AMERICAN OSTEOPATHIC ASSOCIATION

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CY2026 Medicare Physician Fee Schedule and Quality Payment Program Proposed Rule

Overview

On July 14, 2025, the Centers for Medicare & Medicaid Services (CMS) issued the CY2026 Medicare Physician Fee Schedule proposed rule which includes updates to physician payment policies, the Quality Payment Program (QPP), and the Medicare Shared Savings Program. AOA's strong advocacy secured enactment of legislation that includes a positive 2.5% increase to the 2026 conversion factor (CF), and successfully defended the .75% and .25% positive increase to the CF that was included in MACRA, which takes effect in 2026, from being repealed. Key takeaways include the following:

- Beginning in CY26, physicians who are qualifying participants in advanced alternative payment models (AAPMs) under the Quality Payment Program (QPP) are subject to a different conversion factor than physicians who are not qualifying participants (i.e. MIPS participants). Both conversion factors will see an increase over 2025, with the APM CF increasing by 3.837% and the non-APM conversion factor increasing by 3.322%. Much of this CF adjustment is driven by a statutory increase that resulted from AOA advocacy.

- CMS proposes to impose an efficiency adjustment of -2.5% to work RVUs for most non-time-based codes.

- The agency is proposing substantial changes to its practice expense methodology, particularly around indirect practice expense, and has decided not to use data from the AMA's physician practice information survey as part of its rate setting.

- The Centers for Medicare and Medicaid Innovation (CMMI) proposes to launch a 5-year mandatory Ambulatory Specialty Model (ASM) test whether adjusting payment for specialists based on their performance on targeted measures of quality, cost, care coordination, and meaningful use of certified electronic health record (EHR) technology (CEHRT) results in enhanced quality of care and reduced costs through more effective upstream chronic condition management. The model will focus on specialty care for patients with heart failure or low back pain.

- In the Quality Payment Program, CMS proposes to maintain the performance threshold at 75 points through 2028, consistent with AOA past recommendations, and has proposed modest changes to MIPS. In addition, CMS is proposing 6 new MIPS Value Pathways (MVPs) and several policy changes to MVPs to facilitate transition to participation.

Outlined below is an initial summary of this year's proposed rule. The AOA will submit comments to CMS on its proposals ahead of the September 14 comment deadline.

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Physician Fee Schedule

Conversion Factor

Fee-for-service payments under the Medicare program are determined by multiplying the relative value units (RVUs) for work, practice expense, and malpractice for a given service by the fee schedule conversion factor. These values are then adjusted based on geographic practice cost indices (GPCIs). Beginning in CY26, physicians who are qualifying participants (QP) in advanced alternative payment models (AAPMs) under the Quality Payment Program (QPP) are subject to a different conversion factor than physicians who are not qualifying participants (i.e. MIPS participants).

As a result of AOA's extensive advocacy over the last year for a statutory pay increase, CMS is implementing the 2.5% pay increase enacted under the *One Big Beautiful Bill Act*. For 2026, the APM QP conversion factor will be 33.588, a 3.837% increase over 2025, and the non-APM QP conversion factor will be 33.421, an increase of 3.322% over 2025. The factors driving the adjustment are the following:

- A 2.5% increase to the CY2025 conversion factor enacted under the *One Big Beautiful Bill Act*
- A 0.55% positive budget neutrality adjustment
- Statutory adjustments, required under current law, of 0.75% for qualifying APM participants and 0.25% for non-qualifying APM participants.

Statute requires that any change to the fee schedule be applied in a budget neutral manner. This means that any changes to RVUs may not result in a net change to Medicare expenditures greater than $20 million when accounting for anticipated utilization. CMS estimates that the total change in expenditures due to policy modifications, newly payable services, as well as changes to RVUs for existing services, will result in a 0.55% upward budget neutrality adjustment to the conversion factor. However, it is important to note that the positive budget neutrality adjustment is derived from savings generated in other parts of the fee schedule, and policy changes will have disparate impacts across specialties. These changes are described in further detail below.

The AOA will continue to work with Congress to enact long-term physician payment reform to ensure sustainable payment that reflects the rising cost of practicing medicine.

Practice Expense Calculation Changes

CMS' practice expense (PE) methodology currently relies primarily on the AMA's Physician Practice Information (PPI) Survey data. For the last several years, CMS has delayed implementing reallocation of indirect costs for PE RVUs while awaiting more recent data from an AMA PPI survey completed at the end of 2024. However, CMS has decided not to use the PPI survey data in updating practice expense relative values to adjust Medicare Economic Index (MEI) weights impacting the distribution of RVU components. CMS has chosen to independently make updates to its PE methodology, shifting allocation of indirect PE costs from the facility setting to the non-facility setting, resulting in shifts in payment between the sites of service accordingly. CMS states that this change is intended to recognize the shift in the practice landscape, with the share of physicians in private practice steadily declining while the share of physicians employed by hospitals and health systems is growing.

