized in the CY 2023 PFS final rule, the measure currently requires MIPS eligible clinicians to attest "Yes" or "No" regarding their use of certified EHR technology (CEHRT) to query a PDMP when prescribing certain controlled substances. CMS notes growing support for PDMP utilization, broader availability across all states, and increased integration with health IT systems, prompting consideration of a shift toward performance-based scoring in future rulemaking.

Performance-Based Measures in the Public Health and Clinical Data Exchange Objective RFI

CMS is seeking public feedback on potential updates to the Public Health and Clinical Data Exchange objective within the Promoting Interoperability performance category, specifically on transitioning from attestation-based measures to performance-based measures using numerator and denominator reporting. Currently, MIPS eligible

clinicians indicate their level of active engagement with public health agencies (PHAs) but are not evaluated on the quality or completeness of data exchanged. Given advancements in public health reporting infrastructure, CMS aims to improve the comprehensiveness, quality, and timeliness of data shared with PHAs. This request for information builds on responses received in the CY 2025 PFS proposed rule and seeks further input on measure concepts that could better assess performance and enhance public health outcomes.

Data Quality RFI

CMS is seeking public feedback on advancing data quality—defined as the accuracy, completeness, timeliness, consistency, and reliability of health information—as a foundational element of effective health information exchange. CMS states that poor data quality undermines clinical decision-making, patient safety, administrative functions, public health reporting, and clinical research. CMS is urging MIPS eligible clinicians to collaborate with health IT vendors to improve data integrity, reduce burden, and minimize risks associated with low-quality data. As electronic health information becomes more prevalent and value-based care expands, CMS is seeking feedback to promote the use of modern technologies and standards that support the exchange of high-quality, usable data across the care continuum.

Helpful Links

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