***Medicare Physician Fee Schedule (PFS):  
Geographic Practice Cost Indices (GPCIs)   
and Malpractice Risk Index***

***Interim Report***

**CY2026 Medicare Physician Fee Schedule (PFS) Update  
to the Geographic Practice Cost Indices (GPCIs) and   
Malpractice (MP) Risk Index**

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***Interim Report***

**CY 2026 Medicare Physician Fee Schedule (PFS) Update to the Geographic Practice Cost Indices (GPCIs) and Malpractice Risk Index**

# Executive Summary

The Centers for Medicare and Medicaid Services (CMS) is responsible for developing Medicare Physician Fee Schedule (PFS) payment rates for covered Medicare Part B practitioner services. This is accomplished through relative value units (RVUs) that establish relative payment amounts across services and geographic practice cost indexes (GPCIs) that adjust these national amounts for local input price variation. There are RVUs and GPCIs for three distinct types of practitioner inputs: physician work (WORK), practice expense (PE), and malpractice expense (MP). RVUs are updated annually through a process described in detail in annual Notice of Proposed Rulemaking (NPRM) and Final Rule notices in the Federal Register. One of the RVU inputs is a specialty-specific malpractice risk index that is based on malpractice premium data to capture the difference in premiums faced by practitioners of different specialties. The GPCIs and risk indexes are updated every three years, with a new update due for CY 2026. Updating the GPCIs involves collecting data on wages, office rents, and malpractice premiums. Most of the required elements are available from federal data sources, except for the malpractice premium data, which are developed from insurers’ rate filings. These malpractice premium data are used for both the MP risk index and the MP GPCI. This report describes the process used to develop the 2026 MP risk index and GPCIs, from data collection through measure creation.

The refinements included in this update are quite modest compared to those that were implemented with the previous update. This update uses the same approach, with some small changes:

* Minor refinement of the universe of specialties subject to imputation for missing malpractice premiums, and
* Modification of the occupations for which wage data are used, reflecting changes in both BLS definitions and CMS decisions about appropriate codes for inclusion.

The resulting updated GAFs for 2026 are quite similar to current 2025 values, with approximately 54% of RVUs in areas that have a change of less than 0.5 percent. All but two payment areas have updated 2026 GAF values that are within 1.5 percent of their current values; these areas account for nearly 99% percent of total RVUs. The updated MP risk index also leads to relatively modest changes in MP RVUs, with all but three specialties experiencing shifts of less than 1 percent.

# Background

Medicare bases payments for practitioner services, excluding anesthesia services, on the Medicare PFS. It establishes base national payments that are adjusted to reflect local variation in input prices. The PFS is built around three key concepts:

* Relative value units (RVUs): Defined at the service level, RVUs are designed to capture relative resource use across services; separate relative value scales (RVS) are developed for WORK, PE, and MP.
* Geographic practice cost indexes (GPCIs): Defined at the Medicare locality level, GPCIs are defined to capture regional differences in costs associated with providing services; there is a separate GPCI for each of the three RVSs. There are currently 109 PFS localities.
* Conversion factor (CF): The single national conversion factor is used to translate the RVUs of the PFS into dollar payment rates.

RVUs are derived from physician work recommendations, direct cost estimates, and malpractice premiums, while GPCIs are based on malpractice premiums, non-physician occupational wages, employee wages, equipment and supplies, office rents, and purchased services costs. CMS’ Division of Practitioner Services is responsible for managing all aspects of the PFS except the conversion factor, which is calculated by CMS’ Office of the Actuary. RVUs and GPCIs for each of the three elements—WORK, PE, and MP—are multiplied, and then these three products are summed. This geographically adjusted total RVU amount is converted to a dollar payment by multiplying it by the CF for each service on the fee schedule.

This report describes the update of the GPCIs and the MP risk index that underlies the development of Malpractice RVUs for calendar year (CY) 2026. The WORK and PE GPCIs are based on publicly available data, while the MP GPCI and risk index require information about malpractice insurance premium data which are collected as part of this update process.

Prior to the CY 2016 rule cycle, the calculation of MP RVUs was carried out as a task separate from the annual update of the PFS even though clinical labor RVUs (a product of the PE RVU process) and physician work values can both change annually and are inputs to MP RVUs. In CY 2016, a new law that capped the decrease in total RVUs (i.e., the sum of WORK, PE, and MP RVUs) at 20 percent in a given year for any code went into effect[[1]](#footnote-2) and MP RVUs essentially became an input to the PE RVU calculation. As a result, CMS integrated the MP RVUs into the annual PFS update process. The calculation of MP RVUs themselves is only relevant to this update to the extent that the specialty risk index is one of the main inputs, so calculating MP RVUs will help validate new data and understand their implications.

Section 3 of the report describes the process of acquiring and developing the malpractice premium data that are used for the GPCIs and malpractice risk indexes. Section 4 describes the update of the GPCIs for the Medicare PFS for the CY 2026 rule cycle. This starts with a description of the data collection and acquisition process required for each GPCI calculation. It next describes the data development needed to transform the collected data into a format that can be used to create each GPCI and the method for creating the individual GPCIs and geographic adjustment factors (GAF). Post-measure creation adjustments are then described to specify how provisions for budget neutrality, blending, other legislative adjustments, and California localities are incorporated.

Section 5 of the report includes a discussion of the update of the malpractice risk index. A summary of the findings of the report and conclusions as a result of the CY 2026 update are described in Section 6. We have included detailed output data tables in Section 7, key reference tables in Section 8, and additional details on parameters and how we accessed publicly available data in Section 9. Additional information on a proposed process for selecting occupation codes used in the WORK GPCI calculation can be found in Section 10.

# Developing Malpractice Premiums for the Update of the CY 2026 GPCIs and Malpractice Risk Index

## Overview

Underlying the malpractice risk index and MP GPCI are premiums paid for medical professional liability insurance (PLI) across the nation and across practitioner specialties. These data are not readily available from an existing database of either medical practitioners or insurers, so CMS supports development of an updated premium database to calculate these measures. As described below, insurers’ PLI rate filings constitute the most viable source for this information. The premium data collection process is designed to develop a data resource that includes information sufficient for describing malpractice insurance rates in every state for as many CMS specialties as feasible.

As described in this section, the process for collecting these premium data involves several steps:

1. Identify states and localities;
2. Identify sources of premium data;
3. Define criteria for selecting insurance filings;
4. Include Patient Compensation Fund (PCF) surcharges for states with mandatory coverage;
5. Select premiums for each specialty, adjusting base rates to standardized coverage; and
6. Map insurer specialties to CMS specialties.

The data collection process for this CY 2026 update generally follows that of the previous update. Minor refinements to the universe of specialties subject to imputation and the sources of imputation for each specialty are explained in section 3.G below, but otherwise, the approach is unchanged.

## Identify States and Localities for Inclusion

Insurance products are regulated at the state level. Insurance filings were therefore collected for each state and the District of Columbia. Efforts were made to collect filings from Puerto Rico, but recent filings were not submitted. When new data were not available, as in the case of Puerto Rico, ARC used older filings from previous updates. Consistent with previous updates, no filings were collected for the other U.S. territories: American Samoa, Guam, Northern Mariana Islands, and U.S. Virgin Islands.[[2]](#footnote-3)

## Identify Sources of Premium Data

For most states, PLI filings are available online from the System for Electronic Rates and Forms Filing (SERFF) Filing Access Interface (SFA).[[3]](#footnote-4) Because this is a consistent and readily available source of filings, it was used for every state for which data are available.

At the time data were collected for the CY 2026 update, the filings for Florida and Puerto Rico were not available for download via the SFA. The State of Florida maintains a state-sponsored online filing portal, and we obtained filings for this state using the same methodology used for the states with filings available via the SFA. We made attempts via email to obtain filings from the Commonwealth of Puerto Rico but were unable to obtain any updated filings.

## Define Criteria for Selecting Filings

The method of reporting PLI premium rates varies by company and across localities. To produce a consistent database of premiums for determining the specialty risk index and GPCIs, it is necessary to define consistent criteria for the selection of the appropriate premiums. Consistent with prior years, criteria were set for selecting the insurers that would be represented in the dataset, the filings that would be selected, and the characteristics to identify specific premiums.

### Selection of Insurers

In order to focus the data collection on filings necessary for reflecting the market in each state, the largest insurers were identified using the National Association of Insurance Commissioners (NAIC) market share report.[[4]](#footnote-5) Market share is defined as the ratio of the insurer’s direct premiums written to the total direct premiums written for PLI in each state.[[5]](#footnote-6) The NAIC annual report provides state-level market share for entities that provide PLI in the state. We used the most recent available NAIC annual report—reflecting 2023 market share—to select companies. In some states, Risk Retention Groups (RRGs) play a significant role in the PLI market, but they are not required to file rates with state insurance regulators. As a result, we were limited to including the largest *non-RRG* insurers in each state. In 2023, RRGs accounted for at least a fifth of the PLI market in eight states: Connecticut (53%), Indiana (20%), Maryland (33%), Massachusetts (48%), Mississippi (21%), Montana (25%), Pennsylvania (22%), and Wyoming (23%). In states like these, it is impossible to know how well the rates we develop without RRG premiums reflect the state’s PLI market in the absence of RRG rate information.

Consistent with the prior update, filings were collected for the groups and companies with the largest market share in each state, collecting all available filings until either cumulative market share met or exceeded 50 percent or filings had been collected for four insurer groups. If more than one company in an insurance group had PLI filings in the state, available filings for all the group’s companies were collected.

Because the NAIC market share report does not report premium volume for the component companies of an insurer group, we divided the market share for the group equally among all companies in the group that wrote PLI policies in the state. Consistent with the prior update, this allocation of market share was applied on a *specialty* level rather than a *company* level. For example, if a group contained two companies that write PLI, but only one company covered chiropractors, that one company receives the full group market share for chiropractors. If both companies write PLI for obstetricians, the market share for each premium is half of the group market share. This methodology reflects the distinct coverage options available to practitioners in each specialty in each market.

### Selection of Filings

Five criteria were used to select filings for each of the selected insurers: subtype of insurance stated for the filing, coverage trigger, filing type, effective date of the filing, and coverage limits. Based on the criteria described below, the final premium data cover approximately 41 percent of the U.S. population, based on state market share included and state population. Table 7.A displays the market share by state of the filings we obtained; Table 7.B shows the share of the U.S. population covered by the filings, by CMS specialty and service risk group.

#### Subtype of Insurance

PLI is available for a variety of practitioners, and filings are specific to subtype of insurance. Consistent with the prior update, SERFF filings for all subtypes of insurance that appeared to cover CMS specialties involved in PFS PE Ratesetting were included. Subtypes that obviously were not relevant to PFS, such as “Hospital,” “Ambulance,” and “Assisted Living Facility,” were not selected.

#### Coverage Trigger

A coverage trigger is the event that must occur for the policy to be activated. “Claims-made” policies cover claims only when the alleged incident and resulting claim are made during the coverage period, while “occurrence” policies cover claims for incidents that occur during the coverage period regardless of when the resulting claim is filed. Consistent with prior updates, the CY 2026 update used premiums for “claims-made” policies, under the rationale that these are the most common type of policy.

Premiums for claims-made policies may vary depending on the number of years in which the coverage has been in effect. Premiums in the first year of coverage are often lowest, with rates grading upwards until the policy is considered mature—typically 5 or more years. Consistent with prior updates, the CY 2026 update used premiums that were denoted as “mature” within the filing.

#### Effective Date

Filings have distinct effective dates which may apply to existing policies, new policies, or both. When an insurer submits a new filing providing the same type of coverage to the same type of practitioners as covered in a previous filing, the new premiums supersede the prior premiums as of the effective date. ARC’s investigations of the PLI marketplace suggest that the most appropriate indicator of premiums charged by an insurer is the most recent filing, regardless of effective date. Although some states require filings to be submitted even if there is no rate change, in other states premiums remain in effect until a new filing has been submitted and/or approved.

Based on this understanding of the PLI marketplace, the CY 2026 update used the most recent filing for each insurer with an effective date no later than December 31, 2023, as filed. These data represent premiums that were in effect in 2023, consistent with the timing of the most current available NAIC market share data discussed above.

#### Filing Type

Insurers may submit filings for a variety of business and procedural reasons, only one of which is to establish rates. Filings address topics such as changes to the forms that document the coverage purchased and the rules delineating how base premiums and adjustments are applied for various situations, as well as the rates that are charged for coverage. The characteristics of the changes in a particular filing are reflected in the type listed in the title. For the CY 2026 update, SERFF filings were selected if the filing type included “rates” in the description.[[6]](#footnote-7)

State insurance regulators review PLI filings and may request that the insurer provide additional justification for rate changes and/or revise certain aspects of the filing. Ultimately, regulators may disapprove a rate change or the insurer may withdraw the filing. Consistent with prior updates, the CY 2026 update does not include filings that show indications of being disapproved or withdrawn.

#### Coverage Characteristics

PLI is issued with maximum coverage limits. In prior updates premiums were collected for coverage limits of $1 million per occurrence and $3 million aggregate ($1 million/$3 million).[[7]](#footnote-8) The same level of coverage is used for the CY 2026 update.

## Patient Compensation Funds

In some states Patient Compensation Funds (PCFs) have been established to provide additional compensation to patients who suffer damages over and above the amount provided by the medical practitioner’s PLI. Medical practitioners pay a surcharge to participate in the PCF. Although eight states have established surcharge-funded PCFs—Indiana, Kansas, Louisiana, Nebraska, New Mexico, Pennsylvania, South Carolina, and Wisconsin—participation is only mandatory in Kansas, Pennsylvania, and Wisconsin.

Consistent with prior updates, PCF surcharges were included only for states in which participation was mandatory.

For the 2026 update, rates in these three states were selected to result in total combined coverage from primary insurance and PCF coverage as close as possible to the $1 million/$3 million coverage limit selected as standard for all states.[[8]](#footnote-9) Primary coverage is set at the level required by the state, and the appropriate PCF coverage limits were selected as follows:

* Kansas: Primary coverage of $500 thousand/$1.5 million; Healthcare Stabilization Fund coverage of $500 thousand/$1.5 million.[[9]](#footnote-10)
* Pennsylvania: Primary coverage of $500 thousand/$1.5 million; Medical Professional Liability Catastrophe Loss Fund (Mcare) coverage of $500 thousand/$1.5 million.[[10]](#footnote-11)
* Wisconsin: Primary coverage of $1 million/$3 million; no surcharge.[[11]](#footnote-12)

For Kansas and Pennsylvania, surcharges were developed from pricing information reported on the state’s website.[[12]](#footnote-13) For Wisconsin, the primary coverage limits match the standard limit for all states, so no surcharges were added.

## Develop Premiums for Each Specialty in Company Filing

Each company has a distinct manner of pricing PLI. Often premiums are quoted for a base level of coverage, and factors are applied to calculate the applicable premium for a given higher level of coverage. For this exercise, factors (usually multiplicative) are usually required to bring the base level of coverage to $1 million/$3 million aggregate, to reflect the specialty of the practitioner, the locality (if rates are not uniform statewide), and the number of years that the policy has been in effect. Filings often reflect other factors, such as for students or practitioners not practicing full time, but these additional factors were not considered in developing premiums for calculating the GPCIs and MP RVUs. Also, as described above, in Kansas and Pennsylvania PCF surcharges were added to the premiums as a last step.

Some insurers report rates by specialty while others report rates by risk group. In this latter case, the filing also includes a table that maps specialty to risk group. Rates were crosswalked by risk group onto the company’s list of specialties to develop specialty-specific rates.

## Develop Premiums for CMS Specialties and Service Risk Groups

For calculating MP RVUs, CMS’ goal is to establish a measure of relative malpractice risk, as reflected in relative PLI costs, for the specialties used on Medicare claims. Therefore, we matched CMS specialties to the rate that a practitioner in that specialty would have been charged by PLI insurers. We employed several analytic steps to account for the fact that PLI insurers each use their own idiosyncratic processes for determining the rate each practitioner is charged.

### Develop Insurer-Specific Crosswalks to CMS-Defined Specialties

Insurers that provide PLI in more than one state tend to use the same specialty list across markets. Therefore, we developed an insurer-specific list of specialties ever listed by each insurer and created company-specific crosswalks between CMS specialties[[13]](#footnote-14) and the appropriate corresponding company specialty. These crosswalks were used to match CMS specialties with the most appropriate premium available in the filing. This process does *not* result in all CMS specialties being matched with a premium for all filings—many filings apply to a limited list of specialties—nor does every specialty included in each filing match a CMS specialty.[[14]](#footnote-15)

### Subdivide CMS Specialties by Service Risk Group

It is common for insurers to base premiums not only on a practitioner’s specialty but also the mix of services within the specialty the practitioner furnishes. For example, it is very common for OB/GYNs who provide obstetric services to pay higher premiums than those who do not. However, insurers are idiosyncratic about which specialties face different premiums based on the risk represented by the services they provide. CMS’ policy has been to create separate risk measure values within specialties that typically face premiums based on service risk group, i.e., those specialties that insurers typically subdivide when setting premiums. In the OB/GYN example, not only is it common for insurers to charge different premiums based on whether or not the physician provides obstetric services, but also whether or not the physician provides major surgical services as well. Broadly, service-mix based rates are usually categorized for major vs. minor vs. no surgery, or relative to provision of OB services. When making MP RVUs, the MP risk index values are merged onto the utilization data by specialty and service risk class for specialties that face different premiums depending on their service mix. CMS categorizes services with HCPCS codes between HCPCS 59000 and HCPCS 59899 as OB services and those between HCPCS 10000 and HCPCS 69999 (excluding the OB services) as surgical.[[15]](#footnote-16) For many specialties, there are some insurers who price using either more or fewer categories than the majority. For these idiosyncratic insurers, it is necessary to either combine subdivided rates or split aggregated rates.

The example in Table 3.G.1 is provided to clarify this issue, and we discuss its methodological treatment below. Three insurers report the following premium rates for hypothetical Specialty X:

Table 3.G.1: Insurance Rates for Hypothetical Specialty X

| **INSURER** | **SERVICE RISK GROUP** | **RATE** |
| --- | --- | --- |
| A | Major Surgery | $65 |
| A | Minor Surgery | $50 |
| A | No Surgery | $43 |
| B | Surgery | $60 |
| B | No Surgery | $38 |
| C | All | $54 |

In this hypothetical example, each insurer has chosen a different strategy for setting rates for physicians in Specialty X. If all other insurers (not shown) treat Specialty X in the same manner as Insurer C, the specialty would NOT include service risk groups for the purpose of calculating MP risk index, and for consistency, single Specialty X rates need to be created from the component service risk group premiums for Insurers A and B. In the case of Insurer A, the Major Surgery rates will be used to represent the surgical rate, and the Minor Surgery rate will be disregarded. For both Insurers A and B, a single rate “All” is calculated as the weighted average of the Surgery and No Surgery rates, with the specialty’s work RVU shares (shown in Table 3.G.2) used as the weight factor. Given these weights and above rates, the single rate for Specialty X implied by Insurer A’s two rates (omitting Minor Surgery) is $55.10 and that implied by Insurer B’s two rates is $50.10.

**Table 3.G.2 Hypothetical Work RVU Shares by PLI Specialty**

| PLI Specialty | **SHARE OF TOTAL WORK RVUS - OBSTETRICS** | **SHARE OF TOTAL WORK RVUS - SURGERY** | **SHARE OF TOTAL WORK RVUS - NO SURGERY** |
| --- | --- | --- | --- |
| Specialty X | 0% | 55% | 45% |
| Specialty Y | 5% | 30% | 65% |

However, if most insurers adopted Insurer B’s approach, then each insurer’s rates need to be reported for Surgery and No Surgery service risk groups. In the case of Insurer A, the Major Surgery rate will be used as the Surgery Rate. For Insurer C, however, it is necessary to break apart the single rate reported into Surgery and No Surgery rates. This is accomplished by using the market share-weighted[[16]](#footnote-17) average ratio of Surgery to No Surgery rates for those plans that have them (in this example, this value is 1.450088 = (.55\* (65/43) + .30\*(60/38))/.85) and the Specialty X service mix (55 percent Surgery/45 percent No Surgery) to calculate the two rates that have the specialty average ratio and would result in the Insurer C single rate as the solution to a system of two equations with two unknowns.[[17]](#footnote-18)

In this example, the result is that Insurer C’s imputed rate for the Surgery service risk group is $62.77 and the No Surgery rate is $43.28. We calculated specialty WORK RVU shares for OB using the same categorization used to categorize services in the MP RVU process.

To determine which specialties consistently face service-mix based premiums, it was necessary to first document how specialties are typically treated in the insurer filings. Once the rates from the filings were recorded, we examined a weighted frequency of specialty subgrouping, with the weights given by state population and the plan’s market share. Based on this process, most specialties are not subdivided into service risk groups. When a filing reports rates by class for these specialties, the rates have been combined into a single rate by specialty based on the specialty RVU shares reported in Table 8.B. Those specialties that typically face service-mix based premiums are shown in Table 3.G.3 and thus will have more than one service risk group risk index value. For those filings that report a single premium for these specialties, this single rate was split into rates for each service risk group based on the specialty RVU shares for that specialty and the market-share weighted average ratio of surgical to nonsurgical, as shown in the example above. This process of combining or splitting rates does *not* apply to those specialties for which insurers always report a single rate and the final structure requires a single rate, as in the case of Cardiac Surgery and Neurosurgery.

Table 3.G.3: CMS Specialties Subdivided into Service Risk Groups

| **SERVICE RISK GROUPS** | **CMS SPECIALTIES** |
| --- | --- |
| Surgery/No Surgery | Otolaryngology (04), Cardiology (06), Dermatology (07), Gastroenterology (10), Neurology (13), Ophthalmology (18), Cardiac Electrophysiology (21), Urology (34), Geriatric Medicine (38), Nephrology (39), Endocrinology (46), Podiatry (48), Emergency Medicine (93), Unknown Physician Specialty (99) |
| Surgery/No Surgery/OB | General Practice (01), Family Practice (08), OB/GYN (16) |

All CMS specialties that are not listed in Table 3.G.3 typically face a single premium regardless of service mix and so we have developed a single premium at the specialty level. The CY 2026 update uses the same structure of specialty/service risk group as the previous update.

### Impute Premiums for CMS Specialties Not Included in PLI Filings

No CMS specialty was included in *all* available filings, although a few specialties were missing from only a couple of filings. Based on the notion of trying to represent the rate that each PLI insurer would charge a practitioner in each specialty, we determined that it was appropriate to impute premiums in some situations where a specialty was not listed on a PLI filing explicitly. In these cases, we accomplished this imputation by using the premium of a related specialty and service risk group within the same filing.[[18]](#footnote-19) Ultimately, we used imputation to address two general characteristics of the PLI premium data universe.

First, some CMS specialties are often used synonymously within PLI filings. For example, PLI filings often do not distinguish between the CMS specialties General Practice and Family Practice. If a PLI filing lists a premium for one of these specialties but does not explicitly report a premium for the other, we have assumed the listed premium applies to practitioners in *both* specialties. In the example above, we have used the General Practice rate as Family Practice in filings that did not explicitly report a Family Practice premium, *and vice versa*. This form of imputation within a PLI filing helps ensure that these specialties are treated consistently across PLI insurers. Table 8.C.1 lists the CMS specialties and service risk groups that were treated in this fashion when developing the analytic MP premium file.

Additionally, certain CMS specialties are broadly underrepresented in PLI filing data. We identified these specialties by first calculating the share of the U.S. population implicitly covered by each specialty as the sum of the product of population share times market share for each specialty across all filings. We then considered those CMS specialties for which this population share was below 20 percent or that were not included in *any* filings to be “underrepresented” and applied our imputation strategy to those specialties. To accomplish this, we created a map of CMS specialties that sensibly relate to a larger, more commonly reported specialty. In general, we relied on CMS’ standard regulation specialty impact table included with all PFS regulation notices—reproduced below as Table 8.A—to map CMS specialties to related specialties.[[19]](#footnote-20) For example, the CMS specialty of Sports Medicine is included in Family Practice in the policy impact table. As shown in Table 8.C.2, Family Practice/No Surgery is the source for Sports Medicine/All, meaning we have used the Family Practice/No Surgery rate as the rate for Sports Medicine in filings that did not explicitly report a Sports Medicine premium.

Some other underrepresented CMS specialties do not exist within the same “impact specialty” as another specialty that is more commonly reported in PLI filings, so there is not a natural alternative specialty to serve as a source for imputation. In these cases, we reviewed company filings that explicitly reported rates for each underrepresented specialty and determined which more commonly reported specialty was most frequently mapped to the same risk class within the filing.[[20]](#footnote-21) For instance, filings that explicitly reported premiums for Hospice and Palliative Care typically assigned that specialty to the same risk class as Internal Medicine. Therefore, we used the Internal Medicine rate as that for Hospice and Palliative Care in filings that did not explicitly report Hospice and Palliative Care, as shown in Table 8.C.2.