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Physician Work Efficiency Adjustment

CMS is proposing an efficiency adjustment to the work RVUs and intra-service times for nearly all non-time-based services under the physician fee schedule. CMS proposes to use the Medicare Economic Index productivity adjustment, for the prior five years cumulatively applied, to determine the efficiency adjustment. In 2026, this will result in a 2.5% reduction to the work RVUs for all codes, except those that are time-based, such as evaluation and management (E/M) services, care management services, behavioral health services, services on the Medicare telehealth service list, and maternity care services with an MMM global period. CMS also proposes to apply the efficiency adjustment to the intraservice portion of physician time and work RVUs every 3 years.

This action marks a substantial deviation from past policy and disregards recommendations from the physician community via the Relative Value Scale Update Committee (RUC) process, which seeks to ensure that services are appropriately valued over time. CMS states its rationale as “moving away from [RUC] survey data would lead to more accurate valuation of services over time and help address some of the distortions that have occurred in the PFS historically.” The AOA will continue to review this proposal and engage with stakeholders on this issue.

Mandatory Ambulatory Specialty Model (ASM)

CMS proposes a new mandatory innovation model, the Ambulatory Specialty Model (ASM), for specialists treating heart failure or low back pain in outpatient settings. The model would run for five performance years, starting in 2027. The model would include physicians who have historically treated at least 20 patients for heart failure or low back pain over a 12-month period, using existing MIPS episode-based cost measures for each condition to identify participants. Participants would be assessed based on quality, cost, improving interoperability, care improvement activities, such as increasing care coordination. CMS would use ASM scores across these four areas to determine adjustments on future Medicare Part B claims for covered services. In the first payment year, the adjustment would range from -9% to +9%. Physician performance would be assessed against only physicians treating the same chronic condition.

E/M Coding Changes

CMS is proposing to allow the G2211 office/outpatient (O/O) evaluation and management (E/M) care complexity add-on code to be billed with the home or residence evaluation and management visit code family. The agency states that this change is intended to recognize the resource costs involved in building longitudinal care relationships in the home and residence setting, which is not reflected in the corresponding E/M code set.

Advanced Primary Care Management (APCM) Services

In 2025, CMS established 3 new healthcare common procedure coding system (HCPCS) codes for advanced primary care management. These codes were developed to better recognize the work involved in delivering advanced primary care, emphasizing team-based, coordinated primary care. CMS is proposing to build on this effort, creating optional add-on codes for APCM services that would facilitate providing complementary behavioral health integration (BHI) services. These codes would not have the time-based requirements of the existing BHI and Psychiatry Collaborative Care Management (CoCM) codes which are a source of administrative burden and barrier to billing.

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Telehealth

CMS proposes several changes related to telehealth policy, including:

- Simplifying the review process for adding services to the telehealth service list by removing the distinction between provisional and permanent services and focusing review on whether a service can be furnished via interactive, two-way audio-video technology;

- Permanently removing frequency limitations for subsequent inpatient, subsequent nursing facility, and critical care consultation telehealth services;

- Making permanent its definition of direct supervision which allows the physician or supervising practitioner to provide such supervision through real-time audio and visual interactive telecommunications (excluding audio-only); and

- Ending its policy that allows teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings.

It is also important to note that Congressional action is necessary to extend the telehealth flexibilities set to expire in September, which have enabled broader access to telehealth services. Absent legislative action, restrictions that existed prior to the COVID-19 public health emergency, including site and geographic restrictions, will once again go into effect.

Quality Payment Program

In an effort to promote stability in the program, CMS proposes only modest changes under the QPP. Following AOA advocacy urging the agency to maintain the performance threshold until it has multiple years of reliable performance data (following practice disruptions from the COVID-19 public health emergency and Change Healthcare cyberattack), CMS proposes to maintain the performance threshold at 75 points through 2028.

CMS is proposing changes across MIPS measure inventories, as well as 6 new MIPS Value Pathways (MVPs) for diagnostic radiology, interventional radiology, neuropsychology, pathology, podiatry, and vascular surgery. CMS also proposes several policy changes to MVPs to facilitate transition to participation.

AOA continues to work with CMS and Congress to enact comprehensive MIPS reform that alleviates unnecessary burden and supports more appropriate payment.

Conclusion

The AOA will continue its detailed review of the CY2026 Medicare Physician Fee Schedule and will share resources with members as they are developed. In the meantime, if you have any questions, please contact Gabriel Miller, Senior Director of Regulatory Affairs, at gmiller@osteopathic.org.