American Medical Association's Topline Summary

Medicare Physician Fee Schedule (MPFS) Proposed Rule

On July 14, 2025, the Centers for Medicare & Medicaid Services (CMS) released the proposed rule for the 2026 Medicare physician fee schedule (MPFS). While AMA staff will analyze and develop a detailed summary of the nearly 2,000-page proposal, we want to bring a handful of key issues to your immediate attention.

Conversion Factors and Budget Neutrality

For the first time this century, CMS proposed 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. These conversion factors are outlined below:

1. $33.5875, an increase from $32.3465, which reflects a permanent 0.75 percent update, a temporary 2.5 percent update, and a .55 percent budget neutrality adjustment and applies to Medicare payments to QPs in advanced APMs.
2. $33.4209, an increase from $32.3465, which reflects a permanent 0.25 percent update, a temporary 2.5 percent update, and a .55 percent budget neutrality adjustment and applies to Medicare payments to all physicians who are not QPs, including Merit-based Incentive Payment System (MIPS) eligible clinicians.

Similarly, CMS proposes two anesthesia conversion factors, which both reflect permanent updates for QPs and non-QPs, a temporary update, and a budget neutrality adjustment. The anesthesia conversion factor for QPs is $20.6754, and the anesthesia conversion factor for non-QPs is $20.5728; both increased from $20.3178.

Additionally, the conversion factors are affected by a positive .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 relative value units (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 1 percent.

Of note, CMS proposes to accept nearly 90 percent of the AMA/Specialty Society RVS Update Committee's (RUC's) relative value recommendations for 2026.

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 an error made by the Biden administration in significantly over projecting 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.

Congress passed a temporary, one-year 2.5 percent update for 2026 in H.R. 1. 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

The AMA is disappointed that CMS did not propose to factor in the Physician Practice Information (PPI) Survey information in updating 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 modify the indirect practice expense methodology to redistribute 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 dramatic shift of payment between sites-of-service. Facility-based payment to physicians will decrease overall by -7 percent while non-facility-based payment to physicians will increase by 4 percent.

Telehealth

The AMA is concerned about CMS’ decision not to add the CPT telemedicine E/M codes to the Medicare Telehealth List effective for 2026. In 2025 rulemaking, CMS determined that Medicare would not recognize the then-new CPT telemedicine E/M codes, although it published the codes and relative values so that they could be used by other payers. In February, the AMA sent a letter to CMS urging that the codes be added to the 2026 Telehealth List so that Medicare joins other payers that recognize these E/M codes.

Merit-based Incentive Payment System (MIPS)

Following ongoing advocacy by the AMA not to increase the MIPS performance threshold, CMS proposed to maintain the threshold to avoid a MIPS penalty of up to 9 percent at 75 points for the CY 2026 performance year/2028 MIPS payment year and through the CY 2028 performance year/ 2030 MIPS payment year. Research continues to show that MIPS is unduly burdensome; disproportionately harmful to small, rural, and independent practices; exacerbating health inequities; and divorced from meaningful clinical outcomes. In 2025, 14 percent of all MIPS-eligible clinicians are subject to a penalty of up to -9 percent of their Medicare paid amount for covered services as a result of MIPS. By comparison, 29 percent of small practices, 49 percent of solo practitioners, and 18 percent of rural practices are receiving a MIPS penalty. Worse, 13 percent of small practices and 29 percent of solo practitioners are receiving the maximum MIPS penalty of -9 percent. The AMA is strongly urging Congress to make statutory changes to improve MIPS and address fundamental problems with the program by replacing steep penalties that disproportionately hurt small and rural practices and prioritizing access to timely and actionable data.

Proposed Mandatory Payment Model

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. This Ambulatory Specialty Model or 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. Like MIPS, however, ASM performance could generate payment adjustments starting in 2029 of up to +/- 9 percent for the physicians who would be mandated to participate in it.

Additional Resources

- 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