The overall imputation methodology is unchanged from the prior update, yet we have continued to refine the universe of specialties subject to imputation and the sources of imputation for each specialty described above, as appropriate. For the prior update, premium data for Geriatric Medicine, Hospitalist, Internal Medicine, Medical Oncology, Pain Management, and Preventive Medicine were all augmented with some imputed data, but sufficient data was collected for these specialties during this update such that imputation was deemed unnecessary. Additionally, Allergy/Immunology was previously used as the imputation source for both Osteopathic Manipulative Medicine and Addiction Medicine. For this update, more clinically similar specialties were used as the imputation source for these CMS specialties, as shown in Table 8.C.2.

Overall, this imputation strategy allows us to develop as complete an analysis premium file as feasible based on the original premium data without imputing values *across* filings. Further, it is consistent with the overall approach for other specialties of trying to represent the rate that the insurer would charge a practitioner in a specialty, given that the filing does not list the specialty explicitly. It also aims to maintain fidelity to actual PLI filing data by augmenting existing data with additional data rather than ignoring and replacing the data collected from underrepresented specialties entirely.

Premium data were developed for each filing based on imputing values for specialties that were incomplete across filings based on Tables 8.C.1 and 8.C.2 to produce a state/county/company/CMS specialty/service risk group-level analytic dataset of PLI rates. This dataset serves as the key data input for the MP GPCIs, as described in Section 4, as well as the malpractice risk index described in Section 5. The market share captured by the premium data by state is shown in Table 7.A, while Table 7.B shows the share of the U.S. population covered by the filings in the database by CMS specialty and service risk group, based on premium data from the filings and after imputation.

# Update of the CY 2026 GPCIs

The GPCI update process is comprised of the following components: data collection and acquisition, data development, measure creation and post-measure creation adjustments. Data collection involves acquiring the most recently available data of reasonable quality that are needed to update and calculate the CY 2026 GPCIs from various sources. Data development refers to the process of converting the data collected from CMS and public use files into county-level data that can be used to create the GPCIs. The measure creation component is the step in which the raw GPCIs are calculated at the locality level using the developed data from the prior step. Finally, post-measure creation adjustments required by current law are made to the raw budget-neutral values to finalize the payment GPCIs. Each component is described in more detail below, in reference to the CY 2026 update.

## Data Collection and/or Acquisition

Collecting the data underlying development of the GPCIs involves downloading and acquiring the data from a variety of sources. ARC updated several data elements through publicly available Department of Labor data and Census Department data as shown in Table 4.A.1, along with utilization data from CMS and malpractice premium data collected as described above.[[21]](#footnote-22)

Table 4.A.1: Summary of Elements Required for GPCI Calculation

| **COMPONENT** | **MEANING** | **SOURCE** |
| --- | --- | --- |
| Physician Work | Measures regional variation in physician wages | Bureau of Labor Statistics Occupational Employment and Wage Statistics (BLS OEWS) |
| Practice Expense – Employee Wages | Measures regional variation in the cost of hiring physician practice staff, excluding outsourced services | BLS OEWS |
| Practice Expense – Office Rents | Measures regional variation in the cost to rent physician offices | Census Bureau’s American Community Survey (ACS) |
| Practice Expense – Purchased Services | Measures regional variation in the cost of contracted services typically purchased by physicians | BLS OEWS, CMS labor-related classification, MEI |
| Practice Expense – Equipment and Supplies | Measures practice expenses associated with capital goods ranging from chemicals and rubber, to telephone and postage | No data required; 1.0 for all counties |
| Practice Expense – Total | Sum of employee wages, office rents, purchased services, and equipment and supplies | Component cost shares as shown in Table 4.A.2 below |
| Malpractice | Measures regional variation in cost of malpractice insurance | Malpractice premiums |

To develop the WORK GPCI, ARC used the May 2023 Bureau of Labor Statistics (BLS) Occupational Employment and Wage Statistics (OEWS) data.

The PE GPCI comprises four distinct components and incorporates various data sources. The first component of the PE GPCI, Employee Wages (EW), was updated using the BLS OEWS data. The second component, Purchased Services, was updated using BLS OEWS data and CMS labor-related classification data. Additionally, CMS provided data to determine the share of contracted services that physician practices purchase from different industries. ARC used the 2022 5-year data from the American Community Survey (ACS) to update the third PE GPCI component, Office Rent. The final component of the PE GPCI, Equipment and Supplies, does not vary by geographic area and therefore does not require a review of external data sources under the current methodology. CMS assumes a national market for such items and therefore assigns a value of 1.00 for this component in each PFS locality.

The MP GPCI is calculated using the malpractice premium data described above in Section 3, weighted by total WORK RVUs in each area.

### BLS OEWS Wage Data

The Bureau of Labor Statistics publishes OEWS data each year. The OEWS data include estimates of employment and wages for approximately 830 occupation categories at various geographic levels, including national, state, and metropolitan and nonmetropolitan areas. These data were used to update the WORK GPCI and two components of the PE GPCI: Employee Wage Index and Purchased Service Index. For the CY 2026 update, ARC downloaded the most recently available BLS OEWS data (May 2023).[[22]](#footnote-23) The May 2023 data file includes estimates from the following six semiannual panels: May 2023, November 2022, May 2022, November 2021, May 2021, and November 2020.[[23]](#footnote-24)

Additional information on the scope of the survey, the survey sample and estimation methodology can be found on BLS’ website.[[24]](#footnote-25) Details on BLS OEWS data acquisition can be found in Section 9 of the report.

### ACS Data

As discussed in previous GPCI reports, there is not a comprehensive public data resource for office rents in every US county. In the past, commenters have raised concerns about the use of residential, rather than commercial, rent. In the CY 2023 update, ARC described an analysis conducted of potential alternative data sources for the Office Rent Index, including potential public sources, such as the GSA and USPS, as well as various commercial sources of commercial rent data. Since ACS data are available in most areas and appear to be highly correlated with commercial rents, CMS concluded that they remain the most appropriate source for this element of the PE GPCI. This decision reflects the fact that the intention of the data is to capture geographic *variation* in rent, not the level of rent, so the correlation between commercial and residential values supports continued use of the latter. As a result, the Office Rent Index of the PE GPCI continues to use geographically complete data on residential rents from the American Community Survey (ACS) data.[[25]](#footnote-26)

The United States Census Bureau conducts the ACS each year. This survey includes data on various topics including social, housing, economic and demographic population characteristics. From this survey, ARC collected the 2022 ACS 5-year, county-level estimates on the median gross rent for 2-bedrooms for the CY 2026 update of the Office Rent Index. Section 9 of the report includes additional details on ACS data acquisition.

### RVU Data

The 2023 RVU data was provided by CMS. The data file is based on Medicare claims and includes Total RVUs, Total Physician Work RVUs, Total Practice Expense RVUs, and Total Malpractice RVUs at the zip code level. State and county codes are also included on the file.[[26]](#footnote-27)

### MEI Cost Share Weights

CMS provided the MEI cost share weights. As directed by CMS, we used the same MEI cost share weights that were used in the previous update. They are used to combine the four components of the PE GPCI and are shown in Table 4.A.2.

Table 4.A.2 PE GPCI: MEI Shares

| **PE GPCI ELEMENT** | **MEI SHARE** | **SHARE OF PE** |
| --- | --- | --- |
| Practice Expense – Employee Wages | 16.553 | 36.917 |
| Practice Expense – Office Rents | 10.223 | 22.799 |
| Practice Expense – Purchased Services | 8.095 | 18.053 |
| Practice Expense – Equipment and Supplies | 9.968 | 22.231 |
| Practice Expense – Total | 44.839 | 100 |

Source: CMS Office of the Actuary

Independent of this project, CMS examined the recently released Physician Practice Information (PPI) and Clinician Practice Information (CPI) survey data from AMA and Mathematica as a potential data resource for the work, practice expense, and malpractice expense shares required in PFS ratesetting process. In parallel, as part of this GPCI update, we examined how the direct and indirect components reported with those new data could map to the indices underlying the PE GPCI if CMS chose to use the new data, since the reported data do not align with the constituent parts of the PE GPCI. Given the layout of the data received, a proposed mapping for each PE index to the direct and indirect components of the PPI and CPI data would be required to calculate the shares for each PE index. The PPI and CPI data include labor, supplies and equipment (direct), as well as administrative, overhead, information technology and other (indirect).

In Table 4.A.3 below, the rows show the PPI/CPI data categories corresponding to direct (labor, supplies and equipment), and indirect (administrative, overhead, information technology and other). The columns lay out each of the PE GPCI components for which a mapping is required. The percentages in each cell propose a mapping for applying direct and indirect shares to each PE index, if the newly released PPI/CPI data were to be used by DPS for establishing shares.

Table 4.A.3 PE GPCI: Proposed Mapping for PPI/CPI Data Categories to PE Index Elements

| **PROPOSED SHARE OF PPI/CPI CATEGORY BY PE INDEX ELEMENT** | **PE** – **EMPLOYEE WAGES** | **PE** – **PURCHASED SERVICES** | **PE** – **OFFICE RENT** | **PE** – **EQUIPMENT AND SUPPLIES** |
| --- | --- | --- | --- | --- |
| Clinical Labor | 100% | 0% | 0% | 0% |
| Supplies | 0% | 0% | 0% | 100% |
| Equipment | 0% | 0% | 0% | 100% |
| Administrative | 0% | 50% | 50% | 0% |
| Overhead | 0% | 50% | 50% | 0% |
| Information Technology | 0% | 100% | 0% | 0% |
| Other | 0% | 50% | 50% | 0% |

As shown in the table above, if CMS chooses to use the new data, we propose assigning 100% of the clinical labor to *PE index: Employee Wages*, and 100% of supplies and equipment to *PE index: Equipment and Supplies*. *PE index: Office Rent* would be assigned 50% of administrative, overhead, and other (indirect), and *PE index: Purchased Services* would be assigned 50% of administrative, overhead, and other and 100% of information technology.

Given the mapping to PE Index elements shown in Table 4.A.3 above and the PPI/CPI data reported to CMS, ARC calculated the direct and indirect totals (weighted by total RVUs) for each PE GPCI element. The resulting shares of PE are shown in Table 4.A.4 below. Since the *PE index: Equipment and Supplies* element is constant across all areas, the drop in its share of the PE GPCI would possibly lead to more variation in the GPCI across payment areas. If different PPI/CPI data or weights are used, the share of PE would be different than shown here.

Table 4.A.4 PE GPCI: Weights Derived from PPI and CPI Survey Data

| **PE GPCI ELEMENT** | **DIRECT/INDIRECT TOTAL** | **SHARE OF PE** |
| --- | --- | --- |
| Practice Expense – Employee Wages | 38.78 | 25.476% |
| Practice Expense – Office Rents | 46.35 | 30.449% |
| Practice Expense – Purchased Services | 53.76 | 35.317% |
| Practice Expense – Equipment and Supplies | 13.34 | 8.764% |
| Practice Expense – Total | 152.22 | 100% |

Note: Direct/Indirect Total is weighted by total RVUs.

ARC will continue to work with CMS to determine the most appropriate mapping for use if the new PPI/CPI data are to be used in future updates. As stated above, this 2026 update retains the same shares as those used in the 2023 update.

### CMS Labor-Related Classification

Finally, the labor-related classification data was provided by CMS for use in creating the Purchased Services Index of the PE GPCI. Two groups of purchased services, “Professional Services” and “Other Services,” are defined by CMS using NAICS codes. These industry codes identify the occupations for which OEWS data will be used to capture geographic variation in costs associated with purchased services. This CY 2026 update uses the same labor-related classification data as the previous update.

## Data Development and Measure Creation

The GPCIs are intended to capture geographic variation. The underlying data are used to create these measures based on weights that combine the information about variation in a way that can be used to adjust PFS payments in the Medicare Fee Schedule areas. Therefore, the key elements of data development and measure creation, in addition to the data collection/acquisition process described above, are weights and geographic definitions.

ARC created a database of geographic crosswalks and potential weights, including population and Medicare PFS RVUs. The key geographic measures include counties, states, Medicare payment localities, and various definitions of metropolitan area. This geographic database is designed to facilitate the creation of the GPCIs and can be used as a resource to examine changes to the weights and to the definition of localities.

Beginning in 2022, the US Census Bureau adopted nine new Planning Regions as county-equivalent geographic units in Connecticut, replacing the eight legacy counties that were previously used. ACS population and rent data and CMS RVUs underlying the GPCI calculation reflect this change. While developing updated MP premium data for the MP risk index and MP GPCI, we were also able to summarize premiums by these regions. However, the most recent BLS OEWS wage data used to create the work and PE GPCIs are based on the legacy counties. As a result, it was necessary to develop a strategy to crosswalk data between the two geographic constructs, shown in Table 8.G. Since the wage data are the key measure of interest for the work and PE indexes, we have crosswalked the planning region-level population weights to the county to create these two GPCIs. For example, the Lower Connecticut River Valley includes all Middlesex county, as well as part of New London county, which is also part of two other planning regions, Southeastern CT and Northeastern CT. According to the crosswalk, 95 percent of the region’s population is in Middlesex and the remaining 5 percent in New London, so the region’s weights are apportioned accordingly. The state constitutes a single payment area, so the change in underlying geographic units does not require developing a way to map data onto new substate PFS payment areas.

Additional details on acquiring the geographic data are in Section 9 of the report. The sections below provide details on the data development and measure creation processes for each of the GPCIs, which follow previous policies except as noted.

### Physician Work GPCI

The WORK GPCI captures the relative cost of physician and non-physician practitioner labor across Medicare payment localities. Since Medicare payments account for sizable share of practitioner revenue, use of physician and other practitioner wages to create the WORK GPCI would end up being circular in nature, with Medicare policy influencing geographic patterns in wages that are then used to establish geographic adjustment factors of Medicare payments. Instead, a set of occupation groups representing a variety of professionals are used in the calculation. This allows the GPCI to reflect differences in living and other costs faced by practitioners in different areas, since other highly educated professionals face similar costs, and avoids the endogeneity of using practitioner wages directly.

As new data are released, existing codes can be redefined or deleted and new codes added. For the CY 2023 update, we conducted an in-depth review of the occupation codes and groups and ultimately moved from seven to nine occupation groups.[[27]](#footnote-28) For this update, we used data from the same nine occupation groups as the CY 2023 update, including (1) Architecture and Engineering, (2) Computer, Mathematical, Life and Physical Science, (3) Social Science, Community and Social Service and Legal, (4) Education, Training and Library, (5) Registered Nurses, (6) Pharmacists, (7) Art, Design, Entertainment, Sports and Media, (8) Management and (9) Business and Financial Operations.[[28]](#footnote-29) Table 8.D.1-Table 8.D.6 list the occupation codes included in each of the nine occupation groups, and Table 8.D.7 includes a summary of changes to codes from the May 2020 BLS OWES data to the May 2023 BLS OWES data. Based on our review of the current codes, we have added 25 new occupation codes and removed 12.

Over time, the expanding list of codes included in the WORK GPCI has become unwieldy, including codes that are missing in many counties, making it difficult to analyze underlying trends over time. As a result, we examined a more systematic way to create a consolidated set of occupation codes for use in calculating the WORK GPCI. Currently, CMS aims to include a set of proxy occupation groups representing a variety of highly educated professionals in the WORK GPCI calculation. As a result, each GPCI update requires reviewing new and modified occupation codes for any that may meet this vague criterion. In addition, CMS has not historically considered the *completeness* of the data available for each occupation code, which can lead to inclusion of codes that are not widely available across all counties.

As a result, we explored an approach to condense the list of occupation codes using two criteria: educational attainment based on published data and data completeness. Use of a more parsimonious set of occupations could be an improvement in the update process, if it results in essentially the same GPCI values with increased simplicity and clarity for stakeholders and analysts.

We used BLS’s *Educational attainment for workers 25 years and older by detailed occupation*[[29]](#footnote-30) to measure the percentage of workers in each occupation code that attained various levels of education. Because it is a BLS data source, the occupation codes align with the occupation codes in the wage data file that is used in calculating the WORK GPCI. The file provides options for selecting up to seven different levels of educational attainment including: less than high school diploma, high school diploma or equivalent, some college/no degree, Associate's degree, Bachelor's degree, Master's degree, or Doctoral or professional degree. CMS could choose to set an educational attainment level for inclusion of occupation codes based on these reported categories.

We also examined how comprehensively occupation codes are represented in the BLS OEWS data. For an occupation code to provide actual information about geographic variation in the WORK GPCI calculation, it should be well represented and have wage data available across many US counties. We examined data completeness under various thresholds of data existence to get a sense of how different values affect resulting index values. CMS could establish a data completeness level to avoid including occupation codes for which available data are too sparse to provide meaningful information in the WORK GPCI calculation.

Using these two criteria with clearly established education and data completeness thresholds would narrow the list of occupation codes used to calculate the WORK GPCI in a systematic way that could be easily replicable each year and transparent.

More information on the proposed process and examples of alternatives under this methodology can be found in Section 10. ARC will continue to work with CMS to determine appropriate thresholds for educational attainment and data existence and will also continue analytics on the potential effect of using a consolidated set of occupation codes on the WORK GPCI.

#### Physician Work GPCI Data Development

The source data for calculating the WORK GPCI is the BLS OEWS data, which includes counts of employment and various statistics on wages by occupation code. To develop the data needed to create the WORK GPCI, ARC created a national level (all U.S. as a whole and all industries combined) file with the BLS OEWS data for the list of occupations included in the WORK GPCI. Median wages from this file were used to impute missing median wages at the county level. Next, a cross-industry metropolitan statistical area (MSA)-level wage file was created for the WORK GPCI occupation codes that maps MSAs to counties, using BLS area definitions. If the median wage for an occupation was missing in a county, we used the national median wage for that code to impute. Since the occupation wage can vary by industry within a county, ARC computed county median wages for each WORK GPCI occupation code as the total employment weighted average of the median industry-occupation code level wage.

#### Physician Work GPCI Measure Creation

The calculation of the WORK GPCI starts with county-level average hourly earnings by occupation group. National average hourly earnings for each occupation were then calculated by weighting the county-level average with physician work RVUs in each county. By taking the ratio of the county average to the national average, a wage index was constructed for each occupation group at the county level. The occupation-specific wage index was then weighted by each occupation group’s share of the total national wage bill and synthesized into a county-level wage index.

Next, we calculated the Medicare locality level wage index by weighting the county-level wage index with total physician work RVUs in the county. By law, the maximum variation in the WORK GPCI incorporated in the PFS is 25 percent of the full variation, so the locality-level wage index was adjusted accordingly.

### Practice Expense GPCI

The PE GPCI captures the relative cost of operating a physician practice by Medicare locality. It is the weighted average of four components: the cost of employee wages, purchased services, equipment and supplies, and office rent. The weights for each index are based on their shares reported in Table 4.A.2 above. These indices are described in more detail below.

#### Employee Wage Index Data Development

The data development needed to construct the EW Index follows a similar pattern to the data development steps for the WORK GPCI. ARC created a national level file with the BLS OEWS data for the occupations that comprise the total non-physician wages in the Offices of Physicians industry.[[30]](#footnote-31) Next, a cross-industry MSA-level wage file was created for the EW occupation codes that maps MSAs to counties, using BLS area definitions. If the median wage was missing, then the national median wage for a given occupation code was used. Since counties can cross MSAs, ARC computed the total employment weighted average of MSA median wages as the county median wages. Occupations for which BLS does not report a national median wage were excluded, since they were missing data in most counties and the absence of a national median implies that there were not enough data available nationwide to report a reliable estimate.

#### Employee Wage Index Measure Creation

The methodology for creating the EW Index is similar to that for the WORK GPCI. A national average hourly wage was constructed for each occupation by weighting the county-level average hourly earnings by occupation with county-level PE RVUs. The county-level average hourly earnings by occupation were then indexed to the national average. The occupation-specific wage index was then weighted by each occupation’s share of the total wage bill and synthesized into a county-level wage index. The final step is to calculate the Medicare locality level wage index by weighting the county-level wage index with total PE RVUs in the county.

#### Purchased Services Index Data Development

The data development for the Purchased Services Index is similar to the process described above for the data development for the Employee Wage Index, except the occupations reflect contracted services/occupations typically purchased by physicians, such as accounting, information technology, and legal services. ARC created a national level file with the BLS OEWS data for the occupations that are considered purchased services. Next, a cross-industry MSA-level wage file was created for the EW occupation codes that maps MSAs to counties, using BLS area definitions. If the median wage was missing, then the national median wage for a given occupation code was used. Since counties can cross MSAs, ARC computed the total employment weighted average of MSA median wages as the county median wages.

#### Purchased Services Index Measure Creation

The measure creation for the Purchased Services Index follows a methodology similar to the Employee Wage Index, but the calculation uses a slightly different approach for weighting.

A national average hourly wage was constructed for each occupation included in the Purchased Services Index by weighting the county-level average hourly earnings by occupation with county-level PE RVUs. The county-level average hourly earnings by occupation were then indexed to the national average. The occupation-specific wage index was then weighted by each occupation’s share of the total wage bill and synthesized into a county-level wage index. The Medicare locality level wage index was calculated by weighting the county-level wage index with total PE RVUs in the county.

#### Equipment and Supplies Index Data Development

No data development is needed for the Equipment and Supplies Index. The final component of the PE GPCI, Equipment and Supplies, does not vary by geographic area and therefore does not require updating.

#### Equipment and Supplies Index Measure Creation

The Equipment and Supplies Index is set to 1.0 because CMS assumes that these inputs are purchased on a national market and that any geographic variation is negligible.

#### Office Rent Index Data Development

To develop the data needed to create the Office Rent Index, ARC used the 2022 ACS 5-year, county-level estimates on the median gross rent for 2-bedrooms. The ACS data file does not have estimates for the median gross rent for 2-bedrooms for select counties. ARC contacted the U.S. Census Bureau to request data for these counties but did not receive additional data for any of the missing counties at the time of this report. Therefore, in the data development process, ARC imputed county-level rent estimates using the average value for a given county’s MSA. Table 8.E includes the list of the counties that are missing estimates and their imputed values.

#### Office Rent Index Measure Creation

The Office Rent Index is calculated as the ratio of the median gross rent for 2-bedrooms in a county to the average median gross rent for 2-bedrooms nationally. The denominator was calculated as the median gross rent for 2-bedrooms across all counties, weighted by each county’s total Practice Expense RVUs. The county-level rent index was then consolidated to Medicare payment locality level using Practice Expense RVUs as weights.

### Malpractice GPCI

The MP GPCI captures differences in malpractice insurance premiums, which vary by specialty and surgical category.

#### Malpractice GPCI Data Development

As described in the previous section, ARC created a new PLI premium dataset that includes data for multiple insurers for many specialties in each county. To create the MP GPCI, these data were summarized to one value per county. This was accomplished in two steps:

1. A state/county/specialty summary of PLI rates was created as the weighted average of filing rates in each county, where the weights are the company’s share of the state’s PLI market at the specialty level;[[31]](#footnote-32)
2. A single county-level PLI rate was created in each county as the weighted average of the specialty rates within the county, with the weight given by the specialty’s share of malpractice RVUs in the state as captured in a previous year’s claims data, based on data provided by CMS.

The resulting file has a single rate for each state and county, as required for calculating the MP GPCI.

#### Malpractice GPCI Measure Creation

The county-level MP premiums were weighted by the county’s total malpractice RVUs to establish the national average premium. The county-level MP index was constructed as the ratio of the county-level value to the national average premium. Because PFS payments are determined by Medicare payment locality, which covers one or more counties, the county-level MP index was then aggregated to the Medicare locality level using total MP RVUs in each county as weights.

### Geographic Adjustment Factor

The Geographic Adjustment Factor (GAF), as shown in Equation 4.B.4 synthesizes the WORK, PE, and MP GPCIs and illustrates the overall price differences over time and across geographic areas.

Equation 4.B.4: For each locality, L:

It is calculated as the weighted average of the three GPCIs (WORK, PE, and MP), essentially representing the net geographic adjustment of “the typical service.”

The GAF is not used for payment under the PFS but is a useful measure to understand the overall effect of geographic adjustment across Medicare payment areas. As in the CY 2023 update, the weights used in calculating the CY 2026 GAF reflect the share of total RVUs that each component accounts for in the actual Medicare utilization from CY 2023. The use of actual utilization as weights more accurately reflects the actual effect of geographic adjustment on payment than the MEI weights that were set more than 15 years ago and used in GPCI updates prior to 2023. The relative share of total RVUs due to work, PE, and MP reflects the shares used by CMS when setting the RVUs for provider services and utilization under those values. Whenever CMS resets the shares of work, PE, and MP in the ratesetting processes, whether based on MEI weights or some other data source, these utilization-based weights will move toward the ratesetting shares.

