AMERICAN OSTEOPATHIC ASSOCIATION

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CY 2026 Medicare Physician Fee Schedule and Quality Payment Program Final Rule

On October 31, the Centers for Medicare & Medicaid Services (CMS) issued the CY 2026 Medicare Physician Fee Schedule final rule which includes updates to physician payment policies, Medicare Shared Savings Program, and the Quality Payment Program (QPP). The rule makes critical changes to payment of importance to osteopathic physicians across specialties. The Public Policy team will continue to review the final rule thoroughly and develop in-depth summary and assessment, which will be available in the coming days.

Most significantly, 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. CMS is implementing these changes, resulting in an overall increase to the conversion factors. Beginning in CY26, physicians who are qualifying participants (QPs) 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. Merit-Based Incentive Payment System participants). Both conversion factors will see an increase over 2025, with the qualifying APM CF increasing by 3.775% to 33.568, and the non-APM conversion factor increasing by 3.260% to 33.401. CMS has also adjusted the anesthesia conversion factors. The anesthesia qualifying APM CF will be 20.600 and the anesthesia non-APM CF will be 20.498. It is important to note that the increase to payment is only for CY 2026. The Medicare Economic Index, a measure of inflation for healthcare, is expected to increase 2.7% in the coming year, and AOA will continue to advocate with Congress for long-term reform to Medicare physician payment and ensure that payment keeps pace with the cost of practicing medicine.

CY2026 Medicare Conversion Factor Changes

	2025 Conversion Factor	2026 Conversion Factor	Percent Change
APM QP	32.347	33.568	3.775%
Non-APM QP	32.347	33.401	3.260%
Anesthesia APM QP	20.318	20.600	1.388%
Anesthesia Non-APM QP	20.318	20.498	0.886%

The AOA is deeply disappointed that CMS chose to finalize policies imposing a new efficiency adjustment on non-time based services and modifying its approach to calculating indirect practice expense (PE) relative value units (RVUs). Together, these changes will mitigate the benefits of the improved conversion factor for many specialties. First, CMS finalized its proposal to impose a -2.5% efficiency adjustment to work RVUs for non-time based services, with some services exempted. Time-based services, including evaluation/management, care management services, maternity care services with an MMM global period, as well as several other services specified by CMS, will be exempted from the adjustment. Despite AOA advocacy, CMS chose not to exempt OMT codes from this adjustment. CMS also finalized changes to practice expense methodology, reducing the share of indirect PE RVUs assigned based on work RVUs by 50% for facility based services. Outlined below are additional key policy changes across the rule.

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Telehealth

While CMS finalized policies intended to support continued access to telehealth, the agency is currently unable to make payment for most non-mental and behavioral telehealth services due to the expiration of telehealth flexibilities on October 1, 2025. Because Congress did not extend the telehealth flexibilities established during the COVID-19 public health emergency, telehealth services rendered to patients in their homes and outside of rural settings can no longer be paid by Medicare until Congress enacts legislation extending these flexibilities. AOA is working with Congress to ensure Medicare patients can continue to access telehealth services.

Despite the status of statutory telehealth flexibilities, CMS still moved forward with its telehealth proposals, including simplifying the process for adding services to the Medicare telehealth list; and eliminating frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations.

Ambulatory Specialty Model

Beginning in 2027, CMS will begin implementing its Ambulatory Specialty Model (ASM), a mandatory model for physicians in certain specialties treating patients with heart failure or low back pain. The model is largely built on MIPS infrastructure and will impose a similar payment adjustment, with physicians being subject to +/- 9% payment adjustment based on their performance. This payment adjustment will increase to 12% over the course of the model's 6 year duration.

Payment to Improve Care for Chronic Illness and Behavioral Health

CMS finalized policies to improve payment for caring for patients with chronic illness and delivering behavioral health services. First, CMS finalized its proposal to optional add-on codes for Advanced Primary Care Management (APCM) services that would facilitate providing complementary behavioral health integration (BHI) or psychiatric Collaborative Care Model (CoCM) services. Second, CMS is making improvements to billing rules for the G2211 add-on code by permitting the code to be billed with home or residence E/M visits.

Merit-Based Incentive Payment System (MIPS)

In another advocacy win, CMS decided to maintain the Merit-Based Incentive Payment System (MIPS) performance threshold of 75 points for performance year 2026 through performance year 2028. This policy is intended to promote stability within the MIPS program. The AOA expressed concern that raising the performance threshold would disadvantage small and independent practices, especially those that sought extreme and uncontrollable circumstance exemptions from the MIPS program through 2023, and again in 2024 due to the Change Healthcare cyberattack. Many of these practices are just resuming full participation in MIPS, and MIPS performance data is likely skewed by the large number of practices that have sought exemption over the last several years. CMS has finalized several policies modifying reporting requirements and scoring under MIPS, and AOA will develop an in-depth resource for members detailing these changes in the coming weeks. More broadly, AOA will continue to advocate for reforms to the Quality Payment Program to alleviate physician burden.

The AOA will continue to analyze the final rule and provide additional resources in the coming days.