## Post-Measure Creation Adjustments

After the raw GPCIs are calculated, several adjustments are applied. These include an adjustment for territories, budget neutrality, a hold-harmless policy for select California localities, a two-year transition from the current and newly updated GPCIs through a 50/50 blend in the first update year, and other legislative adjustments. These are presented in the order in which they are calculated, since the results are order-dependent.

### Adjustments for Territories

Consistent with previous updates, Puerto Rico and the Virgin Islands are assigned the GPCI value of 1.00 for each index. The Pacific Island territories are assigned the Hawaii locality values.

### Budget Neutrality

The WORK, PE and MP GPCIs are subject to a budget neutrality adjustment. This ensures that total PFS payments do not change as the result of the updated GPCIs. Budget neutrality is achieved by creating a base pool of total RVUs adjusted by current GPCIs and a new pool of RVUs adjusted by updated GPCIs, and then multiplying the newly-calculated GPCIs by the ratio of the base to new pool. For this calculation, CMS has provided WORK, PE, and MP RVUs from CY 2023 which have been used to scale the GPCIs so that they result in the same RVU-weighted sum as the current GPCIs for each of the three relative value scales (WORK, PE, and MP). The payment GPCIs are based on these budget-neutral GPCIs, subject to the following additional adjustments that occur outside budget neutrality.[[32]](#footnote-33)

### California Localities

The definition of California’s payment areas was modified by Section 220 (h) of the Protecting Access to Medicare Act (PAMA) of 2014, moving to an MSA-based set of areas and increasing the total number of areas in the state from 9 to 27. The law also described a process of transitioning payments for some areas in the state over a five-year period from 2017 to 2021 to avoid large abrupt payment changes due to the redefinition. This transition policy applied to the new California localities (areas located in prior localities 03 Marin/Napa/Solano and 99 Rest of California) as indicated in Table 8.F. Since the transition period is finished, this step is not applied to the updated 2026 values.

The law also includes a hold harmless provision which remains in effect, so the value in a transition area cannot be less than the value that would have been in force absent the change in locality definition. As a result, we created budget-neutral GPCIs for the historic localities. These values for the California transition areas establish the GPCI for payment purposes, to comply with the requirements of Section 220 (h) of the PAMA of 2014.

While the intention of PAMA was to develop payment areas based on the 27 MSAs in California, CMS created 29 areas to reflect the interaction of the transition and hold harmless provisions, previous payment area boundaries, and MSAs.[[33]](#footnote-34) Specifically, the San Jose-Sunnyvale-Santa Clara MSA is comprised of two counties (San Benito and Santa Clara) that spans two unique CMS payment areas prior to PAMA (prior CMS localities 09 and 99). As shown in Table 8.F, San Benito County is a transition area while Santa Clara County is not, so these areas may be assigned different GPCIs through the permanent hold harmless provision despite existing within the same MSA. A similar situation exists for the San Francisco-Oakland-Berkeley MSA, where Marin County is a transition area which the other four counties (Alameda, Contra Costa, Marin, San Francisco, and San Mateo) are not. CMS created four locality areas for the seven affected counties discussed above to allow for the possibility of different GPCIs within these MSAs.

In summary, there will be, at most, 29 unique GPCI values among the 27 MSAs in California as long as the hold harmless provision is in effect: the San Francisco-Oakland-Berkeley MSA except Marin County (CMS localities 05), Marin County (CMS locality 52) within the San Francisco-Oakland-Berkeley MSA, Santa Clara County (CMS locality 09) within the San Jose-Sunnyvale-Santa Clara MSA, San Benito County (CMS locality 65) within the San Jose-Sunnyvale-Santa Clara MSA, and each of the remaining 25 MSA-based areas (all other CMS localities).

### 50/50 Blend

The proposed 2026 GPCIs are calculated as two-year transition values using a 50/50 blend of the current GPCIs and the GPCIs based on the updated data. This two-year transition is designed to avoid large changes when data are updated, as required by Section 1848(e)(1)(C) of the Social Security Act.

### Other Legislative Adjustments

There are two other legislatively mandated adjustments to the GPCIs that are used for payment:[[34]](#footnote-35)

* WORK GPCI floor for Alaska of 1.5 (SSA Section 1848(e)(1)(G)); and
* PE GPCI floor of 1.0 in frontier states, which include Montana, Nevada, North Dakota, South Dakota, and Wyoming.[[35]](#footnote-36) (SSA Section 1848(e)(1)(I)).

The updated payment CY 2026 GPCIs reflect these two adjustments as required by current law.

## Comparison of Updated CY 2026 GPCI Values by Locality to Existing Values and Expected Effect on Distribution of Payments

The transition GPCIs for 2026 based on updated source data produce fairly modest changes to the 2026 GAF, as shown in Table 4.D.1. Compared to 2025, the 2026 GAF changes by less than half of a percent in 61 localities that collectively account for about 54 percent of total RVUs, and no locality had a GAF change of more than 4 percent.

The expiration of the 1.0 WORK GPCI floor in all areas other than Alaska leads to a slight downward shift in the distribution of WORK GPCIs. For example, proposed WORK GPCIs in 13 localities are at least 1.5 percent less than their 2025 values. Under the previous 1.0 floor, these localities would have experienced no change to their WORK GPCIs. But otherwise, changes to WORK GPCIs were relatively modest. The proposed 2026 WORK GPCI in 53 areas is less than 0.5 percent different from their 2025 values. These areas account for about 39 percent of work RVUs. The presence of the 1.5 floor in Alaska, along with the limitation of the measure to only 25 percent of the variation in the underlying measures, limit the range of change that can occur in the work GPCI with updated data.

The change from 2025 PE GPCIs to those proposed for 2026 has a broader distribution, with 3 payment areas, accounting for approximately 10 percent of PE RVUs, experiencing an increase of over 1.5 percent while 4 areas decline over 1.5 percent.

The 2026 MP GPCI is more different from 2025, with 3 areas showing a drop of over 10 percent and 5 areas growing by 10 percent or more. Overall, the MP GPCI exhibits slightly less change in this update than in the update three years ago. For example, under the last update, 22 areas accounting for almost 20 percent of MP RVUs had change of more than 10 percent (increase or decline), while under this update only 8 areas accounting for about 6 percent of MP RVUs would experience a change percent of more than 10 percent. Table 7.D.1 presents all of the updated 2026 GPCIs and GAF by locality.

Table 4.D.1: Distribution of Change under Updated GPCIs and GAF, by Count of Localities and Share of RVUs, Transition Values for 2026 compared to 2025 Values

| **SIZE OF CHANGE IN MEASURE** | **WORK GPCI:**  **N** | **WORK GPCI: %WORK RVUs** | **PE GPCI: N** | **PE GPCI: % PE RVUs** | **MP GPCI:**  **N** | **MP GPCI: % MP RVUs** | **GAF: N** | **GAF:**  **% Total RVUs** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| < -10% | 0 | 0.00% | 0 | 0.00% | 3 | 1.49% | 0 | 0.00% |
| -10% to < - 4% | 0 | 0.00% | 0 | 0.00% | 40 | 21.47% | 0 | 0.00% |
| -4% to < -1.5% | 13 | 11.53% | 4 | 3.96% | 27 | 30.98% | 2 | 1.15% |
| -1.5% to < -0.5% | 36 | 44.67% | 25 | 30.73% | 5 | 5.76% | 39 | 40.20% |
| -0.5% to < 0.5% | 53 | 38.82% | 48 | 32.44% | 10 | 10.68% | 61 | 53.62% |
| 0.5% to < 1.5% | 7 | 4.98% | 29 | 22.66% | 3 | 2.86% | 7 | 5.03% |
| 1.5% to < 4% | 0 | 0.00% | 3 | 10.21% | 9 | 15.83% | 0 | 0.00% |
| 4% to < 10% | 0 | 0.00% | 0 | 0.00% | 7 | 6.28% | 0 | 0.00% |
| 10% or more | 0 | 0.00% | 0 | 0.00% | 5 | 4.66% | 0 | 0.00% |

Source: ARC analysis of proposed 2026 GPCIs/GAFs

Another way to examine the effect of the new data on the GPCIs is to consider shifts in relative rankings of localities by GPCI and GAF. This can be done fairly simply by comparing the quintile placement of localities under current values to that which they would have under the updated values. As shown in Table 4.D.2, 99 (the sum of the diagonal cells) of the 109 localities have 2026 GAFs that are in the same quintile as their 2025 value. Of the remaining 10 localities, none moved more than one quintile. The 99 localities that remain in the same quintile under the updated GAF as they had been under current values account for about 87 percent of total RVUs under the PFS.

Table 4.D.2: Distribution of Localities by Current GAF Quintiles by Updated GAF Quintiles

| **# OF STATE/ LOCALITIES** | | **2026 GAF** | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| 1ST QUINT. | 2ND QUINT. | 3RD QUINT. | 4TH QUINT. | 5TH QUINT. |
| **2025 GAF** | 1ST QUINT. | 21 | 0 | 0 | 0 | 0 |
| 2ND QUINT. | 1 | 19 | 2 | 0 | 0 |
| 3RD QUINT | 0 | 2 | 16 | 1 | 0 |
| 4TH QUINT. | 0 | 0 | 0 | 23 | 2 |
| 5TH QUINT. | 0 | 0 | 0 | 2 | 20 |

Source: ARC analysis of proposed 2026 GPCIs/GAFs

Note: Quintiles are defined from lowest to highest, so the lowest GAFs are in the 1st quintile.

# Update of the Malpractice Risk Index

As described in Section 3 above, the base malpractice premium file includes rates for CMS specialties and service risk groups from multiple insurers in each county. As described in Section 4, these premium data support the creation of the MP GPCI, which captures geographic variation in malpractice premiums. These same data are used to calculate the MP Risk Index, a measure that reflects the relative malpractice risk across CMS specialties (and service risk group, as appropriate) at the national level. The MP Risk Index values by specialty are then used as the basis for developing service-level MP RVUs.

This section describes the process—unchanged from the prior update— of creating the MP risk index with the updated premium data and examines the expected effect on MP RVUs.

## County-level Specialty/Service Risk Group Price-adjusted Rates

The base rate data includes premiums for multiple insurers in each county, so the first step in developing the risk index is to create a single county-level rate for each CMS specialty/class. For each specialty/service risk group, the weighted mean premium was calculated in each county, where the weight is the company’s market share. The resulting rates were then adjusted for geographic variation as captured by the MP GPCI. The current GPCI (i.e., CY 2025 MP GPCI) was used for this adjustment.

## National Specialty/Service Risk Group Rates

A single set of national rates by specialty/service risk group was calculated as the weighted mean of the county-level specialty/service risk group rates, with the weights given by the county’s population.

## Calculating Specialty/Service Risk Group Risk Index

Consistent with previous policy, the risk index value for each specialty is expressed as the ratio of the specialty’s national premium to the volume-weighted national average premium across all specialties. Risk index values less than one correspond to specialties with relatively lower malpractice risk than average, and values greater than one correspond to specialties with relatively higher malpractice risk. The volume-weighted national average premium was calculated as the sum of the product of the national average premium and total 2023 PE and WORK RVUs for each specialty/service risk group, then dividing by total 2023 PE and WORK RVUs across all specialties.[[36]](#footnote-37)

## Comparison of Updated CY 2026 Risk Index to Existing Values and The Expected Effect on MP RVUs

Table 7.C shows the specialty/service risk group standardized national premiums and risk index values calculated from the data collection and development processes described above.

Although premiums changed more for some specialties than for others, when weighted by Medicare RVUs, the national average premium across all specialties/service risk groups increased about 1 percent as a result of the 2026 update. This change was not uniform by specialty. Weighted by Medicare RVUs, premiums for non-surgical and OB risk classes increased by roughly 6% on average. In contrast, premiums for surgical risk classes generally remained flat and premiums for specialties with a single risk class declined slightly.

There was relatively little change in relative premiums, based on a comparison of quintiles of current and 2026 standardized national premiums by specialty/service risk group, as shown in Table 5.D.1. Eighty-four (sum of the diagonal cells) of the 104 specialty/service premiums that can be directly compared between 2023 and 2026 are in the same quintile both years; these specialties account for nearly 93 percent of the WORK and PE RVUs provided by the practitioners included in the table. Of the remaining specialties, all but one—Obstetrics/Gynecology (No Surgery)—shifted into an adjacent quintile.

Table 5.D.1: Distribution of Specialty/Service Risk Group National Premiums by Quintiles for Current National Premiums by Those for Updated National Premiums

| **# SPECIALTY / RISK SERVICE GROUPS** | | **UPDATED 2026 NATIONAL PREMIUM** | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| 1ST QUINT. | 2ND QUINT. | 3RD QUINT. | 4TH QUINT. | 5TH QUINT. |
| **CURRENT NATIONAL PREMIUM** | 1ST QUINT. | 18 | 5 | 0 | 0 | 0 |
| 2ND QUINT. | 1 | 15 | 3 | 1 | 0 |
| 3RD QUINT | 0 | 1 | 18 | 3 | 0 |
| 4TH QUINT. | 0 | 0 | 0 | 16 | 6 |
| 5TH QUINT. | 0 | 0 | 0 | 0 | 17 |

Note: Quintiles are defined from lowest to highest, so the lowest premiums are in the 1st quintile.

Given the relative consistency in the process of collecting PLI data and calculating the MP risk index compared to prior updates, the observed changes in national average premium by specialty predominantly reflect changes in the underlying PLI rates rather than methodological changes. The increase in the national premium for Obstetrics/Gynecology (No Surgery), in particular, signifies a recent broader trend in underlying PLI premiums for practitioners providing obstetric and gynecological services. The national premiums for Obstetrics/Gynecology (Surgery), Obstetrics/Gynecology (OB), Family Practice (OB), and General Practice (OB) each increased by 5% or more, and the national premium for Certified Nurse Midwife rose more than 12%. Consequently, all five of these specialties shifted into a higher quintile.

The shifts of some other specialties into adjacent quintiles were at least partly the consequence of refinements to the imputation strategy, as discussed in section 3.G.3 above. For Osteopathic Manipulative Medicine and Addiction Medicine, more clinically similar specialties were used as the imputation source. For the prior update, premium data for Geriatric Medicine (Surgery), Pain Management, and Medical Oncology were all augmented with imputed data, but sufficient data was collected during this update that imputation was deemed unnecessary. The resulting updated national premiums changed relative to the prior update for these specialties, but the updated premiums are more reflective of the actual malpractice risk that practitioners in these specialties face through more extensive data collection and more appropriate assignment of specialties for imputation.

Since the national premiums affect the calculation of MP RVUs, it is also useful to also examine the expected effect of these new data on MP RVUs. For this analysis we recalculated MP RVUs using the CY 2023 and CY 2026 risk index values and all of the same input files as used to create the values for the 2025 Final Rule. The impact on MP RVUs from updated premiums is relatively modest. MP RVUs in most specialties compared with pre-update values changed by no more than 1 percent. The standard impact table CMS uses to report the effect of changes in PFS values shows impacts of 1 percent or more in MP RVUs for three specialties (table not shown):

* One impact specialty had an overall MP RVU increase of 1 percent in the impact table: Emergency Medicine.
* Two impact specialties showed a 1 percent decrease: Clinical Psychologist and Clinical Social Worker.

The estimated changes in MP RVUs for these specialties are consistent with, yet more muted, than observed changes in relative underlying PLI premiums. For Emergency Medicine, national average premiums increased by 19% for practitioners in the No Surgery service risk group and 17% for the Surgery service risk group. Meanwhile, specialists in Psychology and Social Work experienced decreases by 3% or more on average, contrary to the modest overall increase in national average premiums across the PLI landscape as a whole.

Another way to examine the effect of the updated risk index values on MP RVUs is to analyze shifts in relative service-level RVUs from current values to those that were obtained with the updated risk index. Instead of comparing quintiles, as we did with the premium data, we have categorized current and updated MP RVUs into deciles, producing the distribution shown in Table 5.D.2. Overall, the MP RVUs of over 95 percent (the sum of diagonal cells) of services stayed in the same decile after the update. For services with MP RVUs moving out of their pre-update decile, only 0.2 percent of services moved up or down by more one decile. Among all services with MP RVUs remaining in the same decile, their volume-weighted MP RVUs account for 99.4 percent and 99.5 percent of total MP RVUs before and after the update, respectively (data not shown). The relatively stable ranking of MP RVUs before and after the risk index update is consistent with what is shown in the modest specialty impacts described above and suggests that data updates for 2026 have measurable but generally moderate effects on MP RVUs.

Table 5.D.2: Distribution of CY2025 MP RVUs, by Decile, by MP RVUs Based on Updated Risk Index, by Decile

| **DECILES OF MP RVUs from CY 2025 Final Rule** | **DECILES OF MP RVUs CALCULATED WITH UPDATED RISK INDEX** | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ALL | 1ST DEC. | 2ND DEC. | 3RD DEC. | 4TH DEC. | 5TH DEC. | 6TH DEC. | 7TH DEC. | 8TH DEC. | 9TH DEC. | 10TH DEC. |
| ALL | 100 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 |
| 1ST DECILE | 10 | 9.84 | 0.15 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2ND DEC. | 10 | 0.04 | 9.70 | 0.26 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 3RD DEC. | 10 | 0 | 0.16 | 9.52 | 0.33 | 0 | 0 | 0 | 0 | 0 | 0 |
| 4TH DEC. | 10 | 0.02 | 0 | 0.22 | 9.44 | 0.32 | 0 | 0 | 0 | 0 | 0 |
| 5TH DEC. | 10 | 0 | 0 | 0 | 0.23 | 9.44 | 0.33 | 0 | 0 | 0 | 0 |
| 6TH DEC. | 10 | 0.04 | 0 | 0 | 0 | 0.21 | 9.35 | 0.40 | 0 | 0 | 0 |
| 7TH DEC. | 10 | 0 | 0 | 0 | 0 | 0.03 | 0.25 | 9.37 | 0.35 | 0 | 0 |
| 8TH DEC. | 10 | 0 | 0 | 0 | 0 | 0 | 0.06 | 0.22 | 9.40 | 0.32 | 0 |
| 9TH DEC. | 10 | 0.04 | 0 | 0 | 0 | 0 | 0.01 | 0.01 | 0.25 | 9.49 | 0.20 |
| 10TH DEC. | 10 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0.20 | 9.79 |

Note: Deciles are defined from lowest to highest, so the lowest MP RVUs are in the 1st decile.

# Conclusions

This report describes the process used to collect malpractice premium data and then update the GPCIs and MP risk index for 2026, as required by law. Overall, the inclusion of updated data did not lead to much change in the GAFs that would obtain under the updated 2026 GPCIs, with only 9 payment areas experiencing an increase or decrease of more than 1.5 percent. The updated MP risk index also leads to relatively modest changes in MP RVUs, with all but three specialties experiencing shifts of less than 1 percent. Methodologically, this update mimics the previous one with modest changes, such as a slight refinement to how malpractice premiums are imputed when missing for a handful of specialties, and an updated mix of occupations in the wage data used in the WORK and PE GPCIs. As a result, changes in this update of the GPCIs are more directly the result of changes in the underlying data (malpractice premiums, wages, rents) than in the previous updates, when a number of methodological improvements were implemented. The updated MP GPCI differs more from the current GPCI than the other two GPCIs do, with the WORK GPCI updates the most modest, reflecting the policy constraints on how much it can vary.

# Data Tables

This section reports locality-level and specialty-level measures of data characteristics and the final measures of interest.

## Malpractice Insurance Market Share of Filings Captured, by State

The state market share data are reported at the insurance group level, so we have reported the number of groups for which we obtained filings. Many groups offer policies under more than one company within a state, and some companies file more than one filing with different combinations of specialties, for example. Therefore, we obtained many more filings per state than the number of groups.

TABLE 7.A: Number of Insurer Groups and Total Market Share of PLI Filings Captured in Updated Premium Data, by State

| **STATE** | **# OF INSURER GROUPS** | **MARKET SHARE CAPTURED** |
| --- | --- | --- |
| AL | 3 | 58% |
| AK | 3 | 55% |
| AZ | 3 | 52% |
| AR | 4 | 48% |
| CA | 4 | 46% |
| CO | 2 | 53% |
| CT | 4 | 30% |
| DE | 3 | 62% |
| DC | 3 | 51% |
| FL\* | 4 | 50% |
| GA | 3 | 51% |
| HI | 4 | 52% |
| ID | 4 | 50% |
| IL | 4 | 54% |
| IN | 4 | 53% |
| IA | 3 | 62% |
| KS | 3 | 56% |
| KY | 4 | 54% |
| LA | 2 | 54% |
| ME | 1 | 67% |
| MD | 4 | 41% |
| MA | 4 | 34% |
| MI | 4 | 29% |
| MN | 3 | 51% |
| MS | 4 | 34% |
| MO | 2 | 50% |
| MT | 4 | 45% |
| NE | 3 | 62% |
| NV | 4 | 51% |
| NH | 4 | 48% |
| NJ | 3 | 56% |
| NM | 4 | 58% |
| NY | 3 | 58% |
| NC | 4 | 45% |
| ND | 2 | 52% |
| OH | 4 | 55% |
| OK | 2 | 52% |
| OR | 3 | 50% |
| PA | 4 | 26% |
| PR\* | 2 | 25% |
| RI | 3 | 51% |
| SC | 3 | 56% |
| SD | 2 | 64% |
| TN | 2 | 50% |
| TX | 4 | 49% |
| UT | 3 | 57% |
| VT | 2 | 64% |
| VA | 4 | 30% |
| WA | 2 | 50% |
| WV | 2 | 58% |
| WI | 3 | 51% |
| WY | 3 | 51% |

Note: Asterisk (\*) denotes non-SERFF states.

## Share of U.S. Population Covered by Included Malpractice Filings, by Specialty and Service Risk Group

To understand the completeness of specialty/service risk groups included in malpractice filings, we developed a measure of the share of the U.S. population included in a filing, defined as the product of the covered population as a share of the U.S. total and the company’s market share. This measure is reported below at two different stages of data development: (1) the raw filings we collected; and (2) final premium values. As described in the report, some specialty/service risk groups were subject to imputation, so their final population share reflects both raw filing data and additional data imputed from a related specialty.

TABLE 7.B: Share of U.S. Population Covered by Included Malpractice Filings Underlying Updated Risk Index and MP GPCIs, by Specialty and Service Risk Group

| **CMS SPECIALTY** | **SERVICE RISK GROUP** | **% U.S. POP - RAW FILINGS** | **% U.S. POP -**  **FINAL** |
| --- | --- | --- | --- |
| 01-General practice | NO SURG | 35% | 45% |
| 01-General practice | OB | 28% | 39% |
| 01-General practice | SURG | 35% | 45% |
| 02-General surgery | ALL | 45% | 45% |
| 03-Allergy/immunology | ALL | 45% | 45% |
| 04-Otolaryngology | NO SURG | 35% | 35% |
| 04-Otolaryngology | SURG | 45% | 45% |
| 05-Anesthesiology | ALL | 45% | 45% |
| 06-Cardiology | NO SURG | 42% | 42% |
| 06-Cardiology | SURG | 44% | 44% |
| 07-Dermatology | NO SURG | 40% | 40% |
| 07-Dermatology | SURG | 45% | 45% |
| 08-Family practice | NO SURG | 43% | 45% |
| 08-Family practice | OB | 37% | 39% |
| 08-Family practice | SURG | 43% | 45% |
| 09-Interventional pain management | ALL | 19% | 38% |
| 10-Gastroenterology | NO SURG | 40% | 40% |
| 10-Gastroenterology | SURG | 45% | 45% |
| 11-Internal medicine | ALL | 45% | 45% |
| 12-Osteopathic manipulative medicine | ALL | 2% | 45% |
| 13-Neurology | NO SURG | 45% | 45% |
| 13-Neurology | SURG | 45% | 45% |
| 14-Neurosurgery | ALL | 45% | 45% |
| 15-Speech language pathology | ALL | 21% | 25% |
| 16-Obstetrics/gynecology | NO SURG | 35% | 35% |
| 16-Obstetrics/gynecology | OB | 44% | 44% |
| 16-Obstetrics/gynecology | SURG | 45% | 45% |
| 17-Hospice and palliative care | ALL | 7% | 45% |
| 18-Ophthalmology | NO SURG | 45% | 45% |
| 18-Ophthalmology | SURG | 45% | 45% |
| 19-Oral surgery (dental only) | ALL | 20% | 26% |
| 20-Orthopedic surgery | ALL | 45% | 45% |
| 21-Cardiac electrophysiology | NO SURG | 0% | 42% |
| 21-Cardiac electrophysiology | SURG | 0% | 44% |
| 22-Pathology | ALL | 45% | 45% |
| 23-Sports medicine | ALL | 7% | 45% |
| 24-Plastic and reconstructive surgery | ALL | 45% | 45% |
| 25-Physical medicine and rehabilitation | ALL | 45% | 45% |
| 26-Psychiatry | ALL | 46% | 46% |
| 27-Geriatric psychiatry | ALL | 0% | 46% |
| 28-Colorectal surgery | ALL | 44% | 44% |
| 29-Pulmonary disease | ALL | 45% | 45% |
| 30-Diagnostic radiology | ALL | 45% | 45% |
| 31-Intensive cardiac rehab | ALL | 0% | 42% |
| 32-Anesthesiologist assistant | ALL | 20% | 41% |
| 33-Thoracic surgery | ALL | 42% | 42% |
| 34-Urology | NO SURG | 22% | 22% |
| 34-Urology | SURG | 45% | 45% |
| 35-Chiropractic | ALL | 28% | 28% |
| 36-Nuclear medicine | ALL | 40% | 40% |
| 37-Pediatric medicine | ALL | 45% | 45% |
| 38-Geriatric medicine | NO SURG | 33% | 33% |
| 38-Geriatric medicine | SURG | 32% | 32% |
| 39-Nephrology | NO SURG | 35% | 35% |
| 39-Nephrology | SURG | 39% | 39% |
| 40-Hand surgery | ALL | 42% | 42% |
| 41-Optometry | ALL | 34% | 34% |
| 42-Certified nurse midwife | ALL | 36% | 36% |
| 43-Certified registered nurse anesthetist (CRNA) | ALL | 40% | 41% |
| 44-Infectious disease | ALL | 42% | 42% |
| 45-Mammography screening center | ALL | 0% | 23% |
| 46-Endocrinology | NO SURG | 42% | 42% |
| 46-Endocrinology | SURG | 32% | 32% |
| 47-Independent diagnostic testing facility | ALL | 23% | 23% |
| 48-Podiatry | NO SURG | 36% | 36% |
| 48-Podiatry | SURG | 39% | 39% |
| 62-Psychologist | ALL | 33% | 33% |
| 63-Portable x-ray supplier | ALL | 19% | 23% |
| 64-Audiologist | ALL | 25% | 25% |
| 65-Physical therapist | ALL | 27% | 30% |
| 66-Rheumatology | ALL | 43% | 43% |
| 67-Occupational therapist | ALL | 27% | 30% |
| 68-Clinical psychologist | ALL | 11% | 33% |
| 69-Clinical laboratory | ALL | 23% | 23% |
| 70-Multispecialty clinic or group practice | ALL | 0% | 30% |
| 71-Registered dietitian/nutrition professional | ALL | 32% | 32% |
| 72-Pain management | ALL | 36% | 36% |
| 75-Slide preparation facilities | ALL | 0% | 23% |
| 76-Peripheral vascular disease | ALL | 1% | 39% |
| 77-Vascular surgery | ALL | 39% | 39% |
| 78-Cardiac surgery | ALL | 43% | 44% |
| 79-Addiction medicine | ALL | 9% | 46% |
| 80-Licensed clinical social worker | ALL | 29% | 29% |
| 81-Critical care (intensivists) | ALL | 32% | 32% |
| 82-Hematology | ALL | 37% | 42% |
| 83-Hematology/oncology | ALL | 20% | 42% |
| 84-Preventive medicine | ALL | 35% | 35% |
| 85-Maxillofacial surgery | ALL | 18% | 26% |
| 86-Neuropsychiatry | ALL | 0% | 46% |
| 90-Medical oncology | ALL | 23% | 23% |
| 91-Surgical oncology | ALL | 16% | 45% |
| 92-Radiation oncology | ALL | 40% | 40% |
| 93-Emergency medicine | NO SURG | 39% | 39% |
| 93-Emergency medicine | SURG | 34% | 34% |
| 94-Interventional radiology | ALL | 24% | 24% |
| 98-Gynecologist/oncologist | ALL | 0% | 45% |
| 99-Unknown physician specialty | NO SURG | 30% | 30% |
| 99-Unknown physician specialty | SURG | 36% | 36% |
| C0-Sleep medicine | ALL | 9% | 45% |
| C3-Interventional cardiology | ALL | 4% | 44% |
| C6-Hospitalist | ALL | 40% | 40% |
| C7-Advanced heart failure and transplant cardiology | ALL | 0% | 42% |
| C8-Medical toxicology | ALL | 0% | 39% |
| C9-Hematopoietic cell transplantation and cellular therapy | ALL | 0% | 20% |
| E1-Marriage and family therapist (MFT) | ALL | 18% | 29% |
| E2-Mental health counselor (MHC) | ALL | 20% | 29% |
| E3-Dental anesthesiology | ALL | 5% | 45% |
| E6-Oral and maxillofacial pathology | ALL | 5% | 45% |
| E7-Oral and maxillofacial radiology | ALL | 3% | 45% |
| F1-Orofacial pain | ALL | 1% | 36% |

## 

## Malpractice Premiums and Risk Index by Specialty and Service Risk group, Current and 2026

The final normalized national premium and PLI risk index by CMS specialty and service risk group are reported in Table 7.C. The TOTAL column represents the national average premium across all specialties and service risk groups, weighted by total PE and Work RVUs.

TABLE 7.C: National PLI Premiums and Malpractice Risk Index, by CMS Specialty and Service Risk Group, Current and 2026

| **CMS SPECIALTY** | **2026 SERVICE RISK GROUP** | **2026 RISK INDEX** | **2026 NATIONAL PREMIUM** | **CURRENT SERVICE RISK GROUP** | **CURRENT RISK INDEX** | **CURRENT NATIONAL PREMIUM** |
| --- | --- | --- | --- | --- | --- | --- |
| TOTAL |  | 1.000 | $ 21,788 |  | 1.000 | $ 21,647 |
| 01-General practice | NO SURG | 0.723 | $ 15,752 | NO SURG | 0.704 | $ 15,240 |
| 01-General practice | OB | 1.707 | $ 37,182 | OB | 1.637 | $ 35,433 |
| 01-General practice | SURG | 1.438 | $ 31,324 | SURG | 1.475 | $ 31,924 |
| 02-General surgery | ALL | 3.074 | $ 66,981 | ALL | 2.927 | $ 63,363 |
| 03-Allergy/immunology | ALL | 0.427 | $ 9,312 | ALL | 0.430 | $ 9,318 |
| 04-Otolaryngology | NO SURG | 0.711 | $ 15,491 | NO SURG | 0.682 | $ 14,762 |
| 04-Otolaryngology | SURG | 1.679 | $ 36,589 | SURG | 1.659 | $ 35,922 |
| 05-Anesthesiology | ALL | 0.967 | $ 21,074 | ALL | 0.933 | $ 20,203 |
| 06-Cardiology | NO SURG | 0.815 | $ 17,761 | NO SURG | 0.777 | $ 16,826 |
| 06-Cardiology | SURG | 2.754 | $ 60,007 | SURG | 2.628 | $ 56,888 |
| 07-Dermatology | NO SURG | 0.492 | $ 10,710 | NO SURG | 0.491 | $ 10,632 |
| 07-Dermatology | SURG | 1.135 | $ 24,733 | SURG | 1.192 | $ 25,799 |
| 08-Family practice | NO SURG | 0.726 | $ 15,823 | NO SURG | 0.715 | $ 15,469 |
| 08-Family practice | OB | 1.716 | $ 37,387 | OB | 1.636 | $ 35,409 |
| 08-Family practice | SURG | 1.494 | $ 32,555 | SURG | 1.534 | $ 33,209 |
| 09-Interventional pain management | ALL | 1.190 | $ 25,918 | ALL | 1.202 | $ 26,013 |
| 10-Gastroenterology | NO SURG | 0.867 | $ 18,888 | NO SURG | 0.786 | $ 17,018 |
| 10-Gastroenterology | SURG | 1.290 | $ 28,111 | SURG | 1.353 | $ 29,293 |
| 11-Internal medicine | ALL | 0.793 | $ 17,287 | ALL | 0.757 | $ 16,387 |
| 12-Osteopathic manipulative medicine | ALL | 0.590 | $ 12,851 | ALL | 0.434 | $ 9,388 |
| 13-Neurology | NO SURG | 0.968 | $ 21,096 | NO SURG | 0.936 | $ 20,272 |
| 13-Neurology | SURG | 4.845 | $ 105,572 | SURG | 4.726 | $ 102,296 |
| 14-Neurosurgery | ALL | 4.845 | $ 105,572 | ALL | 4.726 | $ 102,296 |
| 15-Speech language pathology | ALL | 0.012 | $ 269 | ALL | 0.011 | $ 230 |
| 16-Obstetrics/gynecology | NO SURG | 0.992 | $ 21,606 | NO SURG | 0.669 | $ 14,485 |
| 16-Obstetrics/gynecology | OB | 3.686 | $ 80,320 | OB | 3.485 | $ 75,445 |
| 16-Obstetrics/gynecology | SURG | 2.018 | $ 43,959 | SURG | 1.925 | $ 41,677 |
| 17-Hospice and palliative care | ALL | 0.780 | $ 17,002 | ALL | 0.747 | $ 16,167 |
| 18-Ophthalmology | NO SURG | 0.505 | $ 11,009 | NO SURG | 0.493 | $ 10,678 |
| 18-Ophthalmology | SURG | 0.918 | $ 19,992 | SURG | 0.894 | $ 19,358 |
| 19-Oral surgery (dental only) | ALL | 1.313 | $ 28,608 | ALL | 1.099 | $ 23,786 |
| 20-Orthopedic surgery | ALL | 2.451 | $ 53,407 | ALL | 2.349 | $ 50,841 |
| 21-Cardiac electrophysiology | NO SURG | 0.815 | $ 17,761 | NO SURG | 0.777 | $ 16,826 |
| 21-Cardiac electrophysiology | SURG | 2.763 | $ 60,199 | SURG | 2.626 | $ 56,854 |
| 22-Pathology | ALL | 0.655 | $ 14,274 | ALL | 0.636 | $ 13,765 |
| 23-Sports medicine | ALL | 0.740 | $ 16,125 | ALL | 0.732 | $ 15,836 |
| 24-Plastic and reconstructive surgery | ALL | 2.136 | $ 46,546 | ALL | 2.103 | $ 45,525 |
| 25-Physical medicine and rehabilitation | ALL | 0.600 | $ 13,072 | ALL | 0.608 | $ 13,163 |
| 26-Psychiatry | ALL | 0.475 | $ 10,350 | ALL | 0.460 | $ 9,962 |
| 27-Geriatric psychiatry | ALL | 0.475 | $ 10,350 | ALL | 0.460 | $ 9,962 |
| 28-Colorectal surgery | ALL | 1.657 | $ 36,106 | ALL | 1.546 | $ 33,458 |
| 29-Pulmonary disease | ALL | 0.971 | $ 21,160 | ALL | 0.896 | $ 19,400 |
| 30-Diagnostic radiology | ALL | 1.099 | $ 23,935 | ALL | 1.011 | $ 21,889 |
| 31-Intensive cardiac rehab | ALL | 0.815 | $ 17,761 | ALL | 0.777 | $ 16,826 |
| 32-Anesthesiologist assistant | ALL | 0.264 | $ 5,752 | ALL | 0.272 | $ 5,898 |
| 33-Thoracic surgery | ALL | 2.895 | $ 63,085 | ALL | 2.809 | $ 60,804 |
| 34-Urology | NO SURG | 0.830 | $ 18,076 | NO SURG | 0.817 | $ 17,684 |
| 34-Urology | SURG | 1.480 | $ 32,245 | SURG | 1.388 | $ 30,041 |
| 35-Chiropractic | ALL | 0.154 | $ 3,348 | ALL | 0.147 | $ 3,191 |
| 36-Nuclear medicine | ALL | 0.602 | $ 13,109 | ALL | 0.570 | $ 12,348 |
| 37-Pediatric medicine | ALL | 0.705 | $ 15,365 | ALL | 0.782 | $ 16,918 |
| 38-Geriatric medicine | NO SURG | 0.682 | $ 14,864 | NO SURG | 0.656 | $ 14,208 |
| 38-Geriatric medicine | SURG | 1.649 | $ 35,925 | SURG | 1.549 | $ 33,529 |
| 39-Nephrology | NO SURG | 0.713 | $ 15,545 | NO SURG | 0.684 | $ 14,812 |
| 39-Nephrology | SURG | 1.143 | $ 24,908 | SURG | 1.162 | $ 25,153 |
| 40-Hand surgery | ALL | 1.964 | $ 42,792 | ALL | 1.959 | $ 42,397 |
| 41-Optometry | ALL | 0.046 | $ 1,003 | ALL | 0.046 | $ 1,006 |
| 42-Certified nurse midwife | ALL | 1.021 | $ 22,246 | ALL | 0.914 | $ 19,782 |
| 43-Certified registered nurse anesthetist (CRNA) | ALL | 0.269 | $ 5,872 | ALL | 0.276 | $ 5,968 |
| 44-Infectious disease | ALL | 0.910 | $ 19,830 | ALL | 0.870 | $ 18,823 |
| 45-Mammography screening center | ALL | 0.016 | $ 347 | ALL | 0.018 | $ 379 |
| 46-Endocrinology | NO SURG | 0.770 | $ 16,771 | NO SURG | 0.661 | $ 14,312 |
| 46-Endocrinology | SURG | 1.430 | $ 31,150 | SURG | 1.285 | $ 27,818 |
| 47-Independent diagnostic testing facility | ALL | 0.016 | $ 347 | ALL | 0.018 | $ 379 |
| 48-Podiatry | NO SURG | 0.452 | $ 9,843 | NO SURG | 0.495 | $ 10,717 |
| 48-Podiatry | SURG | 0.982 | $ 21,388 | SURG | 0.902 | $ 19,531 |
| 62-Psychologist | ALL | 0.064 | $ 1,397 | ALL | 0.066 | $ 1,436 |
| 63-Portable x-ray supplier | ALL | 0.014 | $ 313 | ALL | 0.015 | $ 326 |
| 64-Audiologist | ALL | 0.015 | $ 335 | ALL | 0.013 | $ 282 |
| 65-Physical therapist | ALL | 0.034 | $ 745 | ALL | 0.034 | $ 739 |
| 66-Rheumatology | ALL | 0.674 | $ 14,682 | ALL | 0.667 | $ 14,435 |
| 67-Occupational therapist | ALL | 0.024 | $ 517 | ALL | 0.018 | $ 395 |
| 68-Clinical psychologist | ALL | 0.064 | $ 1,387 | ALL | 0.068 | $ 1,466 |
| 69-Clinical laboratory | ALL | 0.016 | $ 347 | ALL | 0.018 | $ 379 |
| 70-Multispecialty clinic or group practice | ALL | 0.714 | $ 15,558 | ALL | 0.686 | $ 14,851 |
| 71-Registered dietitian/nutrition professional | ALL | 0.192 | $ 4,182 | ALL | 0.264 | $ 5,720 |
| 72-Pain management | ALL | 1.128 | $ 24,579 | ALL | 1.008 | $ 21,812 |
| 75-Slide preparation facilities | ALL | 0.016 | $ 347 | ALL | 0.018 | $ 379 |
| 76-Peripheral vascular disease | ALL | 2.938 | $ 64,004 | ALL | 2.831 | $ 61,289 |
| 77-Vascular surgery | ALL | 2.938 | $ 64,004 | ALL | 2.830 | $ 61,259 |
| 78-Cardiac surgery | ALL | 2.754 | $ 60,007 | ALL | 2.628 | $ 56,888 |
| 79-Addiction medicine | ALL | 0.484 | $ 10,544 | ALL | 0.449 | $ 9,723 |
| 80-Licensed clinical social worker | ALL | 0.022 | $ 478 | ALL | 0.023 | $ 500 |
| 81-Critical care (intensivists) | ALL | 1.201 | $ 26,157 | ALL | 1.126 | $ 24,385 |
| 82-Hematology | ALL | 0.750 | $ 16,349 | ALL | 0.725 | $ 15,687 |
| 83-Hematology/oncology | ALL | 0.782 | $ 17,035 | ALL | 0.743 | $ 16,073 |
| 84-Preventive medicine | ALL | 0.544 | $ 11,860 | ALL | 0.580 | $ 12,554 |
| 85-Maxillofacial surgery | ALL | 1.452 | $ 31,633 | ALL | 1.170 | $ 25,328 |
| 86-Neuropsychiatry | ALL | 0.475 | $ 10,350 | ALL | 0.460 | $ 9,962 |
| 90-Medical oncology | ALL | 0.746 | $ 16,259 | ALL | 0.737 | $ 15,958 |
| 91-Surgical oncology | ALL | 2.664 | $ 58,050 | ALL | 2.777 | $ 60,118 |
| 92-Radiation oncology | ALL | 0.918 | $ 20,005 | ALL | 0.907 | $ 19,626 |
| 93-Emergency medicine | NO SURG | 1.478 | $ 32,210 | NO SURG | 1.252 | $ 27,102 |
| 93-Emergency medicine | SURG | 2.854 | $ 62,182 | SURG | 2.446 | $ 52,942 |
| 94-Interventional radiology | ALL | 1.501 | $ 32,697 | ALL | 1.407 | $ 30,457 |
| 98-Gynecologist/oncologist | ALL | 2.664 | $ 58,050 | ALL | 2.777 | $ 60,118 |
| 99-Unknown physician specialty | NO SURG | 0.714 | $ 15,558 | NO SURG | 0.686 | $ 14,851 |
| 99-Unknown physician specialty | SURG | 1.229 | $ 26,769 | SURG | 1.166 | $ 25,246 |
| C0-Sleep medicine | ALL | 0.909 | $ 19,797 | ALL | 0.889 | $ 19,249 |
| C3-Interventional cardiology | ALL | 2.725 | $ 59,364 | ALL | 2.589 | $ 56,042 |
| C6-Hospitalist | ALL | 0.940 | $ 20,485 | ALL | 0.841 | $ 18,197 |
| C7-Advanced heart failure and transplant cardiology | ALL | 0.815 | $ 17,761 | ALL | 0.777 | $ 16,826 |
| C8-Medical toxicology | ALL | 1.478 | $ 32,210 | ALL | 1.252 | $ 27,102 |
| C9-Hematopoietic cell transplantation and cellular therapy | ALL | 0.799 | $ 17,415 | ALL | 0.780 | $ 16,876 |
| E1-Marriage and family therapist (MFT)\* | ALL | 0.022 | $ 475 | ALL | - | - |
| E2-Mental health counselor (MHC)\* | ALL | 0.022 | $ 488 | ALL | - | - |
| E3-Dental anesthesiology\* | ALL | 0.954 | $ 20,778 | ALL | - | - |
| E6-Oral and maxillofacial pathology\* | ALL | 0.609 | $ 13,277 | ALL | - | - |
| E7-Oral and maxillofacial radiology\* | ALL | 1.083 | $ 23,593 | ALL | - | - |
| F1-Orofacial pain\* | ALL | 1.121 | $ 24,435 | ALL | - | - |

Note: CMS specialty codes denoted with an asterisk (\*) were established for billing purposes effective January 1, 2024. This is the first update for which risk index values have been calculated for these specialties.

## GPCIs, GAFs, and Related Data

**TABLE 7.D.1: CY 2026 GPCIs and GAF Based on Updated Data and Change from CY 2025, by Payment Locality**

| **STATE** | **LOC. CODE** | **STATE/LOCALITY NAME** | **WORK GPCI** | **PE GPCI** | **MP GPCI** | **GAF** | **% CHANGE WORK GPCI** | **% CHANGE PE GPCI** | **% CHANGE MP GPCI** | **% CHANGE GAF** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| AL | 00 | ALABAMA | 0.988 | 0.875 | 0.566 | 0.919 | -1.20 | 0.69 | -1.57 | -0.33 |
| AK | 01 | ALASKA | 1.500 | 1.065 | 0.551 | 1.261 | 0.00 | -1.48 | -6.93 | -0.71 |
| AZ | 00 | ARIZONA | 0.991 | 0.969 | 0.856 | 0.975 | -0.90 | -0.62 | 0.23 | -0.81 |
| AR | 13 | ARKANSAS | 0.974 | 0.859 | 0.515 | 0.902 | -2.60 | -0.12 | -0.58 | -1.53 |
| CA | 05 | SAN FRANCISCO-OAKLAND-HAYWARD (SAN FRANCISCO/SAN MATEO/ALAMEDA/CONTRA COSTA CNTY) | 1.095 | 1.410 | 0.425 | 1.214 | 0.64 | -0.63 | -4.49 | -0.08 |
| CA | 09 | SAN JOSE-SUNNYVALE-SANTA CLARA (SANTA CLARA CNTY) | 1.110 | 1.442 | 0.397 | 1.235 | 0.91 | 0.49 | -5.48 | 0.65 |
| CA | 17 | OXNARD-THOUSAND OAKS-VENTURA | 1.028 | 1.182 | 0.623 | 1.083 | 0.19 | -0.08 | -4.30 | 0.00 |
| CA | 18 | LOS ANGELES-LONG BEACH-ANAHEIM (LOS ANGELES/ORANGE CNTY) | 1.041 | 1.183 | 0.664 | 1.091 | -0.10 | -0.92 | -3.77 | -0.64 |
| CA | 51 | NAPA | 1.063 | 1.318 | 0.508 | 1.158 | 0.47 | 0.61 | -2.50 | 0.43 |
| CA | 52 | SAN FRANCISCO-OAKLAND-HAYWARD (MARIN CNTY) | 1.095 | 1.410 | 0.459 | 1.215 | 0.64 | -0.63 | -2.34 | -0.08 |
| CA | 53 | VALLEJO-FAIRFIELD | 1.063 | 1.318 | 0.459 | 1.157 | 0.47 | 0.61 | -2.34 | 0.52 |
| CA | 54 | BAKERSFIELD | 1.019 | 1.096 | 0.609 | 1.038 | 0.20 | 0.27 | -8.01 | 0.00 |
| CA | 55 | CHICO | 1.017 | 1.096 | 0.536 | 1.034 | 0.30 | 0.27 | -4.29 | 0.19 |
| CA | 56 | FRESNO | 1.017 | 1.096 | 0.536 | 1.034 | 0.30 | 0.27 | -4.29 | 0.19 |
| CA | 57 | HANFORD-CORCORAN | 1.017 | 1.096 | 0.536 | 1.034 | 0.30 | 0.27 | -4.29 | 0.19 |
| CA | 58 | MADERA | 1.017 | 1.096 | 0.536 | 1.034 | 0.30 | 0.27 | -4.29 | 0.19 |
| CA | 59 | MERCED | 1.017 | 1.096 | 0.536 | 1.034 | 0.30 | 0.27 | -4.29 | 0.19 |
| CA | 60 | MODESTO | 1.017 | 1.096 | 0.536 | 1.034 | 0.30 | 0.27 | -4.29 | 0.19 |
| CA | 61 | REDDING | 1.017 | 1.096 | 0.536 | 1.034 | 0.30 | 0.27 | -4.29 | 0.19 |
| CA | 62 | RIVERSIDE-SAN BERNARDINO-ONTARIO | 1.018 | 1.096 | 0.853 | 1.047 | 0.39 | 0.27 | -4.37 | 0.10 |
| CA | 63 | SACRAMENTO-ROSEVILLE-ARDEN-ARCADE | 1.036 | 1.163 | 0.536 | 1.075 | 0.19 | 0.61 | -4.29 | 0.37 |
| CA | 64 | SALINAS | 1.031 | 1.159 | 0.536 | 1.070 | -0.39 | -0.52 | -4.29 | -0.56 |
| CA | 65 | SAN JOSE-SUNNYVALE-SANTA CLARA (SAN BENITO CNTY) | 1.110 | 1.442 | 0.536 | 1.240 | 0.91 | 0.49 | -4.29 | 0.57 |
| CA | 66 | SANTA CRUZ-WATSONVILLE | 1.021 | 1.215 | 0.536 | 1.091 | 0.39 | 0.50 | -4.29 | 0.37 |
| CA | 67 | SANTA ROSA | 1.030 | 1.228 | 0.536 | 1.102 | 0.29 | -0.32 | -4.29 | -0.09 |
| CA | 68 | STOCKTON-LODI | 1.017 | 1.096 | 0.536 | 1.034 | 0.30 | 0.27 | -4.29 | 0.19 |
| CA | 69 | VISALIA-PORTERVILLE | 1.017 | 1.096 | 0.536 | 1.034 | 0.30 | 0.27 | -4.29 | 0.19 |
| CA | 70 | YUBA CITY | 1.017 | 1.096 | 0.536 | 1.034 | 0.30 | 0.27 | -4.29 | 0.19 |
| CA | 71 | EL CENTRO | 1.017 | 1.096 | 0.541 | 1.034 | 0.30 | 0.27 | -5.09 | 0.10 |
| CA | 72 | SAN DIEGO-CARLSBAD | 1.030 | 1.196 | 0.542 | 1.087 | 0.19 | 0.42 | -5.24 | 0.18 |
| CA | 73 | SAN LUIS OBISPO-PASO ROBLES-ARROYO GRANDE | 1.017 | 1.139 | 0.536 | 1.054 | 0.30 | 0.62 | -4.29 | 0.38 |
| CA | 74 | SANTA MARIA-SANTA BARBARA | 1.028 | 1.166 | 0.536 | 1.072 | 0.59 | -0.77 | -4.29 | -0.19 |
| CA | 75 | REST OF CALIFORNIA | 1.017 | 1.096 | 0.536 | 1.034 | 0.30 | 0.27 | -4.29 | 0.19 |
| CO | 01 | COLORADO | 1.012 | 1.064 | 0.781 | 1.027 | 0.40 | 1.04 | -5.56 | 0.59 |
| CT | 00 | CONNECTICUT | 1.020 | 1.077 | 1.210 | 1.054 | -0.20 | -1.28 | 0.25 | -0.66 |
| DE | 01 | DELAWARE | 1.005 | 0.988 | 0.899 | 0.993 | -0.40 | -0.40 | -5.27 | -0.60 |
| DC | 01 | DC + MD/VA SUBURBS | 1.054 | 1.178 | 1.113 | 1.114 | -0.28 | -1.17 | -4.71 | -0.89 |
| FL | 03 | FORT LAUDERDALE | 0.993 | 1.013 | 1.808 | 1.035 | -0.70 | 1.50 | 2.15 | 0.49 |
| FL | 04 | MIAMI | 0.994 | 1.041 | 2.529 | 1.078 | -0.60 | 1.36 | 1.16 | 0.47 |
| FL | 99 | REST OF FLORIDA | 0.989 | 0.956 | 1.503 | 0.994 | -1.10 | 1.70 | 2.45 | 0.30 |
| GA | 01 | ATLANTA | 1.003 | 1.016 | 1.201 | 1.017 | 0.30 | 1.91 | 6.47 | 1.29 |
| GA | 99 | REST OF GEORGIA | 0.986 | 0.892 | 1.192 | 0.951 | -1.40 | 1.02 | 5.96 | 0.00 |
| HI | 01 | HAWAII | 0.998 | 1.137 | 0.579 | 1.045 | -0.20 | -1.04 | 3.21 | -0.57 |
| ID | 00 | IDAHO | 0.980 | 0.920 | 0.473 | 0.932 | -2.00 | 1.32 | 2.60 | -0.43 |
| IL | 12 | EAST ST. LOUIS | 0.988 | 0.920 | 2.014 | 0.998 | -1.20 | 0.22 | 12.89 | 0.40 |
| IL | 15 | SUBURBAN CHICAGO | 1.007 | 1.027 | 1.772 | 1.047 | 0.00 | -2.00 | 13.88 | -0.10 |
| IL | 16 | CHICAGO | 1.007 | 1.005 | 2.295 | 1.058 | 0.00 | -1.76 | 13.73 | 0.28 |
| IL | 99 | REST OF ILLINOIS | 0.988 | 0.913 | 1.563 | 0.977 | -1.20 | 0.11 | 13.18 | 0.21 |
| IN | 00 | INDIANA | 0.988 | 0.927 | 0.486 | 0.940 | -1.20 | 0.54 | 0.21 | -0.32 |
| IA | 00 | IOWA | 0.984 | 0.915 | 0.397 | 0.928 | -1.60 | 0.22 | -13.13 | -1.07 |
| KS | 00 | KANSAS | 0.984 | 0.904 | 0.504 | 0.928 | -1.60 | -0.22 | -6.67 | -1.07 |
| KY | 00 | KENTUCKY | 0.981 | 0.889 | 0.915 | 0.936 | -1.90 | 1.37 | 0.22 | -0.43 |
| LA | 01 | NEW ORLEANS | 0.989 | 0.941 | 1.136 | 0.973 | -1.10 | 0.64 | -1.73 | -0.31 |
| LA | 99 | REST OF LOUISIANA | 0.985 | 0.885 | 0.958 | 0.938 | -1.50 | 0.45 | -2.44 | -0.64 |
| ME | 03 | SOUTHERN MAINE | 0.990 | 0.991 | 0.631 | 0.976 | -1.00 | -2.08 | -3.81 | -1.61 |
| ME | 99 | REST OF MAINE | 0.984 | 0.920 | 0.622 | 0.940 | -1.60 | 0.77 | -4.31 | -0.63 |
| MD | 01 | BALTIMORE/SURR. CNTYS | 1.016 | 1.073 | 1.236 | 1.051 | -0.39 | -0.46 | -5.58 | -0.66 |
| MD | 99 | REST OF MARYLAND | 1.010 | 1.012 | 0.918 | 1.007 | -0.20 | -0.39 | -5.65 | -0.49 |
| MA | 01 | METROPOLITAN BOSTON | 1.041 | 1.194 | 0.890 | 1.106 | -0.10 | -0.25 | -0.45 | -0.18 |
| MA | 99 | REST OF MASSACHUSETTS | 1.016 | 1.053 | 0.797 | 1.024 | -0.10 | -0.75 | 0.13 | -0.39 |
| MI | 01 | DETROIT | 0.997 | 0.965 | 1.686 | 1.010 | -0.60 | -2.13 | -1.86 | -1.37 |
| MI | 99 | REST OF MICHIGAN | 0.986 | 0.913 | 1.129 | 0.958 | -1.40 | 0.22 | -3.75 | -0.83 |
| MN | 00 | MINNESOTA | 1.000 | 1.029 | 0.296 | 0.985 | 0.00 | 0.39 | -1.33 | 0.20 |
| MS | 00 | MISSISSIPPI | 0.974 | 0.861 | 0.739 | 0.912 | -2.60 | 1.06 | -3.78 | -1.08 |
| MO | 01 | METROPOLITAN ST. LOUIS | 0.988 | 0.952 | 1.002 | 0.972 | -1.20 | 0.00 | 0.80 | -0.61 |
| MO | 02 | METROPOLITAN KANSAS CITY | 0.989 | 0.939 | 0.977 | 0.965 | -1.10 | -0.95 | -1.51 | -1.13 |
| MO | 99 | REST OF MISSOURI | 0.976 | 0.862 | 0.974 | 0.923 | -2.40 | 0.35 | 0.00 | -1.18 |
| MT | 01 | MONTANA | 0.984 | 1.000 | 0.998 | 0.992 | -1.60 | 0.00 | 2.04 | -0.70 |
| NE | 00 | NEBRASKA | 0.983 | 0.923 | 0.378 | 0.931 | -1.70 | 0.65 | 24.34 | -0.32 |
| NV | 00 | NEVADA | 0.989 | 1.001 | 0.833 | 0.988 | -1.10 | 0.10 | -1.30 | -0.60 |
| NH | 40 | NEW HAMPSHIRE | 0.997 | 1.041 | 0.875 | 1.012 | -0.30 | 0.68 | -2.56 | 0.00 |
| NJ | 01 | NORTHERN NJ | 1.063 | 1.160 | 1.068 | 1.108 | -0.09 | -1.02 | 3.49 | -0.45 |
| NJ | 99 | REST OF NEW JERSEY | 1.040 | 1.092 | 1.097 | 1.066 | -0.19 | -1.27 | 2.62 | -0.65 |
| NM | 05 | NEW MEXICO | 0.990 | 0.917 | 1.201 | 0.965 | -1.00 | 0.99 | 2.47 | 0.10 |
| NY | 01 | MANHATTAN | 1.064 | 1.162 | 1.586 | 1.130 | -0.09 | -0.34 | -4.23 | -0.53 |
| NY | 02 | NYC SUBURBS/LONG ISLAND | 1.064 | 1.189 | 1.857 | 1.154 | -0.09 | -0.92 | -2.83 | -0.69 |
| NY | 03 | POUGHKPSIE/N NYC SUBURBS | 1.045 | 1.095 | 1.210 | 1.075 | -0.10 | -0.99 | -4.65 | -0.74 |
| NY | 04 | QUEENS | 1.064 | 1.182 | 1.442 | 1.134 | -0.09 | -1.09 | -1.37 | -0.61 |
| NY | 99 | REST OF NEW YORK | 0.995 | 0.950 | 0.703 | 0.962 | -0.50 | 0.11 | -3.96 | -0.41 |
| NC | 00 | NORTH CAROLINA | 0.991 | 0.933 | 0.639 | 0.950 | -0.90 | 0.76 | -3.91 | -0.21 |
| ND | 01 | NORTH DAKOTA | 0.987 | 1.000 | 0.406 | 0.970 | -1.30 | 0.00 | -21.47 | -1.12 |
| OH | 00 | OHIO | 0.990 | 0.913 | 1.008 | 0.955 | -1.00 | 0.22 | -2.42 | -0.52 |
| OK | 00 | OKLAHOMA | 0.983 | 0.893 | 0.777 | 0.933 | -1.70 | 0.22 | -4.43 | -0.96 |
| OR | 01 | PORTLAND | 1.016 | 1.111 | 0.744 | 1.049 | 0.30 | 0.73 | 8.14 | 0.77 |
| OR | 99 | REST OF OREGON | 0.991 | 0.996 | 0.703 | 0.982 | -0.90 | 1.01 | 9.33 | 0.31 |
| PA | 01 | METROPOLITAN PHILADELPHIA | 1.018 | 1.041 | 1.193 | 1.036 | -0.59 | -1.14 | 1.36 | -0.77 |
| PA | 99 | REST OF PENNSYLVANIA | 0.990 | 0.918 | 0.945 | 0.955 | -1.00 | -0.97 | 2.16 | -0.83 |
| RI | 01 | RHODE ISLAND | 1.019 | 1.033 | 0.892 | 1.020 | -0.59 | -0.58 | 5.06 | -0.39 |
| SC | 01 | SOUTH CAROLINA | 0.986 | 0.924 | 0.850 | 0.952 | -1.40 | 1.20 | 4.04 | 0.00 |
| SD | 02 | SOUTH DAKOTA | 0.990 | 1.000 | 0.336 | 0.968 | -1.00 | 0.00 | -12.04 | -0.72 |
| TN | 35 | TENNESSEE | 0.984 | 0.909 | 0.537 | 0.931 | -1.60 | 1.45 | -1.29 | -0.32 |
| TX | 09 | BRAZORIA | 1.008 | 0.991 | 0.780 | 0.991 | -0.59 | -1.49 | -1.89 | -1.00 |
| TX | 11 | DALLAS | 1.009 | 0.996 | 0.857 | 0.997 | -0.20 | -1.09 | -2.28 | -0.70 |
| TX | 15 | GALVESTON | 1.008 | 0.993 | 0.827 | 0.994 | -0.59 | -0.70 | -3.27 | -0.70 |
| TX | 18 | HOUSTON | 1.008 | 0.993 | 1.376 | 1.016 | -0.59 | -1.00 | -2.34 | -0.88 |
| TX | 20 | BEAUMONT | 0.989 | 0.910 | 0.929 | 0.950 | -1.10 | 0.78 | -1.90 | -0.31 |
| TX | 28 | FORT WORTH | 1.009 | 0.986 | 0.871 | 0.993 | -0.20 | -1.20 | -3.44 | -0.80 |
| TX | 31 | AUSTIN | 1.002 | 1.058 | 0.886 | 1.023 | 0.20 | 1.15 | -3.06 | 0.49 |
| TX | 99 | REST OF TEXAS | 0.991 | 0.949 | 0.903 | 0.968 | -0.90 | 0.42 | -3.32 | -0.41 |
| UT | 09 | UTAH | 0.985 | 0.940 | 0.898 | 0.961 | -1.50 | 0.75 | -3.44 | -0.52 |
| VT | 50 | VERMONT | 0.988 | 0.990 | 0.506 | 0.969 | -1.20 | -0.30 | -2.32 | -0.82 |
| VA | 00 | VIRGINIA | 1.000 | 0.983 | 0.706 | 0.980 | -0.20 | -0.10 | -6.49 | -0.41 |
| WA | 02 | SEATTLE (KING CNTY) | 1.050 | 1.227 | 0.816 | 1.122 | 0.67 | 0.57 | -4.34 | 0.45 |
| WA | 99 | REST OF WASHINGTON | 1.013 | 1.053 | 0.761 | 1.021 | 0.60 | 1.25 | -5.23 | 0.69 |
| WV | 16 | WEST VIRGINIA | 0.980 | 0.869 | 1.431 | 0.947 | -2.00 | 0.93 | 7.35 | -0.21 |
| WI | 00 | WISCONSIN | 0.993 | 0.958 | 0.308 | 0.949 | -0.70 | 0.10 | -6.95 | -0.42 |
| WY | 21 | WYOMING | 0.991 | 1.000 | 0.740 | 0.985 | -0.90 | 0.00 | 0.14 | -0.40 |
| PR | 20 | PUERTO RICO | 1.000 | 1.011 | 0.985 | 1.004 | 0.00 | 0.40 | 0.31 | 0.10 |
| VI | 50 | VIRGIN ISLANDS | 1.000 | 1.011 | 0.985 | 1.004 | 0.00 | 0.40 | 0.31 | 0.10 |

**TABLE 7.D.2: Components of Updated 2026 PE GPCI, by Payment Locality**

| **STATE** | **LOCALITY CODE** | **STATE/LOCALITY NAME** | **INDEX - EMPLOYEE WAGES** | **INDEX - OFFICE RENTS** | **INDEX - PURCHASED SERVICES** |
| --- | --- | --- | --- | --- | --- |
| AK | 01 | ALASKA | 1.098 | 0.960 | 1.036 |
| AL | 00 | ALABAMA | 0.876 | 0.670 | 0.934 |
| AR | 13 | ARKANSAS | 0.863 | 0.631 | 0.892 |
| AZ | 00 | ARIZONA | 0.909 | 0.940 | 0.979 |
| CA | 05 | SAN FRANCISCO-OAKLAND-HAYWARD (SAN FRANCISCO/SAN MATEO/ALAMEDA/CONTRA COSTA CNTY) | 1.400 | 1.860 | 1.199 |
| CA | 09 | SAN JOSE-SUNNYVALE-SANTA CLARA (SANTA CLARA CNTY) | 1.414 | 2.022 | 1.228 |
| CA | 17 | OXNARD-THOUSAND OAKS-VENTURA | 1.128 | 1.478 | 1.039 |
| CA | 18 | LOS ANGELES-LONG BEACH-ANAHEIM (LOS ANGELES/ORANGE CNTY) | 1.094 | 1.467 | 1.068 |
| CA | 51 | NAPA | 1.294 | 1.548 | 1.081 |
| CA | 52 | SAN FRANCISCO-OAKLAND-HAYWARD (MARIN CNTY) | 1.400 | 1.860 | 1.199 |
| CA | 53 | VALLEJO-FAIRFIELD | 1.357 | 1.378 | 1.059 |
| CA | 54 | BAKERSFIELD | 0.955 | 0.777 | 1.009 |
| CA | 55 | CHICO | 1.129 | 0.912 | 0.996 |
| CA | 56 | FRESNO | 1.121 | 0.835 | 0.995 |
| CA | 57 | HANFORD-CORCORAN | 1.037 | 0.749 | 0.999 |
| CA | 58 | MADERA | 1.070 | 0.735 | 0.992 |
| CA | 59 | MERCED | 0.975 | 0.783 | 0.998 |
| CA | 60 | MODESTO | 1.164 | 0.953 | 1.028 |
| CA | 61 | REDDING | 1.095 | 0.848 | 0.996 |
| CA | 62 | RIVERSIDE-SAN BERNARDINO-ONTARIO | 0.960 | 1.127 | 1.018 |
| CA | 63 | SACRAMENTO--ROSEVILLE--ARDEN-ARCADE | 1.263 | 1.193 | 1.066 |
| CA | 64 | SALINAS | 1.152 | 1.323 | 1.031 |
| CA | 65 | SAN JOSE-SUNNYVALE-SANTA CLARA (SAN BENITO CNTY) | 1.414 | 2.022 | 1.228 |
| CA | 66 | SANTA CRUZ-WATSONVILLE | 1.146 | 1.621 | 1.046 |
| CA | 67 | SANTA ROSA | 1.221 | 1.497 | 1.066 |
| CA | 68 | STOCKTON-LODI | 1.071 | 1.005 | 1.035 |
| CA | 69 | VISALIA-PORTERVILLE | 1.091 | 0.751 | 0.992 |
| CA | 70 | YUBA CITY | 1.053 | 0.826 | 0.996 |
| CA | 71 | EL CENTRO | 1.063 | 0.686 | 0.993 |
| CA | 72 | SAN DIEGO-CARLSBAD | 1.165 | 1.492 | 1.052 |
| CA | 73 | SAN LUIS OBISPO-PASO ROBLES-ARROYO GRANDE | 1.144 | 1.321 | 1.020 |
| CA | 74 | SANTA MARIA-SANTA BARBARA | 1.084 | 1.436 | 1.051 |
| CA | 75 | REST OF CALIFORNIA | 1.121 | 0.895 | 1.001 |
| CO | 01 | COLORADO | 1.051 | 1.142 | 1.049 |
| CT | 00 | CONNECTICUT | 1.043 | 1.105 | 1.037 |
| DC | 01 | DC + MD/VA SUBURBS | 1.084 | 1.431 | 1.097 |
| DE | 01 | DELAWARE | 0.984 | 0.892 | 0.993 |
| FL | 03 | FORT LAUDERDALE | 0.980 | 1.117 | 0.961 |
| FL | 04 | MIAMI | 0.983 | 1.228 | 0.971 |
| FL | 99 | REST OF FLORIDA | 0.950 | 0.934 | 0.945 |
| GA | 01 | ATLANTA | 1.018 | 1.057 | 0.995 |
| GA | 99 | REST OF GEORGIA | 0.920 | 0.694 | 0.928 |
| HI | 01 | HAWAII | 1.085 | 1.332 | 1.008 |
| IA | 00 | IOWA | 0.949 | 0.690 | 0.957 |
| ID | 00 | IDAHO | 0.966 | 0.749 | 0.936 |
| IL | 12 | EAST ST. LOUIS | 0.966 | 0.681 | 0.967 |
| IL | 15 | SUBURBAN CHICAGO | 0.932 | 1.045 | 1.032 |
| IL | 16 | CHICAGO | 0.932 | 0.962 | 1.032 |
| IL | 99 | REST OF ILLINOIS | 0.944 | 0.678 | 0.968 |
| IN | 00 | INDIANA | 0.960 | 0.728 | 0.967 |
| KS | 00 | KANSAS | 0.882 | 0.744 | 0.942 |
| KY | 00 | KENTUCKY | 0.930 | 0.679 | 0.921 |
| LA | 01 | NEW ORLEANS | 0.948 | 0.844 | 0.936 |
| LA | 99 | REST OF LOUISIANA | 0.899 | 0.688 | 0.917 |
| MA | 01 | METROPOLITAN BOSTON | 1.112 | 1.504 | 1.089 |
| MA | 99 | REST OF MASSACHUSETTS | 1.041 | 1.032 | 1.042 |
| MD | 01 | BALTIMORE/SURR. CNTYS | 1.047 | 1.140 | 1.019 |
| MD | 99 | REST OF MARYLAND | 1.024 | 0.924 | 1.016 |
| ME | 03 | SOUTHERN MAINE | 0.851 | 1.063 | 0.981 |
| ME | 99 | REST OF MAINE | 0.970 | 0.701 | 0.957 |
| MI | 01 | DETROIT | 0.880 | 0.890 | 0.997 |
| MI | 99 | REST OF MICHIGAN | 0.936 | 0.703 | 0.954 |
| MN | 00 | MINNESOTA | 1.084 | 0.920 | 1.027 |
| MO | 01 | METROPOLITAN ST. LOUIS | 0.967 | 0.807 | 0.968 |
| MO | 02 | METROPOLITAN KANSAS CITY | 0.908 | 0.798 | 0.980 |
| MO | 99 | REST OF MISSOURI | 0.890 | 0.602 | 0.912 |
| MS | 00 | MISSISSIPPI | 0.879 | 0.662 | 0.878 |
| MT | 01 | MONTANA | 0.984 | 0.749 | 0.954 |
| NC | 00 | NORTH CAROLINA | 0.955 | 0.781 | 0.959 |
| ND | 01 | NORTH DAKOTA | 0.996 | 0.665 | 0.984 |
| NE | 00 | NEBRASKA | 0.964 | 0.731 | 0.942 |
| NH | 40 | NEW HAMPSHIRE | 1.039 | 1.075 | 1.006 |
| NJ | 01 | NORTHERN NJ | 1.112 | 1.294 | 1.120 |
| NJ | 99 | REST OF NEW JERSEY | 1.042 | 1.146 | 1.071 |
| NM | 05 | NEW MEXICO | 0.972 | 0.709 | 0.940 |
| NV | 00 | NEVADA | 1.014 | 0.952 | 0.963 |
| NY | 01 | MANHATTAN | 1.115 | 1.334 | 1.123 |
| NY | 02 | NYC SUBURBS/LONG ISLAND | 1.115 | 1.422 | 1.123 |
| NY | 03 | POUGHKPSIE/N NYC SUBURBS | 1.080 | 1.098 | 1.091 |
| NY | 04 | QUEENS | 1.115 | 1.383 | 1.123 |
| NY | 99 | REST OF NEW YORK | 0.974 | 0.769 | 0.989 |
| OH | 00 | OHIO | 0.945 | 0.695 | 0.958 |
| OK | 00 | OKLAHOMA | 0.916 | 0.687 | 0.920 |
| OR | 01 | PORTLAND | 1.148 | 1.176 | 1.045 |
| OR | 99 | REST OF OREGON | 1.074 | 0.864 | 0.973 |
| PA | 01 | METROPOLITAN PHILADELPHIA | 0.978 | 1.079 | 1.023 |
| PA | 99 | REST OF PENNSYLVANIA | 0.891 | 0.756 | 0.956 |
| PR | 20 | PUERTO RICO | 1.000 | 1.000 | 1.000 |
| RI | 01 | RHODE ISLAND | 1.051 | 0.945 | 1.030 |
| SC | 01 | SOUTH CAROLINA | 0.943 | 0.796 | 0.934 |
| SD | 02 | SOUTH DAKOTA | 0.945 | 0.701 | 0.965 |
| TN | 35 | TENNESSEE | 0.926 | 0.768 | 0.936 |
| TX | 09 | BRAZORIA | 0.970 | 0.903 | 0.973 |
| TX | 11 | DALLAS | 0.903 | 1.030 | 0.992 |
| TX | 15 | GALVESTON | 0.970 | 0.942 | 0.973 |
| TX | 18 | HOUSTON | 0.970 | 0.930 | 0.973 |
| TX | 20 | BEAUMONT | 0.933 | 0.729 | 0.940 |
| TX | 28 | FORT WORTH | 0.903 | 0.984 | 0.992 |
| TX | 31 | AUSTIN | 1.024 | 1.205 | 0.993 |
| TX | 99 | REST OF TEXAS | 0.931 | 0.887 | 0.942 |
| UT | 09 | UTAH | 0.918 | 0.878 | 0.953 |
| VA | 00 | VIRGINIA | 0.963 | 0.924 | 0.991 |
| VI | 50 | VIRGIN ISLANDS | 1.000 | 1.000 | 1.000 |
| VT | 50 | VERMONT | 0.961 | 0.955 | 0.987 |
| WA | 02 | SEATTLE (KING CNTY) | 1.206 | 1.505 | 1.140 |
| WA | 99 | REST OF WASHINGTON | 1.114 | 0.986 | 1.057 |
| WI | 00 | WISCONSIN | 1.003 | 0.760 | 0.985 |
| WV | 16 | WEST VIRGINIA | 0.909 | 0.621 | 0.908 |
| WY | 21 | WYOMING | 0.971 | 0.676 | 0.973 |

# Reference Tables

This section details data and policy constructs referenced in this report.

## CMS Specialties and Their Impact Specialty

The regulatory impact table included in all PFS Federal Register notices groups CMS specialties (present on Medicare claims) into clusters of related specialties (“Impact” specialties) when CMS examines the potential impact of CMS payment policies on the distribution of payments by providers. The relationship of CMS specialties and Impact specialties as shown in Table 8.A was used to identify sources for imputing malpractice premium data for CMS specialties that were not included in a filing.

Table 8.A CMS Specialty Map into Impact Specialty

| **CMS SPECIALTY** | **IMPACT SPECIALTY** |
| --- | --- |
| 01-General practice | General practice |
| 02-General surgery | General surgery |
| 03-Allergy/immunology | Allergy/immunology |
| 04-Otolaryngology | Otolaryngology |
| 05-Anesthesiology | Anesthesiology |
| 06-Cardiology | Cardiology |
| 07-Dermatology | Dermatology |
| 08-Family practice | Family practice |
| 09-Interventional pain management | Interventional pain management |
| 10-Gastroenterology | Gastroenterology |
| 11-Internal medicine | Internal medicine |
| 12-Osteopathic manipulative medicine | Multispecialty clinic/other physician |
| 13-Neurology | Neurology |
| 14-Neurosurgery | Neurosurgery |
| 15-Speech language pathology | Physical/occupational therapy |
| 16-Obstetrics/gynecology | Obstetrics/gynecology |
| 17-Hospice and palliative care | Multispecialty clinic/other physician |
| 18-Ophthalmology | Ophthalmology |
| 19-Oral surgery (dental only) | Oral/maxillofacial surgery |
| 20-Orthopedic surgery | Orthopedic surgery |
| 21-Cardiac electrophysiology | Cardiology |
| 22-Pathology | Pathology |
| 23-Sports medicine | Family practice |
| 24-Plastic and reconstructive surgery | Plastic surgery |
| 25-Physical medicine and rehabilitation | Physical medicine |
| 26-Psychiatry | Psychiatry |
| 27-Geriatric psychiatry | Psychiatry |
| 28-Colorectal surgery | Colon and rectal surgery |
| 29-Pulmonary disease | Pulmonary disease |
| 30-Diagnostic radiology | Radiology |
| 31-Intensive cardiac rehab | Other |
| 32-Anesthesiologist assistant | Nurse anesthetist/anesthesiologist assistant |
| 33-Thoracic surgery | Thoracic surgery |
| 34-Urology | Urology |
| 35-Chiropractic | Chiropractor |
| 36-Nuclear medicine | Nuclear medicine |
| 37-Pediatric medicine | Pediatrics |
| 38-Geriatric medicine | Geriatrics |
| 39-Nephrology | Nephrology |
| 40-Hand surgery | Hand surgery |
| 41-Optometry | Optometry |
| 42-Certified nurse midwife | Obstetrics/gynecology |
| 43-Certified registered nurse anesthetist (CRNA) | Nurse anesthetist/anesthesiologist assistant |
| 44-Infectious disease | Infectious disease |
| 45-Mammography screening center | Diagnostic testing facility |
| 46-Endocrinology | Endocrinology |
| 47-Independent diagnostic testing facility | Diagnostic testing facility |
| 48-Podiatry | Podiatry |
| 62-Psychologist | Clinical psychologist |
| 63-Portable x-ray supplier | Portable x-ray supplier |
| 64-Audiologist | Audiologist |
| 65-Physical therapist | Physical/occupational therapy |
| 66-Rheumatology | Rheumatology |
| 67-Occupational therapist | Physical/occupational therapy |
| 68-Clinical psychologist | Clinical psychologist |
| 69-Clinical laboratory | Independent laboratory |
| 70-Multispecialty clinic or group practice | Multispecialty clinic/other physician |
| 71-Registered dietitian/nutrition professional | Other |
| 72-Pain management | Interventional pain management |
| 75-Slide preparation facilities | Independent laboratory |
| 76-Peripheral vascular disease | Vascular surgery |
| 77-Vascular surgery | Vascular surgery |
| 78-Cardiac surgery | Cardiac surgery |
| 79-Addiction medicine | Other |
| 80-Licensed clinical social worker | Clinical social worker |
| 81-Critical care (intensivists) | Critical care |
| 82-Hematology | Hematology/oncology |
| 83-Hematology/oncology | Hematology/oncology |
| 84-Preventive medicine | Internal medicine |
| 85-Maxillofacial surgery | Oral/maxillofacial surgery |
| 86-Neuropsychiatry | Psychiatry |
| 90-Medical oncology | Hematology/oncology |
| 91-Surgical oncology | General Surgery |
| 92-Radiation oncology | Radiation oncology and radiation therapy centers |
| 93-Emergency medicine | Emergency medicine |
| 94-Interventional radiology | Interventional radiology |
| 98-Gynecologist/oncologist | Obstetrics/gynecology |
| 99-Unknown physician specialty | Multispecialty clinic/other physician |
| C0-Sleep medicine | General practice |
| C3-Interventional cardiology | Cardiology |
| C6-Hospitalist | Internal medicine |
| C7-Advanced heart failure and transplant cardiology | Cardiology |
| C8-Medical toxicology | Emergency medicine |
| C9-Hematopoietic cell transplantation and cellular therapy | Hematology/oncology |
| E1-Marriage and family therapist (MFT) | Clinical social worker |
| E2-Mental health counselor (MHC) | Clinical social worker |
| E3-Dental anesthesiology | Anesthesiology |
| E6-Oral and maxillofacial pathology | Pathology |
| E7-Oral and maxillofacial radiology | Radiology |
| F1-Orofacial pain | Interventional pain management |

## Distribution of Physician Work RVUs by Service Risk Group by PLI Filing Specialty

As described in Section 3.G in the report, in some cases premiums as reported on filings had to be combined or split across service risk groups to match our final set of specialty/service risk groups. That process requires a measure to weight different service groups within each PLI Filing Specialty, for which we used these physician work shares by specialty based on 2023 Medicare claims.

Table 8.B Volume-weighted Distribution of 2023 Physician Work RVUs by Service Risk Type by CMS Specialty

| **PLI FILING SPECIALTY** | **ASSOCIATED CMS SPECIALTY CODES** | **APPROX. TOTAL WORK RVUS - ALL SERVICES** | **SHARE OF TOTAL WORK RVUS - OBSTETRICS** | **SHARE OF TOTAL WORK RVUS - SURGERY** | **SHARE OF TOTAL WORK RVUS - NO SURGERY** |
| --- | --- | --- | --- | --- | --- |
| General practice | 01 | 4,555,000 | 0.00% | 7.66% | 92.34% |
| General surgery | 02 | 23,826,000 | 0.00% | 58.01% | 41.99% |
| Allergy/immunology | 03 | 1,858,000 | 0.00% | 0.52% | 99.48% |
| Otolaryngology | 04 | 13,739,000 | 0.00% | 41.12% | 58.88% |
| Anesthesiology | 05 | 8,102,000 | 0.00% | 47.35% | 52.65% |
| Cardiology | 06, 78 | 61,901,000 | 0.00% | 13.28% | 86.73% |
| Dermatology | 07 | 36,884,000 | 0.00% | 52.99% | 47.01% |
| Family practice | 08 | 83,983,000 | 0.01% | 2.33% | 97.67% |
| Interventional pain management | 09 | 4,165,000 | 0.00% | 42.49% | 57.51% |
| Gastroenterology | 10 | 24,207,000 | 0.00% | 55.77% | 44.23% |
| Internal medicine | 11 | 137,825,000 | 0.00% | 1.60% | 98.41% |
| Osteopathic manipulative medicine | 12 | 761,000 | 0.01% | 12.05% | 87.94% |
| Neurology | 13, 14 | 31,015,000 | 0.00% | 29.12% | 70.88% |
| Speech language pathology | 15 | 1,838,000 | 0.00% | 0.65% | 99.35% |
| Obstetrics/gynecology | 16 | 6,280,000 | 2.25% | 36.25% | 61.50% |
| Hospice and palliative care | 17 | 1,275,000 | 0.00% | 0.46% | 99.54% |
| Ophthalmology | 18 | 58,484,000 | 0.00% | 43.90% | 56.10% |
| Oral surgery (dental only) | 19 | 456,000 | 0.00% | 68.26% | 31.74% |
| Orthopedic surgery | 20 | 48,081,000 | 0.00% | 63.43% | 36.57% |
| Cardiac electrophysiology | 21 | 10,529,000 | 0.00% | 37.17% | 62.83% |
| Pathology | 22 | 17,877,000 | 0.00% | 0.40% | 99.60% |
| Sports medicine | 23 | 2,283,000 | 0.00% | 39.56% | 60.44% |
| Plastic and reconstructive surgery | 24 | 4,066,000 | 0.00% | 73.98% | 26.02% |
| Physical medicine and rehabilitation | 25 | 17,826,000 | 0.00% | 14.12% | 85.88% |
| Psychiatry | 26 | 15,013,000 | 0.00% | 0.10% | 99.90% |
| Geriatric psychiatry | 27 | 220,000 | 0.00% | 0.00% | 100.00% |
| Colorectal surgery | 28 | 2,266,000 | 0.00% | 69.17% | 30.83% |
| Pulmonary disease | 29 | 21,922,000 | 0.00% | 4.20% | 95.80% |
| Diagnostic radiology | 30 | 69,137,000 | 0.00% | 6.41% | 93.60% |
| Intensive cardiac rehab | 31 | 24,000 | 0.00% | 0.88% | 99.12% |
| Anesthesiologist assistant | 32 | 6,000 | 0.00% | 91.25% | 8.75% |
| Thoracic surgery | 33 | 4,965,000 | 0.00% | 79.95% | 20.05% |
| Urology | 34 | 22,236,000 | 0.00% | 40.33% | 59.67% |
| Chiropractic | 35 | 11,966,000 | 0.00% | 0.00% | 100.00% |
| Nuclear medicine | 36 | 728,000 | 0.00% | 1.18% | 98.82% |
| Pediatric medicine | 37 | 850,000 | 0.01% | 6.33% | 93.66% |
| Geriatric medicine | 38 | 3,563,000 | 0.00% | 0.42% | 99.58% |
| Nephrology | 39 | 30,812,000 | 0.00% | 1.63% | 98.38% |
| Hand surgery | 40 | 3,382,000 | 0.00% | 54.29% | 45.71% |
| Optometry | 41 | 17,493,000 | 0.00% | 9.83% | 90.17% |
| Certified nurse midwife | 42 | 78,000 | 12.99% | 11.81% | 75.20% |
| Certified registered nurse anesthetist (CRNA) | 43 | 358,000 | 0.00% | 81.95% | 18.05% |
| Infectious disease | 44 | 10,479,000 | 0.00% | 0.51% | 99.49% |
| Mammography screening center | 45 | 11,000 | 0.00% | 0.02% | 99.98% |
| Endocrinology | 46 | 7,946,000 | 0.00% | 0.63% | 99.37% |
| Independent diagnostic testing facility | 47 | 1,908,000 | 0.00% | 0.38% | 99.62% |
| Podiatry | 48 | 23,684,000 | 0.00% | 41.41% | 58.59% |
| Psychologist | 62 | 274,000 | 0.00% | 0.00% | 100.00% |
| Portable x-ray supplier | 63 | 311,000 | 0.00% | 0.00% | 100.00% |
| Audiologist | 64 | 1,033,000 | 0.00% | 0.08% | 99.92% |
| Physical therapist | 65 | 76,728,000 | 0.00% | 1.30% | 98.70% |
| Rheumatology | 66 | 6,660,000 | 0.00% | 4.37% | 95.63% |
| Occupational therapist | 67 | 8,394,000 | 0.00% | 0.52% | 99.49% |
| Clinical psychologist | 68 | 15,482,000 | 0.00% | 0.00% | 100.00% |
| Clinical laboratory | 69 | 4,217,000 | 0.00% | 0.04% | 99.96% |
| Multispecialty clinic or group practice | 70 | 28,000 | 0.00% | 6.44% | 93.57% |
| Registered dietitian/nutrition professional | 71 | 273,000 | 0.00% | 0.00% | 100.00% |
| Pain management | 72 | 6,495,000 | 0.00% | 40.40% | 59.60% |
| Slide preparation facilities | 75 | <1,000 | 0.00% | 0.00% | 100.00% |
| Peripheral vascular disease | 76 | 146,000 | 0.00% | 44.16% | 55.84% |
| Vascular surgery | 77 | 8,863,000 | 0.00% | 56.64% | 43.36% |
| Addiction medicine | 79 | 133,000 | 0.00% | 1.14% | 98.86% |
| Licensed clinical social worker | 80 | 18,874,000 | 0.00% | 0.00% | 100.00% |
| Critical care (intensivists) | 81 | 6,424,000 | 0.00% | 6.87% | 93.13% |
| Hematology | 82 | 1,031,000 | 0.00% | 0.54% | 99.46% |
| Hematology/oncology | 83 | 16,055,000 | 0.00% | 0.29% | 99.71% |
| Preventive medicine | 84 | 204,000 | 0.00% | 11.20% | 88.80% |
| Maxillofacial surgery | 85 | 189,000 | 0.00% | 59.13% | 40.87% |
| Neuropsychiatry | 86 | 165,000 | 0.00% | 4.68% | 95.32% |
| Medical oncology | 90 | 5,084,000 | 0.00% | 0.25% | 99.75% |
| Surgical oncology | 91 | 1,399,000 | 0.00% | 64.67% | 35.33% |
| Radiation oncology | 92 | 13,984,000 | 0.00% | 0.96% | 99.04% |
| Emergency medicine | 93 | 53,204,000 | 0.00% | 2.50% | 97.50% |
| Interventional radiology | 94 | 4,586,000 | 0.00% | 48.76% | 51.24% |
| Gynecologist/oncologist | 98 | 1,208,000 | 0.01% | 51.63% | 48.36% |
| Unknown physician specialty | 99 | 445,000 | 0.02% | 41.20% | 58.79% |
| Sleep medicine | C0 | 908,000 | 0.00% | 0.64% | 99.36% |
| Interventional cardiology | C3 | 16,111,000 | 0.00% | 31.08% | 68.92% |
| Hospitalist | C6 | 25,057,000 | 0.00% | 0.33% | 99.67% |
| Advanced heart failure and transplant cardiology | C7 | 1,451,000 | 0.00% | 4.58% | 95.42% |
| Medical toxicology | C8 | 24,000 | 0.00% | 2.14% | 97.87% |
| Hematopoietic cell transplantation and cellular therapy | C9 | 146,000 | 0.00% | 1.86% | 98.14% |
| Marriage and family therapist (MFT) | E1\* | n/a | n/a | n/a | n/a |
| Mental health counselor (MHC) | E2\* | n/a | n/a | n/a | n/a |
| Dental anesthesiology | E3\* | n/a | n/a | n/a | n/a |
| Oral and maxillofacial pathology | E6\* | n/a | n/a | n/a | n/a |
| Oral and maxillofacial radiology | E7\* | n/a | n/a | n/a | n/a |
| Orofacial pain | F1\* | n/a | n/a | n/a | n/a |

Note: CMS specialty codes denoted with an asterisk (\*) were established for billing purposes effective January 1, 2024. Therefore, there are no 2023 paid claims, and therefore no weights for use here, available for this update.

## Source for Specialty for Imputation

Development of the analytic premium data required imputing premiums on filings that did not include certain CMS specialties. For CMS specialties that were reported on some filings but missing from others, we used the premium of a related specialty and service risk group within the same filing based on the source specialty/service risk groups in the tables below. Table 8.C.1 represents CMS specialties that are often used synonymously within PLI filings. Table 8.C.2 reflects CMS specialties that were broadly underrepresented in PLI filings.

Table 8.C.1 Source Specialty/Service Risk Group for Imputation for Updated PLI Premium Data – Specialties Used Synonymously

| **CMS SPECIALTY/SERVICE RISK GROUP** | **CMS SPECIALTY/SERVICE RISK GROUP USED AS SOURCE FOR IMPUTATION** |
| --- | --- |
| 01-General practice (NO SURG) | 08-Family practice (NO SURG) |
| 01-General practice (OB) | 08-Family practice (OB) |
| 01-General practice (SURG) | 08-Family practice (SURG) |
| 06-Cardiology (SURG) | 78-Cardiac surgery (ALL) |
| 08-Family practice (NO SURG) | 01-General practice (NO SURG) |
| 08-Family practice (OB) | 01-General practice (OB) |
| 08-Family practice (SURG) | 01-General practice (SURG) |
| 13-Neurology (SURG) | 14-Neurosurgery (ALL) |
| 14-Neurosurgery (ALL) | 13-Neurology (SURG) |
| 15-Speech language pathology (ALL) | 64-Audiologist (ALL) |
| 32-Anesthesiologist assistant (ALL) | 43-Certified registered nurse anesthetist (CRNA) (ALL) |
| 43-Certified registered nurse anesthetist (CRNA) (ALL) | 32-Anesthesiologist assistant (ALL) |
| 62-Psychologist (ALL) | 68-Clinical psychologist (ALL) |
| 64-Audiologist (ALL) | 15-Speech language pathology (ALL) |
| 65-Physical therapist (ALL) | 67-Occupational therapist (ALL) |
| 67-Occupational therapist (ALL) | 65-Physical therapist (ALL) |
| 68-Clinical psychologist (ALL) | 62-Psychologist (ALL) |
| 78-Cardiac surgery (ALL) | 06-Cardiology (SURG) |

Table 8.C.2 Source Specialty/Service Risk Group for Imputation for Updated PLI Premium Data – Underrepresented Specialties

| **CMS SPECIALTY/SERVICE RISK GROUP** | **CMS SPECIALTY/SERVICE RISK GROUP USED AS SOURCE FOR IMPUTATION** |
| --- | --- |
| 09-Interventional pain management (ALL) | 72-Pain management (ALL) |
| 12-Osteopathic manipulative medicine (ALL) | 25-Physical medicine and rehabilitation (ALL) |
| 17-Hospice and palliative care (ALL) | 11-Internal medicine (ALL) |
| 19-Oral surgery (dental only) (ALL) | 85-Maxillofacial surgery (ALL) |
| 21-Cardiac electrophysiology (NO SURG) | 06-Cardiology (NO SURG) |
| 21-Cardiac electrophysiology (SURG) | 06-Cardiology (SURG) |
| 23-Sports medicine (ALL) | 08-Family practice (NO SURG) |
| 27-Geriatric psychiatry (ALL) | 26-Psychiatry (ALL) |
| 31-Intensive cardiac rehab (ALL) | 06-Cardiology (NO SURG) |
| 45-Mammography screening center (ALL) | 47-Independent diagnostic testing facility (ALL) |
| 63-Portable x-ray supplier (ALL) | 69-Clinical laboratory (ALL) |
| 70-Multispecialty clinic or group practice (ALL) | 99-Unknown physician specialty (NO SURG) |
| 75-Slide preparation facilities (ALL) | 69-Clinical laboratory (ALL) |
| 76-Peripheral vascular disease (ALL) | 77-Vascular surgery (ALL) |
| 79-Addiction medicine (ALL) | 26-Psychiatry (ALL) |
| 82-Hematology (ALL) | 83-Hematology/oncology (ALL) |
| 83-Hematology/oncology (ALL) | 82-Hematology (ALL) |
| 85-Maxillofacial surgery (ALL) | 19-Oral surgery (dental only) (ALL) |
| 86-Neuropsychiatry (ALL) | 26-Psychiatry (ALL) |
| 91-Surgical oncology (ALL) | 02-General surgery (ALL) |
| 98-Gynecologist/oncologist (ALL)\* | 91-Surgical oncology (ALL) |
| C0-Sleep medicine (ALL) | 13-Neurology (NO SURG) |
| C3-Interventional cardiology (ALL) | 06-Cardiology (SURG) |
| C7-Advanced heart failure and transplant cardiology (ALL) | 06-Cardiology (NO SURG) |
| C8-Medical toxicology (ALL) | 93-Emergency medicine (NO SURG) |
| C9-Hematopoietic cell transplantation and cellular therapy (ALL) | 83-Hematology/oncology (ALL) |
| E1-Marriage and family therapist (MFT) (ALL) | 80-Licensed clinical social worker (ALL) |
| E2-Mental health counselor (MHC) (ALL) | 80-Licensed clinical social worker (ALL) |
| E3-Dental anesthesiology (ALL) | 05-Anesthesiology (ALL) |
| E6-Oral and maxillofacial pathology (ALL) | 22-Pathology (ALL) |
| E7-Oral and maxillofacial radiology (ALL) | 30-Diagnostic radiology (ALL) |
| F1-Orofacial pain (ALL) | 72-Pain management (ALL |

\*Per guidance we received from CMS, the national premium for 98-Gynecologist/oncologist (ALL) was set equal to the national premium and risk index value for 91-Surgical oncology (ALL).

## Occupations Included in the Physician Work GPCI

Tables 8.D.1-8.D.6 below show the list of occupation codes and titles that comprise the nine occupation groups used in the WORK GPCI calculation. The source is the BLS OEWS Data. The Occupation Code is the 6-digit Standard Occupational Classification (SOC) code or OES-specific code for the occupation.

Based on changes in the May 2023 Occupation Profiles, some of the occupation codes and titles from the CY 2023 Update have been replaced in the CY 2026 Update. These new codes are denoted with an asterisk (\*) in Tables 8.D.1-8.D.6 and are summarized in Table 8.D.7 below.

Table 8.D.1: List of Occupations Included in the Updated WORK GPCI – Architecture and Engineering

| **OCCUPATION CODE** | **OCCUPATION TITLE** |
| --- | --- |
| 17-1011 | Architects, Except Landscape and Naval |
| 17-1012 | Landscape Architects |
| 17-1021 | Cartographers and Photogrammetrists |
| 17-1022 | Surveyors |
| 17-2011 | Aerospace Engineers |
| 17-2021 | Agricultural Engineers |
| 17-2031 | Bioengineers and Biomedical Engineers |
| 17-2041 | Chemical Engineers |
| 17-2051 | Civil Engineers |
| 17-2061 | Computer Hardware Engineers |
| 17-2071 | Electrical Engineers |
| 17-2072 | Electronics Engineers, Except Computer |
| 17-2081 | Environmental Engineers |
| 17-2111 | Health and Safety Engineers, Except Mining Safety Engineers and Inspectors |
| 17-2112 | Industrial Engineers |
| 17-2121 | Marine Engineers and Naval Architects |
| 17-2131 | Materials Engineers |
| 17-2141 | Mechanical Engineers |
| 17-2151 | Mining and Geological Engineers, Including Mining Safety Engineers |
| 17-2161 | Nuclear Engineers |
| 17-2171 | Petroleum Engineers |
| 17-2199 | Engineers, All Other |
| 17-3031 | Surveying and Mapping Technicians |

Table 8.D.2: List of Occupations Included in the Updated WORK GPCI – Computer, Mathematical, Life and Physical Science

| **OCCUPATION CODE** | **OCCUPATION TITLE** |
| --- | --- |
| 15-1221 | Computer and Information Research Scientists |
| 15-1211 | Computer Systems Analysts |
| 15-1212 | Information Security Analysts |
| 15-1241 | Computer Network Architects |
| 15-1251 | Computer Programmers |
| 15-1252 | Software Developers\* |
| 15-1253 | Software Quality Assurance Analysts and Testers\* |
| 15-1254 | Web Developers\* |
| 15-1255 | Web and Digital Interface Designers\* |
| 15-1242 | Database Administrators\* |
| 15-1243 | Database Architects\* |
| 15-1244 | Network and Computer Systems Administrators |
| 15-1232 | Computer User Support Specialists |
| 15-1231 | Computer Network Support Specialists |
| 15-1299 | Computer Occupations, All Other |
| 15-2011 | Actuaries |
| 15-2021 | Mathematicians |
| 15-2031 | Operations Research Analysts |
| 15-2041 | Statisticians |
| 15-2051 | Data Scientists\* |
| 15-2099 | Mathematical Science Occupations, All Other\* |
| 19-1011 | Animal Scientists |
| 19-1012 | Food Scientists and Technologists |
| 19-1013 | Soil and Plant Scientists |
| 19-1021 | Biochemists and Biophysicists |
| 19-1022 | Microbiologists |
| 19-1023 | Zoologists and Wildlife Biologists |
| 19-1029 | Biological Scientists, All Other |
| 19-1031 | Conservation Scientists |
| 19-1032 | Foresters |
| 19-1041 | Epidemiologists |
| 19-1042 | Medical Scientists, Except Epidemiologists |
| 19-1099 | Life Scientists, All Other |
| 19-2011 | Astronomers |
| 19-2012 | Physicists |
| 19-2021 | Atmospheric and Space Scientists |
| 19-2031 | Chemists |
| 19-2032 | Materials Scientists |
| 19-2041 | Environmental Scientists and Specialists, Including Health |
| 19-2042 | Geoscientists, Except Hydrologists and Geographers |
| 19-2043 | Hydrologists |
| 19-2099 | Physical Scientists, All Other |

Table 8.D.3: List of Occupations Included in the Updated WORK GPCI – Social Science, Community and Social Service and Legal

| **OCCUPATION CODE** | **OCCUPATION TITLE** |
| --- | --- |
| 19-3011 | Economists |
| 19-3022 | Survey Researchers |
| 19-3033 | Clinical and Counseling Psychologists\* |
| 19-3034 | School Psychologists\* |
| 19-3032 | Industrial-Organizational Psychologists |
| 19-3039 | Psychologists, All Other |
| 19-3041 | Sociologists |
| 19-3051 | Urban and Regional Planners |
| 19-3091 | Anthropologists and Archeologists |
| 19-3092 | Geographers |
| 19-3093 | Historians |
| 19-3094 | Political Scientists |
| 19-3099 | Social Scientists and Related Workers, All Other |
| 19-4012 | Agricultural Technicians\* |
| 19-4013 | Food Science Technicians\* |
| 19-4021 | Biological Technicians |
| 19-4031 | Chemical Technicians |
| 19-4043 | Geological Technicians, Except Hydrologic Technicians\* |
| 19-4044 | Hydrologic Technicians\* |
| 19-4051 | Nuclear Technicians |
| 19-4061 | Social Science Research Assistants |
| 19-4042 | Environmental Science and Protection Technicians, Including Health |
| 19-4092 | Forensic Science Technicians |
| 19-4071 | Forest and Conservation Technicians |
| 19-4099 | Life, Physical, and Social Science Technicians, All Other |
| 19-5011 | Occupational Health and Safety Specialists |
| 21-1012 | Educational, Guidance, and Career Counselors and Advisors |
| 21-1013 | Marriage and Family Therapists |
| 21-1018 | Substance Abuse, Behavioral Disorder, and Mental Health Counselors |
| 21-1015 | Rehabilitation Counselors |
| 21-1019 | Counselors, All Other |
| 21-1021 | Child, Family, and School Social Workers |
| 21-1022 | Healthcare Social Workers |
| 21-1023 | Mental Health and Substance Abuse Social Workers |
| 21-1029 | Social Workers, All Other |
| 21-1091 | Health Education Specialists |
| 21-1092 | Probation Officers and Correctional Treatment Specialists |
| 21-1093 | Social and Human Service Assistants |
| 21-1099 | Community and Social Service Specialists, All Other |
| 21-2011 | Clergy |
| 21-2021 | Directors, Religious Activities and Education |
| 21-2099 | Religious Workers, All Other |
| 23-1011 | Lawyers |
| 23-1012 | Judicial Law Clerks |
| 23-1021 | Administrative Law Judges, Adjudicators, and Hearing Officers |
| 23-1022 | Arbitrators, Mediators, and Conciliators |
| 23-1023 | Judges, Magistrate Judges, and Magistrates |
| 23-2011 | Paralegals and Legal Assistants |
| 23-2093 | Title Examiners, Abstractors, and Searchers |
| 23-2099 | Legal Support Workers, All Other |

Table 8.D.4: List of Occupations Included in the Updated WORK GPCI – Other Occupation Groups

| **OCCUPATION GROUP** | **OCCUPATION CODE** | **OCCUPATION TITLE** |
| --- | --- | --- |
| Educational Instruction and Library Occupations | 25-0000 | Educational Instruction and Library Occupations |
| Registered Nurses | 29-1141 | Registered Nurses |
| Pharmacists | 29-1051 | Pharmacists |
| Art, Design, Entertainment, Sports, and Media | 27-0000 | Arts, Design, Entertainment, Sports, and Media Occupations |

Table 8.D.5: List of Occupations Included in the Updated WORK GPCI – Management

| **OCCUPATION CODE** | **OCCUPATION TITLE** |
| --- | --- |
| 11-1011 | Chief Executives |
| 11-1021 | General and Operations Managers |
| 11-2011 | Advertising and Promotions Managers |
| 11-2021 | Marketing Managers |
| 11-2022 | Sales Managers |
| 11-2032 | Public Relations Managers\* |
| 11-2033 | Fundraising Managers\* |
| 11-3012 | Administrative Services Managers\* |
| 11-3013 | Facilities Managers\* |
| 11-3021 | Computer and Information Systems Managers |
| 11-3031 | Financial Managers |
| 11-3051 | Industrial Production Managers |
| 11-3061 | Purchasing Managers |
| 11-3111 | Compensation and Benefits Managers |
| 11-3121 | Human Resources Managers |
| 11-3131 | Training and Development Managers |
| 11-9021 | Construction Managers |
| 11-9031 | Education and Childcare Administrators, Preschool and Daycare |
| 11-9032 | Education Administrators, Kindergarten through Secondary |
| 11-9033 | Education Administrators, Postsecondary |
| 11-9039 | Education Administrators, All Other |
| 11-9041 | Architectural and Engineering Managers |
| 11-9111 | Medical and Health Services Managers |
| 11-9121 | Natural Sciences Managers |
| 11-9151 | Social and Community Service Managers |
| 11-9161 | Emergency Management Directors |
| 11-9197 | Personal Service Managers, All Other\* |
| 11-9199 | Managers, All Other\* |

Table 8.D.6: List of Occupations Included in the Updated WORK GPCI – Business and Financial Operation

| **OCCUPATION CODE** | **OCCUPATION TITLE** |
| --- | --- |
| 13-1011 | Agents and Business Managers of Artists, Performers, and Athletes |
| 13-1020 | Buyers and Purchasing Agents |
| 13-1041 | Compliance Officers |
| 13-1051 | Cost Estimators |
| 13-1071 | Human Resources Specialists |
| 13-1075 | Labor Relations Specialists |
| 13-1081 | Logisticians |
| 13-1111 | Management Analysts |
| 13-1121 | Meeting, Convention, and Event Planners |
| 13-1131 | Fundraisers |
| 13-1141 | Compensation, Benefits, and Job Analysis Specialists |
| 13-1151 | Training and Development Specialists |
| 13-1161 | Market Research Analysts and Marketing Specialists |
| 13-1082 | Project Management Specialists\* |
| 13-1199 | Business Operations Specialists, All Other\* |
| 13-2011 | Accountants and Auditors |
| 13-2020 | Property Appraisers and Assessors |
| 13-2031 | Budget Analysts |
| 13-2041 | Credit Analysts |
| 13-2052 | Personal Financial Advisors |
| 13-2053 | Insurance Underwriters |
| 13-2061 | Financial Examiners |
| 13-2071 | Credit Counselors |
| 13-2072 | Loan Officers |
| 13-2081 | Tax Examiners and Collectors, and Revenue Agents |
| 13-2051 | Financial and Investment Analysts\* |
| 13-2054 | Financial Risk Specialists\* |
| 13-2099 | Financial Specialists, All Other\* |

Table 8.D.7: Summary of Changes in Occupation Codes: May 2020 BLS OWES Data to May 2023 BLS OWES Data

| **May 2020 OCC. CODE** | **May 2020 OCCUPATION TITLE** | **May 2023 OCC. CODE** | **May 2023 OCCUPATION TITLE** |
| --- | --- | --- | --- |
| 15-1256 | Software Developers and Software Quality Assurance Analysts and Testers | 15-1252 | Software Developers |
| 15-1253 | Software Quality Assurance Analysts and Testers |
| 15-1257 | Web Developers and Digital Interface Designers | 15-1254 | Web Developers |
| 15-1255 | Web and Digital Interface Designers |
| 15-1245 | Database Administrators and Architects | 15-1242 | Database Administrators |
| 15-1243 | Database Architects |
| 15-2098 | Data Scientists and Mathematical Science Occupations, All Other | 15-2051 | Data Scientists |
| 15-2099 | Mathematical Science Occupations, All Other |
| 19-3031 | Clinical, Counseling, and School Psychologists | 19-3033 | Clinical and Counseling Psychologists |
| 19-3034 | School Psychologists |
| 19-4010 | Agricultural and Food Science Technicians | 19-4012 | Agricultural Technicians |
| 19-4013 | Food Science Technicians |
| 19-4045 | Geological and Hydrologic Technicians | 19-4043 | Geological Technicians, Except Hydrologic Technicians |
| 19-4044 | Hydrologic Technicians |
| 11-2030 | Public Relations and Fundraising Managers | 11-2032 | Public Relations Managers |
| 11-2033 | Fundraising Managers |
| 11-3010 | Administrative Services and Facilities Managers | 11-3012 | Administrative Services Managers |
| 11-3013 | Facilities Managers |
| 11-9198 | Personal Service Managers, All Other; Entertainment and Recreation Managers, Except Gambling; and Managers, All Other | 11-9197 | Personal Service Managers, All Other |
| 11-9199 | Managers, All Other |
| 13-1198 | Project Management Specialists and Business Operations Specialists, All Other | 13-1082 | Project Management Specialists |
| 13-1199 | Business Operations Specialists, All Other |
| 13-2098 | Financial and Investment Analysts, Financial Risk Specialists, and Financial Specialists, All Other | 13-2051 | Financial and Investment Analysts |
| 13-2054 | Financial Risk Specialists |
| 13-2099 | Financial Specialists, All Other |

## Counties Missing County-Level Estimates of Median Gross Rent for 2-Bedrooms

ARC used the 2022 ACS 5-year, county-level estimates (2018-2022) on the median gross rent for 2-bedrooms to develop the data needed to create the Office Rent Index. Since the ACS data file is missing estimates for the median gross rent for 2-bedrooms for select counties and Census was unable to provide additional values at the time of this report, ARC imputed county-level rent estimates using the average value for a given county’s MSA. Table 8.E below includes a list of the counties that are missing estimates and these imputed values.

Table 8.E: Counties Missing County-Level Estimates of Median Gross Rent for 2-Bedrooms and Imputed Amount

| **COUNTY NAME** | **IMPUTED VALUE:**  **MEDIAN GROSS RENT FOR 2-BEDROOMS** |
| --- | --- |
| Prince of Wales-Outer Ketchikan Census Area, Alaska | $1,319 |
| Skagway-Hoonah-Angoon Census Area, Alaska | $1,319 |
| Wade Hampton Census Area, Alaska | $1,319 |
| Wrangell-Petersburg Census Area, Alaska | $1,319 |
| Yakutat Borough, Alaska | $1,319 |
| Alpine County, California | $1,214 |
| Lafayette County, Florida | $753 |
| Quitman County, Georgia | $736 |
| Kalawao County, Hawaii | $1,812 |
| Butte County, Idaho | $902 |
| Stanton County, Kansas | $790 |
| Elliott County, Kentucky | $632 |
| Martin County, Kentucky | $632 |
| Owsley County, Kentucky | $632 |
| Cameron Parish, Louisiana | $1,009 |
| Franklin County, Mississippi | $702 |
| Issaquena County, Mississippi | $655 |
| Judith Basin County, Montana | $721 |
| Petroleum County, Montana | $721 |
| Prairie County, Montana | $721 |
| Treasure County, Montana | $721 |
| Wibaux County, Montana | $721 |
| Yellowstone National Park (Part), Montana | $1,080 |
| Arthur County, Nebraska | $794 |
| Banner County, Nebraska | $816 |
| Grant County, Nebraska | $794 |
| McPherson County, Nebraska | $794 |
| Eureka County, Nevada | $1,010 |
| Chowan County, North Carolina | $788 |
| Hyde County, North Carolina | $788 |
| Slope County, North Dakota | $926 |
| Buffalo County, South Dakota | $709 |
| Haakon County, South Dakota | $709 |
| Jackson County, South Dakota | $709 |
| Jerauld County, South Dakota | $774 |
| Sully County, South Dakota | $709 |
| Oak Ridge Reservation, Tennessee | $756 |
| Borden County, Texas | $815 |
| Briscoe County, Texas | $815 |
| Crockett County, Texas | $815 |
| Culberson County, Texas | $815 |
| Duval County, Texas | $812 |
| Glasscock County, Texas | $815 |
| Jeff Davis County, Texas | $815 |
| Kenedy County, Texas | $812 |
| Kent County, Texas | $815 |
| King County, Texas | $815 |
| Kinney County, Texas | $818 |
| Loving County, Texas | $815 |
| McMullen County, Texas | $812 |
| Martin County, Texas | $1,427 |
| Roberts County, Texas | $815 |
| Stephens County, Texas | $877 |
| Sterling County, Texas | $935 |
| Stonewall County, Texas | $815 |
| Sutton County, Texas | $935 |
| Terrell County, Texas | $815 |
| Upton County, Texas | $815 |
| Daggett County, Utah | $1,082 |
| Piute County, Utah | $842 |
| Bedford city, Virginia | $849 |
| Clifton Forge city, Virginia | $872 |
| Niobrara County, Wyoming | $878 |
| Ciudad Modelo, Puerto Rico | $394 |
| Culebra, Puerto Rico | $394 |
| Rio Piedras, Puerto Rico | $394 |
| Santurce, Puerto Rico | $394 |

Source: Median Gross Rent by Bedrooms (B25031); 2022 ACS 5-year estimates (2018-2022)

## Current California Localities with Prior Locality and Transition Area Status

GPCIs in California areas are subject to a hold-harmless provision resulting from the change from the prior 9 localities to the current set of 29 areas used by CMS. Calculation of new GPCIs for California requires calculating values for the prior localities based on the updated input data and hold-harmless values, as described in Section 4 of the report, based on the updated budget-neutral values under the new area definitions and those under the previous locality definition. Table 8.F shows the relationship between current and prior localities, along with the transition status of current areas. As described above, the counties within all but two MSAs will have the same GPCIs, but two – San Francisco and San Jose – include counties that can have values that differ from others within the MSA due to the hold harmless provision. As a result, there can be up to 29 different GPCI values across the state's 27 MSAs.

Table 8.F: Current California Localities with Prior Locality and Transition Area Status

| **CURRENT LOCALITY CODE** | **CURRENT STATE/LOCALITY NAME** | **PRIOR LOCALITY CODE** | **PRIOR STATE/LOCALITY NAME** | **TRANSITION AREA?** |
| --- | --- | --- | --- | --- |
| 05 | SAN FRANCISCO-OAKLAND-BERKELEY (SAN FRANCISCO/SAN MATEO/ALAMEDA/CONTRA COSTA CNTY) | 05 | SAN FRANCISCO | N |
| 09 | SAN JOSE-SUNNYVALE-SANTA CLARA (SANTA CLARA CNTY) | 09 | SANTA CLARA | N |
| 17 | OXNARD-THOUSAND OAKS-VENTURA | 17 | VENTURA | N |
| 18 | LOS ANGELES-LONG BEACH-ANAHEIM (LOS ANGELES/ORANGE CNTY) | 18 | LOS ANGELES | N |
| 51 | NAPA | 03 | MARIN/NAPA/SOLANO | Y |
| 52 | SAN FRANCISCO-OAKLAND-BERKELEY (MARIN CNTY) | 03 | MARIN/NAPA/SOLANO | Y |
| 53 | VALLEJO | 03 | MARIN/NAPA/SOLANO | Y |
| 54 | BAKERSFIELD | 99 | REST OF CALIFORNIA | Y |
| 55 | CHICO | 99 | REST OF CALIFORNIA | Y |
| 56 | FRESNO | 99 | REST OF CALIFORNIA | Y |
| 57 | HANFORD-CORCORAN | 99 | REST OF CALIFORNIA | Y |
| 58 | MADERA | 99 | REST OF CALIFORNIA | Y |
| 59 | MERCED | 99 | REST OF CALIFORNIA | Y |
| 60 | MODESTO | 99 | REST OF CALIFORNIA | Y |
| 61 | REDDING | 99 | REST OF CALIFORNIA | Y |
| 62 | RIVERSIDE-SAN BERNARDINO-ONTARIO | 99 | REST OF CALIFORNIA | Y |
| 63 | SACRAMENTO-ROSEVILLE-ARDEN-ARCADE | 99 | REST OF CALIFORNIA | Y |
| 64 | SALINAS | 99 | REST OF CALIFORNIA | Y |
| 65 | SAN JOSE-SUNNYVALE-SANTA CLARA (SAN BENITO CNTY) | 99 | REST OF CALIFORNIA | Y |
| 66 | SANTA CRUZ-WATSONVILLE | 99 | REST OF CALIFORNIA | Y |
| 67 | SANTA ROSA-PETALUMA | 99 | REST OF CALIFORNIA | Y |
| 68 | STOCKTON | 99 | REST OF CALIFORNIA | Y |
| 69 | VISALIA | 99 | REST OF CALIFORNIA | Y |
| 70 | YUBA CITY | 99 | REST OF CALIFORNIA | Y |
| 71 | EL CENTRO | 99 | REST OF CALIFORNIA | Y |
| 72 | SAN DIEGO-CHULA VISTA-CARLSBAD | 99 | REST OF CALIFORNIA | Y |
| 73 | SAN LUIS OBISPO-PASO ROBLES | 99 | REST OF CALIFORNIA | Y |
| 74 | SANTA MARIA-SANTA BARBARA | 99 | REST OF CALIFORNIA | Y |
| 75 | REST OF CALIFORNIA | 99 | REST OF CALIFORNIA | Y |

## Crosswalk of Connecticut Counties and Planning Regions

Beginning in 2022, the US Census Bureau adopted nine new Planning Regions as county-equivalent geographic units in Connecticut for purposes of collecting, tabulating, and disseminating statistical data, replacing the eight legacy counties used in prior data.[[37]](#footnote-38) ACS population and rent data, MP premium data, CMS RVUs underlying the GPCI calculations reflect this change, but the latest available BLS OEWS data rely on the legacy county definitions. The table below summarizes total population for each legacy county and planning region, as well as the population shared between the two.[[38]](#footnote-39) As described in Section 4.B in the report, this table was used to crosswalk data between the two geographic constructs in Connecticut, as necessary.

Table 8.G: Connecticut Population, by Legacy County and Planning Region

| **LEGACY COUNTY** | **PLANNING REGION** | **TOTAL LEGACY COUNTY POP** | **TOTAL PLANNING REGION POP** | **SHARED POPULATION** | **% TOTAL LEGACY COUNTY POP** | **% TOTAL PLANNING REGION POP** |
| --- | --- | --- | --- | --- | --- | --- |
| 001-Fairfield | 120-Bridgeport | 958,371 | 326,381 | 326,381 | 34% | 100% |
| 001-Fairfield | 140-Naugatuck Valley | 958,371 | 451,887 | 41,206 | 4% | 9% |
| 001-Fairfield | 190-Western CT | 958,371 | 620,666 | 590,784 | 62% | 95% |
| 003-Hartford | 110-Capitol | 897,903 | 977,165 | 825,488 | 92% | 84% |
| 003-Hartford | 140-Naugatuck Valley | 897,903 | 451,887 | 61,052 | 7% | 14% |
| 003-Hartford | 160-Northwest Hills | 897,903 | 112,696 | 11,363 | 1% | 10% |
| 005-Litchfield | 140-Naugatuck Valley | 185,765 | 451,887 | 54,550 | 29% | 12% |
| 005-Litchfield | 160-Northwest Hills | 185,765 | 112,696 | 101,333 | 55% | 90% |
| 005-Litchfield | 190-Western CT | 185,765 | 620,666 | 29,882 | 16% | 5% |
| 007-Middlesex | 130-Lower CT River Valley | 165,206 | 175,244 | 165,206 | 100% | 94% |
| 009-New Haven | 140-Naugatuck Valley | 866,377 | 451,887 | 295,079 | 34% | 65% |
| 009-New Haven | 170-South Central CT | 866,377 | 571,298 | 571,298 | 66% | 100% |
| 011-New London | 130-Lower CT River Valley | 268,448 | 175,244 | 10,038 | 4% | 6% |
| 011-New London | 150-Northeastern CT | 268,448 | 95,687 | 2,567 | 1% | 3% |
| 011-New London | 180-Southeastern CT | 268,448 | 280,293 | 255,843 | 95% | 91% |
| 013-Tolland | 110-Capitol | 152,594 | 977,165 | 151,677 | 99% | 16% |
| 013-Tolland | 150-Northeastern CT | 152,594 | 95,687 | 917 | 1% | 1% |
| 015-Windham | 150-Northeastern CT | 116,653 | 95,687 | 92,203 | 79% | 96% |
| 015-Windham | 180-Southeastern CT | 116,653 | 280,293 | 24,450 | 21% | 9% |

# Acquiring Publicly Available Data for GPCI Development

This section includes additional details on acquiring the publicly available data for developing the updated GPCIs.

## Bureau of Labor Statistics Occupational Employment and Wage Statistics

The May 2023 BLS OEWS data is available through the U.S. Department of Labor’s OEWS Data website.[[39]](#footnote-40) The OEWS data on the website is organized by date, with the most recently available data shown at the top of the webpage. ARC downloaded the publicly available data under the headings “OEWS Data,” “May 2023.”[[40]](#footnote-41) The data files are available in both HTML and XLS formats.

ARC also downloaded the May 2023 Metropolitan and Nonmetropolitan Area Definitions. This file is available as a Microsoft Excel file and can be found here: [May 2023 OEWS Metropolitan and Nonmetropolitan Area Definitions](https://www.bls.gov/oes/current/msa_def.htm).

## United States Census Bureau American Community Survey

[The following steps were used in the CY 2026 update to download the ACS rent data used in creating the Office Rent index:](https://data.census.gov)

1. Navigate to [data.census.gov](https://data.census.gov/)
2. Under “Explore Census Data” choose “Advanced Search”
3. Enter “B25031” in Table Id
4. Narrow Search with Filter
   1. Geography – choose “County” – select “All Counties within the United States and Puerto Rico”
   2. Survey – choose “American Community Survey” – select “5-Year Estimates”
   3. Then select “Search”
5. Then Select “View All Tables”
   1. Choose “Download Table”
6. Then Select “ACS 5-Year Estimates Detailed Tables”
   1. Choose “Download”

The download includes 1 .csv file (metadata), 1 .csv file (data) and 1 .txt file (table notes).

## Geographic Crosswalks and Weights

ARC downloaded the following publicly available data to create a database of geographic crosswalks and weights that were used in developing the updated GPCIs.

Table 9.C.: List of Geographic Data Files Used in Developing Updated GPCIs

| **Description** | **Source** | **Link** |
| --- | --- | --- |
| 2022 State, County, Minor Civil Division, and Incorporated Place FIPS Codes | US Census Bureau | <https://www2.census.gov/programs-surveys/popest/geographies/2022/all-geocodes-v2022.xlsx> |
| CBSA, MSA, CSA Delineation file, March 2023 | US Census Bureau | <https://www2.census.gov/programs-surveys/metro-micro/geographies/reference-files/2023/delineation-files/list1_2023.xlsx> |
| Total US Population by County | 2022 American Community Survey 5-Year Estimates (2018-2022) | <https://data.census.gov/table>[[41]](#footnote-42) |
| Total US Population by County Subdivision | 2022 American Community Survey 5-Year Estimates (2018-2022) | <https://data.census.gov/table>[[42]](#footnote-43) |
| 2024 Medicare PFS Locality Configuration, filename: 24LOCCO | CMS | <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/PFSLOCCO.zip> |
| Connecticut County-to-County Subdivision Crosswalk | US Census Bureau | <https://www2.census.gov/geo/docs/reference/ct_change/ct_cou_to_cousub_crosswalk.xlsx> |

As previously mentioned in the report, the key geographic measures include counties, states, Medicare payment localities, and various definitions of metropolitan area. This geographic database facilitated the creation of the GPCIs and was used to crosswalk various geographic areas and create county-level population weights.

# Proposed Process for Consolidating Occupation Codes for Use in the WORK GPCI

## Overview

In the CY 2023 update, we reviewed the list of occupation codes based on the current methodology and ultimately added two new occupation groups (including Management Occupations and Business and Financial Operation Occupations). This research also resulted in the addition of four occupation codes to the existing occupation group Computer, Mathematical, Life, and Physical Science group and three occupation codes to existing Social Science, Community and Social Service, and Legal group in the CY 2023 PFS final rule. The effect of the inclusion of additional groups/codes on the resulting WORK GPCIs was minimal but resulted in a more complete set of codes based on the current methodology.[[43]](#footnote-44)

In the CY 2026 update, we tracked changes in codes from the prior list over time to align with the updated BLS data. As described in the report, for the CY 2026 update, we used the same nine occupation groups as the prior update, including (1) Architecture and Engineering, (2) Computer, Mathematical, Life and Physical Science, (3) Social Science, Community and Social Service and Legal, (4) Education, Training and Library, (5) Registered Nurses, (6) Pharmacists, (7) Art, Design, Entertainment, Sports and Media, (8) Management and (9) Business and Financial Operations.

Our research also focused on the potential value of using public data in a more systematic way to create a consolidated set of occupation codes for use in calculating the WORK GPCI versus the current approach. Use of a more parsimonious set of occupations could be an improvement in the update process, if it results in essentially the same GPCI values with increased simplicity and clarity for stakeholders and analysts. It can also provide for a consistent and transparent method for selecting occupation codes used in the calculation.

As the number of codes included in the WORK GPCI increases, it presents a few challenges. For example, it becomes challenging to track changes over time. This also means that as new codes are added, the full list of occupation codes should be periodically reviewed for inclusion as well (as was done in the CY 2023 update). However, as BLS continues to refine and revise the occupation codes, data are often missing in many counties for newly created or uncommon occupations. As a result, although the list of included codes expands over time, it is not clear that the inclusion of many occupations improves the WORK GPCI’s ability to capture across-area variation in professional wages. In other words, the extensive list of included occupations may be misleading with regard to the extent to which they actually have enough data available across the nation to improve the WORK GPCI’s ability to reflect geographic variation in wages. Given there is not currently systematic inclusion criteria for the codes, ARC researched the potential value of using public data to create a consolidated set of occupation codes for use in calculating the WORK GPCI versus the current approach. We researched available data and potential processes to propose a more methodological approach for selecting occupation codes used in calculating the WORK GPCI that doesn’t rely on simply adding new codes to the increasingly long list of codes. By using information about educational attainment for each occupation and about geographic data completeness, CMS could establish clear, consistent inclusion criteria across future WORK GPCI updates.

Due to the timing for completing the current update (CY 2026), our research on the process for consolidating the list of occupation codes used in calculating the WORK GPCI was based on a combination of files from the current (CY 2026) and prior update (CY 2023) and the findings presented in this section can be used as proof-of-concept for the process. Once thresholds and selection criteria (explained in more detail below) are determined, ARC can re-run the analysis presented in this section to produce a final list of codes that meet the agreed upon thresholds. We can then compare the final list to these proof-of-concept lists of codes chosen to see if there are any changes. While we do not expect significant changes based on analysis using current data, it is important to clarify that the numbers shown below in this section are not considered final and subject to change.

## Proposed Process

We explored an approach to condense the list of codes in a more systematic and efficient way using two criteria: educational attainment and data existence.[[44]](#footnote-45)

### Educational Attainment

Educational attainment is the foundation of the current approach for selecting occupation codes used in calculating the WORK GPCI, but there is currently not a systematic way for determining what occupations typically require higher education and what level of educational attainment is appropriate to use. This leads to the selection being more subjective and could result in inconsistencies over time. To add transparency and efficiency in selecting occupations based on educational attachment, we propose using the following BLS data file: *Educational attainment for workers 25 years and older by detailed occupation*.[[45]](#footnote-46) This file includes the education level for workers 25 years and older for each occupation code in the BLS data.

The use of this file is beneficial for a number of reasons. Firstly, since it is a BLS data source, the occupation codes align with the occupation codes in the wage data. No imputation or mapping is necessary. Additionally, it provides options for selecting up to seven different levels of educational attainment including: less than high school diploma, high school diploma or equivalent, some college/no degree, associate’s degree, bachelor's degree, master's degree, or Doctoral or professional degree. Finally, this data file presents the information in a clear way that allows for complete transparency when selecting occupation codes based on educational attainment. There is no bias or subjective nature to determining occupations that require certain levels of education. The education level attained (percent of workers 25 years and older) for each occupation code in the BLS data is publicly available in the data file and can be easily accessed through BLS’ website.

In our research, we used this file to summarize the number of codes where at least 50%, 75%, and 90% of employees in that occupation attained a certain level of education, and we subset the list of occupation codes to exclude occupation codes in Group 29 that are typically paid on the Physician Fee Schedule. We identified 274, 157 and 90 occupation codes with at least 50%, 75%, and 90% having a bachelor’s degree or higher, excluding occupation codes in Group 29 that are paid on the Fee Schedule, respectively from the May 2023 OEWS data. These stratifications were used as examples and can be modified if alternative levels are identified. Additional analyses can be done using alternative levels of education attainment and/or subsets of occupation codes.

### Data Existence

After selecting occupation codes under the education criteria for this illustration, we then reviewed how well those codes are represented in the BLS OEWS data. For an occupation code to provide a robust impact in the WORK GPCI calculation, it should exist in multiple counties across the U.S. and be reasonably-well represented in the data file.

In order to determine various levels of data completeness, we tabulated which occupation codes that met the educational attainment criteria above were present in at least 50%, 75%, and 90% of U.S. counties. This analysis was based on geographic data as of the summer of 2024, before the data used for this CY 2026 update were released. As a result, the specific list of occupations included under each scenario should be considered illustrative. We do not expect significant changes but caution that the list of included specialties could change if the analysis were updated based on more recent employment and completeness analyses, which could, in turn, affect the measured effect on the WORK GPCI.

## Consolidating Occupation Codes

Table 10.C.1 below shows the various subsets of occupation codes for those that meet an educational attainment threshold and with wage data for at least 50% of U.S. counties, for at least 75% of U.S. counties, and for at least 90% of U.S. counties.

**Table 10.C.1: Occupation Codes by Level of Educational Attainment and Data Existence, (Excluding Occupation Codes in Group 29 that are Typically Paid on the Physician Fee Schedule)**

| **OCCUPATION CODE SUBSET** | **BACHELOR’S DEGREE OR HIGHER ≥ 50%** | **BACHELOR’S DEGREE OR HIGHER ≥ 75%** | **BACHELOR’S DEGREE OR HIGHER ≥ 90%** |
| --- | --- | --- | --- |
| All occupation codes | 274 (100%) | 157 (100%) | 90 (100%) |
| Codes with wage data for at least 50% of U.S. counties | 112 (41%) | 57 (36%) | 23 (26%) |
| Codes with wage data for at least 75% of U.S. counties | 69 (25%) | 31 (20%) | 8 (9%) |
| Codes with wage data for at least 90% of U.S. counties | 45 (16%) | 19 (12%) | 4 (4%) |

Disclaimer:Given the timing of this research, ARC used the May 2023 BLS wage data in conjunction with the geography files from the prior update (CY 2023). If CMS were to adopt this approach for selecting occupation codes used in calculating the WORK GPCI described in this section, the results based on more updated data may differ from those shown in this table.

## Comparison of Changes in the WORK GPCIs

Based on numbers of occupations under the various scenarios reported above, CMS requested that we focus on two scenarios to examine the effect on the CY 2026 WORK GPCI of different thresholds: (1) occupation codes with at least 75% of Bachelor’s Degree or Higher excluding Group 29 and wage data for at least 50% of U.S. counties, resulting in a list of 57 occupation codes and (2) occupation codes with at least 75% of Bachelor’s Degree or Higher excluding Group 29 and wage data for at least 75% of U.S. counties, resulting in a list of 31 occupation codes from the May 2023 OWES data. Tables 10.D.1 and 10.D.2 below show the preliminary list of occupation codes in each group.

**Table 10.D.1: Occupation codes with ≥75% Bachelors’ degrees (or higher) and data existence for ≥50% of U.S. counties**

| **OCCUPATION CODE** | **OCCUPATION TITLE** |
| --- | --- |
| 11-2021 | Marketing Managers |
| 11-9031 | Education and Childcare Administrators, Preschool and Daycare |
| 11-9032 | Education Administrators, Kindergarten through Secondary |
| 11-9033 | Education Administrators, Postsecondary |
| Nov-41 | Architectural and Engineering Managers |
| 13-1111 | Management Analysts |
| 13-1131 | Fundraisers |
| 13-1161 | Market Research Analysts and Marketing Specialists |
| 13-2011 | Accountants and Auditors |
| 13-2051 | Financial and Investment Analysts |
| 13-2052 | Personal Financial Advisors |
| 15-1252 | Software Developers |
| 15-2051 | Data Scientists |
| 17-1022 | Surveyors |
| 17-2051 | Civil Engineers |
| 17-2071 | Electrical Engineers |
| 17-2141 | Mechanical Engineers |
| 17-2199 | Engineers, All Other |
| 19-1031 | Conservation Scientists |
| 19-2031 | Chemists |
| 19-2041 | Environmental Scientists and Specialists, Including Health |
| 19-3033 | Clinical and Counseling Psychologists |
| 19-3034 | School Psychologists |
| 21-1012 | Educational, Guidance, and Career Counselors and Advisors |
| 21-1018 | Substance Abuse, Behavioral Disorder, and Mental Health |
| 21-1021 | Child, Family, and School Social Workers |
| 21-1023 | Mental Health and Substance Abuse Social Workers |
| 21-1029 | Social Workers, All Other |
| 21-1092 | Probation Officers and Correctional Treatment Specialists |
| 21-2011 | Clergy |
| 23-1011 | Lawyers |
| 23-1023 | Judges, Magistrate Judges, and Magistrates |
| 25-1011 | Business Teachers, Postsecondary |
| 25-1022 | Mathematical Science Teachers, Postsecondary |
| 25-1042 | Biological Science Teachers, Postsecondary |
| 25-1071 | Health Specialties Teachers, Postsecondary |
| 25-1072 | Nursing Instructors and Teachers, Postsecondary |
| 25-1081 | Education Teachers, Postsecondary |
| 25-1121 | Art, Drama, and Music Teachers, Postsecondary |
| 25-1123 | English Language and Literature Teachers, Postsecondary |
| 25-1194 | Career/Technical Education Teachers, Postsecondary |
| 25-1199 | Postsecondary Teachers, All Other |
| 25-2021 | Elementary School Teachers, Except Special Education |
| 25-2022 | Middle School Teachers, Except Special and Career/Technical |
| 25-2031 | Secondary School Teachers, Except Special and Career/Techni |
| 25-2032 | Career/Technical Education Teachers, Secondary School |
| 25-2052 | Special Education Teachers, Kindergarten and Elementary Sch |
| 25-2057 | Special Education Teachers, Middle School |
| 25-2058 | Special Education Teachers, Secondary School |
| 25-3041 | Tutors |
| 25-4022 | Librarians and Media Collections Specialists |
| 25-9031 | Instructional Coordinators |
| 25-9099 | Educational Instruction and Library Workers, All Other |
| 27-2012 | Producers and Directors |
| 27-3031 | Public Relations Specialists |
| 27-3041 | Editors |
| 29-1131 | Veterinarians |
| Disclaimer:Given the timing of this research, ARC used the May 2023 BLS wage data in conjunction with the geography files from the prior update (CY 2023). If CMS were to adopt this approach for selecting occupation codes used in calculating the WORK GPCI described in this section, the results based on more updated data may differ from those shown in this table. | |

**Table 10.D.2: Occupation Codes with ≥75% Bachelors’ Degrees (or Higher) and Data Existence for ≥75% of U.S. Counties**

| **OCCUPATION CODE** | **OCCUPATION TITLE** |
| --- | --- |
| 11-2021 | Marketing Managers |
| 11-9032 | Education Administrators, Kindergarten through Secondary |
| 11-9033 | Education Administrators, Postsecondary |
| Nov-41 | Architectural and Engineering Managers |
| 13-1111 | Management Analysts |
| 13-1161 | Market Research Analysts and Marketing Specialists |
| 13-2011 | Accountants and Auditors |
| 13-2051 | Financial and Investment Analysts |
| 13-2052 | Personal Financial Advisors |
| 15-1252 | Software Developers |
| 17-2051 | Civil Engineers |
| 17-2071 | Electrical Engineers |
| 17-2141 | Mechanical Engineers |
| 21-1012 | Educational, Guidance, and Career Counselors and Advisors |
| 21-1018 | Substance Abuse, Behavioral Disorder, and Mental Health |
| 21-1021 | Child, Family, and School Social Workers |
| 21-1023 | Mental Health and Substance Abuse Social Workers |
| 21-1092 | Probation Officers and Correctional Treatment Specialists |
| 23-1011 | Lawyers |
| 25-1194 | Career/Technical Education Teachers, Postsecondary |
| 25-2021 | Elementary School Teachers, Except Special Education |
| 25-2022 | Middle School Teachers, Except Special and Career/Technical |
| 25-2031 | Secondary School Teachers, Except Special and Career/Techni |
| 25-2032 | Career/Technical Education Teachers, Secondary School |
| 25-2052 | Special Education Teachers, Kindergarten and Elementary Sch |
| 25-2058 | Special Education Teachers, Secondary School |
| 25-3041 | Tutors |
| 25-4022 | Librarians and Media Collections Specialists |
| 25-9031 | Instructional Coordinators |
| 27-3031 | Public Relations Specialists |
| 29-1131 | Veterinarians |
| Disclaimer:Given the timing of this research, ARC used the May 2023 BLS wage data in conjunction with the geography files from the prior update (CY 2023). If CMS were to adopt this approach for selecting occupation codes used in calculating the WORK GPCI described in this section, the results based on more updated data may differ from those shown in this table. | |

As shown in Table 10.D.3, the WORK GPCIs under both scenarios result in changes relative to current CY 2025 values that are very similar to those under the CY 2026 GPCI update. Very little redistribution would be expected based on the two alternatives using the educational attainment and data existence thresholds relative to current values.

**Table 10.D.3: Distribution of Work GPCI Change Under Consolidated Occupation Code Lists, Transition Values for CY 2026 Compared to CY 2025 Values**

| **SIZE OF CHANGE IN MEASURE** | **CY 2026 Update** | **BACHELOR’S DEGREE OR HIGHER ≥ 75%, WAGE DATA FOR ≥ 50% OF U.S. COUNTIES** | **BACHELOR’S DEGREE OR HIGHER ≥ 75%, WAGE DATA FOR ≥ 75% OF U.S. COUNTIES** |
| --- | --- | --- | --- |
| < - 4% | 0 | 0 | 0 |
| -4% to < -1.5% | 13 | 12 | 13 |
| -1.5% to < -0.5% | 36 | 37 | 37 |
| -0.5% to < 0.5% | 53 | 54 | 53 |
| 0.5% to < 1.5% | 7 | 6 | 6 |
| 1.5% or more | 0 | 0 | 0 |

Disclaimer:Given the timing of this research, ARC used the May 2023 BLS wage data in conjunction with the geography files from the prior update (CY 2023). If CMS were to adopt this approach for selecting occupation codes used in calculating the WORK GPCI described in this section, the results based on more updated data may differ from those shown in this table.

## Next Steps

As noted above, the research described in this section for consolidating the list of occupation codes initially started using files from the prior update (CY 2023). Because of the timing for completing the current update (CY 2026), the findings presented here can be used as proof-of-concept for the process.

We also note that the practical effect of consolidating the list of occupation codes is likely minimal because of the 25 percent limit on variation in WORK GPCI that is allowed by Section 1848(e)(1)(A)(iii) of the Social Security Act. This legislation states that the WORK GPCI should reflect “¼ of the difference between the relative value of physicians’ work effort in each of the different fee schedule areas and the national average of such work effort.”[[46]](#footnote-47)

ARC will continue to work with CMS to determine appropriate thresholds for educational attainment and data existence and will incorporate feedback and comments received on the proposed data and processes. If CMS decides to move forward with this process for selecting occupation codes used in calculating the WORK GPCI, ARC will finalize the list of codes based on current data and analyze the potential effect of using the new set of occupation codes on the WORK GPCI. We can then compare the final list to these proof-of-concept lists of codes chosen to see if there are any changes, as well as compare that effect to changes in WORK GPCI values that occur as a result of the standard 3-year data update process.[[47]](#footnote-48) While we do not expect significant changes based on analysis using current data, it is important to clarify that the numbers this section are not considered final.

1. Some codes are exempted from this policy. [↑](#footnote-ref-2)
2. As explained in a later section, Puerto Rico and the Virgin Islands are assigned GPCI values of 1 and the other Pacific territories are assigned Hawaii’s GPCI values. [↑](#footnote-ref-3)
3. See <https://www.serff.com/serff_filing_access.htm>. [↑](#footnote-ref-4)
4. National Association of Insurance Commissioners (NAIC). 2023 Market Share Reports for Property/Casualty Groups and Companies by State and Countrywide. (August 2024). <https://content.naic.org/sites/default/files/publication-msr-pb-property-casualty.pdf>. Accessed October 15, 2024. [↑](#footnote-ref-5)
5. Insurance groups are made up of insurance companies that are related by ownership. The NAIC market share report presents data by group for those insurers that are members of a group to better reflect the number of distinct entities competing against one another for business in a market. [↑](#footnote-ref-6)
6. “Consent-to-rate” filings are not considered rate filings. [↑](#footnote-ref-7)
7. As described in Section 3.E, several states have Patient Compensation Funds. In these states, different coverage limits may apply. [↑](#footnote-ref-8)
8. In a few instances a filing provided premiums for coverage of $1 million/$3 million. In these cases, no PCF surcharge was applied. [↑](#footnote-ref-9)
9. Kansas Health Care Stabilization Fund, General Information. (May 2022). <https://hcsf.kansas.gov/wp-content/uploads/2022/05/General-Information-doc-2022.pdf>. Accessed October 15, 2024. [↑](#footnote-ref-10)
10. Pennsylvania Insurance Department. 2023 Mcare Assessment Manual. (January 2023). <https://www.pa.gov/content/dam/copapwp-pagov/en/insurance/documents/specialfunds/mcare/documents/2023%20mcare%20assessment%20manual.pdf>. Accessed October 15, 2024. [↑](#footnote-ref-11)
11. State of Wisconsin, Office of the Commissioner of Insurance. IPFCF Coverage; Overview. (April 2024). <https://oci.wi.gov/Pages/Funds/IPFCFCoverage.aspx>. Accessed October 15, 2024. [↑](#footnote-ref-12)
12. Pennsylvania: 2023 Mcare Assessment Manual.pdf; Kansas: 2023-Surchage-Rate-Table.pdf and HCSF-Classification-Groups.pdf. Accessed October 15, 2024. [↑](#footnote-ref-13)
13. Based on CMS policy beginning in CY 2020, we did not develop premium data for CMS specialties that are excluded from the PE Ratesetting process. [↑](#footnote-ref-14)
14. For example, although Yoga Instructor is included on some filings, it has not been mapped to a CMS specialty. [↑](#footnote-ref-15)
15. In addition to this standard range of surgical codes, services included in CMS’s list of Invasive Cardiology Services Outside of Surgical HCPCS Code Range Considered Surgery are also considered as SURGICAL for the purpose of MP RVU development. This list is included with each PFS Notice of Proposed Rulemaking and Final Rule. [↑](#footnote-ref-16)
16. For this calculation, Insurer A was assumed to have 55 percent of the market while Insurer B had 30 percent. [↑](#footnote-ref-17)
17. The two equations are:

    (1) Insurer C’s single rate is weighted average of implicit Surgery (S) and No Surgery (NS) rates: 54=.55\* S +.45\*NS

    (2) The ratio of Insurer C’s S/NS rates will be similar to the market-share weighted average of other insurers for the specialty: 1.450088 = S/NS

    This allows us to calculate the rates for Insurer C as: NS = 54 / (.55\*1.45 + .45) = 43.28; S= 1.45\*43.28=62.77 [↑](#footnote-ref-18)
18. Based on input from stakeholders CMS advised us to make an exception for the CMS specialty Gynecologist/oncologist. Per this guidance, the *national* premium for 98-Gynecologist/oncologist (ALL) was set equal to the *national* premium for 91-Surgical oncology (ALL). [↑](#footnote-ref-19)
19. Based on input from stakeholders, CMS requested that three specialties be mapped to a source other than their impact specialty: 98-Gynecologist/oncologists (ALL), C0-Sleep Medicine (ALL), C7- Advanced Heart Failure and Transplant Cardiology (ALL). [↑](#footnote-ref-20)
20. If multiple specialties were frequently mapped to the same risk class as the underrepresented specialty, we selected the specialty that was more clinically related as the source for imputation. For example, Osteopathic Manipulative Therapy was typically assigned to the same risk class as both Allergy/Immunology and Physical Medicine and Rehabilitation, and we selected the latter as the imputation source. [↑](#footnote-ref-21)
21. See Section 9 for a more detailed description of how to access the public data resources referred to in this section. [↑](#footnote-ref-22)
22. United States Department of Labor, Bureau of Labor Statistics. Occupational Employment and Wage Statistics. OEWS data. <https://www.bls.gov/oes/tables.htm>. Downloaded July 17, 2024. [↑](#footnote-ref-23)
23. United States Department of Labor, Bureau of Labor Statistics. Occupational Employment and Wage Statistics. Technical Notes for May 2023 OEWS Estimates. April 3, 2024. <https://www.bls.gov/oes/current/oes_tec.htm>. Accessed December 5, 2024. [↑](#footnote-ref-24)
24. Ibid. [↑](#footnote-ref-25)
25. The CY 2023 Update report can be found here: [CY 2023 PFS Final Rule GPCI-MP Update Report](https://www.cms.gov/files/zip/cy-2023-pfs-final-rule-gpci-mp-update-report.zip). Research on commercial rent data sources is and will continue to be needed to understand what data is available and if data sources have been changed or improved over time, or if new commercial data sources become available for use. [↑](#footnote-ref-26)
26. Preparing the RVU data for use in the GPCI measure creation entailed dropping observations where MTUS, total Work RVUs, total PE RVUs, or total MP RVUs were less than or equal to zero. [↑](#footnote-ref-27)
27. For more information, please see the CY 2023 Update Report: [CY 2023 PFS Final Rule GPCI-MP Update Report](https://www.cms.gov/files/zip/cy-2023-pfs-final-rule-gpci-mp-update-report.zip). [↑](#footnote-ref-28)
28. ARC has conducted preliminary research on an approach to update the list of occupation codes used in the WORK GPCI based on educational attainment and data completeness which could be used as an alternative approach to updating this measure every three years. [↑](#footnote-ref-29)
29. BLS Employment Projections; Table 5.3 [Educational attainment for workers 25 years and older by detailed occupation : U.S. Bureau of Labor Statistics](https://www.bls.gov/emp/tables/educational-attainment.htm) [↑](#footnote-ref-30)
30. Specifically, we used NAIC 621100, but then excluded these occupation codes: 19-3039, 29-1011, 29-1021,

    29-1022, 29-1023, 29-1029, 29-1041, 29-1211, 29-1215, 29-1216, 29-1218, 29-1221, 29-1223, 29-1248, 29-1228, 29-1071, 29-1081, 29-1122, 29-1123, 29-1125, 29-1128, 29-1129. [↑](#footnote-ref-31)
31. We apportioned the known group-level market share to the company/specialty level based on how many cases for the specialty were included across the group’s filings. So, for example, if a group had two companies, its market share was divided by two for any specialty included in both companies’ filings but was given entirely to any specialty that was only included on one of the filings. This process ensured that the group’s market share was consistent in aggregate across all specialties ever reported by a company of the group. [↑](#footnote-ref-32)
32. For use in ratesetting, the budget-neutral GPCIs are subject to the 50/50 blend. [↑](#footnote-ref-33)
33. While the number of localities increases from 9 to 27 under the MSA-based structure, CMS originally recognized 32 localities for the purposes of payment. CMS finalized the retirement of three localities that were no longer operationally necessary in CY 2023 rulemaking, resulting in a total of 29, effective for CY 2024. See <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Locality.html> for additional details on the locality configuration. Accessed January 8, 2025. [↑](#footnote-ref-34)
34. The WORK GPCI floor of 1.0 that was applied in previous updates was extended only through September 30, 2025 by Section 2206 of Full-Year Continuing Appropriations and Extensions Act, 2025. Therefore, this floor does not apply for the CY2026 update under current law. [↑](#footnote-ref-35)
35. The definition of frontier state is based on 2010 Census data and remains unchanged from the current GPCI calculations. As of 2015, the states which qualified as frontier states were: Montana, Nevada, North Dakota, South Dakota, and Wyoming. [↑](#footnote-ref-36)
36. MP RVUs are not included in the calculation due to concerns about endogeneity. [↑](#footnote-ref-37)
37. US Department of Commerce. Change to County-Equivalents in the State of Connecticut. 87 FR 34235. (June 2022). <https://www.federalregister.gov/d/2022-12063>. Accessed January 8, 2025. [↑](#footnote-ref-38)
38. The US Census Bureau published a crosswalk of each Connecticut county subdivision to both legacy county and planning region. See <https://www2.census.gov/geo/docs/reference/ct_change/ct_cou_to_cousub_crosswalk.xlsx> (Accessed January 8, 2025). Population statistics were calculated by applying this crosswalk to the same American Community Survey (ACS) population data used for weighting throughout the GPCI calculation. See section 9.C below for more information about the Geographic Crosswalk and Weight data used to facilitate the GPCI calculation. [↑](#footnote-ref-39)
39. The OEWS May 2023 data can be found here: <https://www.bls.gov/oes/#data> <https://www.bls.gov/oes/tables.htm> [↑](#footnote-ref-40)
40. At the time of the GPCI data collection, May 2023 was the most recently available OEWS data. [↑](#footnote-ref-41)
41. Create table from Census Website, Advanced Search: Surveys = American Community Survey -> 5-Year Estimates -> Detailed Tables; Topic = Populations and People -> Populations and People; Geography = County -> All Counties within United States and Puerto Rico. Finally, select table B01003 – Total Population. [↑](#footnote-ref-42)
42. Create table from Census Website, Advanced Search: Surveys = American Community Survey -> 5-Year Estimates -> Detailed Tables; Topic = Populations and People -> Populations and People; Geography = County Subdivision, then select the following states: CT, MA, ME, NH, RI, VT. Finally, select table B01003 – Total Population. [↑](#footnote-ref-43)
43. The current approach uses a list of occupation codes representing a variety of highly educated professionals in the WORK GPCI calculation (not considering how well the occupation codes are represented geographically). [↑](#footnote-ref-44)
44. These criteria were used to provide examples of how the list of occupation codes can be consolidated in a more systematic way. Additional criteria and/or alternative stratification for selecting occupation codes can also be considered. [↑](#footnote-ref-45)
45. BLS Employment Projections; Table 5.3 [Educational attainment for workers 25 years and older by detailed occupation : U.S. Bureau of Labor Statistics](https://www.bls.gov/emp/tables/educational-attainment.htm) [↑](#footnote-ref-46)
46. U.S. Social Security Administration. Compilation of the Social Security Laws. Payment for Physicians’ Services. Sec. 1848. 42 U.S.C. 1395w–4 (a) Payment Based on Fee Schedule. <https://www.ssa.gov/OP_Home/ssact/title18/1848.htm>. Accessed January 10, 2022. [↑](#footnote-ref-47)
47. It is important to note that given the 25% limitation on variation and the data existence and sufficiency analyzed on the current set of occupation codes, the 3-year data update would likely affect GPCI values more than the refinement of included occupations analyzed. [↑](#footnote-ref-48)