

***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

1 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.

2 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 effect¹ 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

¹ Some codes are exempted from this policy.

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.

3 Developing Malpractice Premiums for the Update of the CY 2026 GPICs and Malpractice Risk Index

A. Overview

Underlying the malpractice risk index and MP GPIC 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.

B. 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

C. 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 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.

D. 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.

1. 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 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 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%),

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.

³ See https://www.serff.com/serff_filing_access.htm.

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.

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.

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.

2. 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.

a) 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.

b) 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.

c) 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.

d) 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

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.

⁶ “Consent-to-rate” filings are not considered rate filings.

e) 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 The same level of coverage is used for the CY 2026 update.

E. 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 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
- Pennsylvania: Primary coverage of \$500 thousand/\$1.5 million; Medical Professional Liability Catastrophe Loss Fund (Mcare) coverage of \$500 thousand/\$1.5 million.¹⁰
- Wisconsin: Primary coverage of \$1 million/\$3 million; no surcharge.¹¹

⁷ As described in Section 3.E, several states have Patient Compensation Funds. In these states, different coverage limits may apply.

⁸ In a few instances a filing provided premiums for coverage of \$1 million/\$3 million. In these cases, no PCF surcharge was applied.

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.

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.

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.

For Kansas and Pennsylvania, surcharges were developed from pricing information reported on the state's website.¹² For Wisconsin, the primary coverage limits match the standard limit for all states, so no surcharges were added.

F. 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.

G. 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.

1. 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 specialties¹³ 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

¹² Pennsylvania: 2023 Mcare Assessment Manual.pdf; Kansas: 2023-Surcharge-Rate-Table.pdf and HCSF-Classification-Groups.pdf. Accessed October 15, 2024.

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.

¹⁴ For example, although Yoga Instructor is included on some filings, it has not been mapped to a CMS specialty.

2. 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 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

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.

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-weighted¹⁶ 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

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.

¹⁶ For this calculation, Insurer A was assumed to have 55 percent of the market while Insurer B had 30 percent.

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: $NS = 54 / (.55 * 1.45 + .45) = 43.28$; $S = 1.45 * 43.28 = 62.77$

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.

3. 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 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 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 For instance, filings that explicitly reported premiums for Hospice and Palliative Care

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).

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).

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

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.

4 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

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.

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.

A. 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

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

²¹ See Section 9 for a more detailed description of how to access the public data resources referred to in this section.

COMPONENT	MEANING	SOURCE
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.

1. 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 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

Additional information on the scope of the survey, the survey sample and estimation methodology can be found on BLS' website.²⁴ Details on BLS OEWS data acquisition can be found in Section 9 of the report.

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.

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.

²⁴ Ibid.

2. 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

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.

3. 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

4. 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

²⁵ The CY 2023 Update report can be found here: [CY 2023 PFS Final Rule GPCI-MP Update Report](#). 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.

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.

PE GPCI ELEMENT	MEI SHARE	SHARE OF PE
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.

5. 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.

B. 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.

1. 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 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 Table 8.D.1-Table 8.D.6 list the occupation codes

²⁷ For more information, please see the CY 2023 Update Report: [CY 2023 PFS Final Rule GPCI-MP Update Report](#).

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.

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 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.

²⁹ BLS Employment Projections; Table 5.3 [Educational attainment for workers 25 years and older by detailed occupation : U.S. Bureau of Labor Statistics](#)

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.

a) 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.

b) 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.

2. 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.

a) 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 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.

b) 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.

c) 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.

d) 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

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.

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.

e) 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.

f) 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.

g) 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.

h) 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.

3. Malpractice GPCI

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

a) 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
- 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.

b) 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.

4. Geographic Adjustment Factor

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

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

$$GAF_L = (GPCI_{WORK,L} \times 0.497343357) + (GPCI_{PE,L} \times 0.4622908972) + (GPCI_{MP,L} \times 0.0403657458)$$

It is calculated as the weighted average of the three GPICs (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

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.

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.

C. 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.

1. 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.

2. 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

3. 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.

³² For use in ratesetting, the budget-neutral GPCIs are subject to the 50/50 blend.

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 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).

4. 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.

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.

5. Other Legislative Adjustments

There are two other legislatively mandated adjustments to the GPCIs that are used for payment:³⁴

- 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 (SSA Section 1848(e)(1)(I)).

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

D. 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

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.

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.

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.

5 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.

A. 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.

B. 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.

C. 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

³⁶ MP RVUs are not included in the calculation due to concerns about endogeneity.

D. 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	1 ST DEC.	2 ND DEC.	3 RD DEC.	4 TH DEC.	5 TH DEC.	6 TH DEC.	7 TH DEC.	8 TH DEC.	9 TH DEC.	10 TH DEC.
ALL	100	10	10	10	10	10	10	10	10	10	10
1 ST DECILE	10	9.84	0.15	0	0	0	0	0	0	0	0
2 ND DEC.	10	0.04	9.70	0.26	0	0	0	0	0	0	0
3 RD DEC.	10	0	0.16	9.52	0.33	0	0	0	0	0	0
4 TH DEC.	10	0.02	0	0.22	9.44	0.32	0	0	0	0	0
5 TH DEC.	10	0	0	0	0.23	9.44	0.33	0	0	0	0
6 TH DEC.	10	0.04	0	0	0	0.21	9.35	0.40	0	0	0
7 TH DEC.	10	0	0	0	0	0.03	0.25	9.37	0.35	0	0
8 TH DEC.	10	0	0	0	0	0	0.06	0.22	9.40	0.32	0
9 TH DEC.	10	0.04	0	0	0	0	0.01	0.01	0.25	9.49	0.20
10 TH 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.

6 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.

7 Data Tables

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

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

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

B. 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%

CMS SPECIALTY	SERVICE RISK GROUP	% U.S. POP - RAW FILINGS	% U.S. POP - FINAL
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%

CMS SPECIALTY	SERVICE RISK GROUP	% U.S. POP - RAW FILINGS	% U.S. POP - FINAL
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%

CMS SPECIALTY	SERVICE RISK GROUP	% U.S. POP - RAW FILINGS	% U.S. POP - FINAL
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%

CMS SPECIALTY	SERVICE RISK GROUP	% U.S. POP - RAW FILINGS	% U.S. POP - FINAL
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%

C. 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

CMS SPECIALTY	2026 SERVICE RISK GROUP	2026 RISK INDEX	2026 NATIONAL PREMIUM	CURRENT SERVICE RISK GROUP	CURRENT RISK INDEX	CURRENT NATIONAL PREMIUM
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

CMS SPECIALTY	2026 SERVICE RISK GROUP	2026 RISK INDEX	2026 NATIONAL PREMIUM	CURRENT SERVICE RISK GROUP	CURRENT RISK INDEX	CURRENT NATIONAL PREMIUM
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

CMS SPECIALTY	2026 SERVICE RISK GROUP	2026 RISK INDEX	2026 NATIONAL PREMIUM	CURRENT SERVICE RISK GROUP	CURRENT RISK INDEX	CURRENT NATIONAL PREMIUM
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

CMS SPECIALTY	2026 SERVICE RISK GROUP	2026 RISK INDEX	2026 NATIONAL PREMIUM	CURRENT SERVICE RISK GROUP	CURRENT RISK INDEX	CURRENT NATIONAL PREMIUM
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.

D. 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

STATE	LOC. CODE	STATE/LOCALITY NAME	WORK GPCI	PE GPCI	MP GPCI	GAF	% CHANGE WORK GPCI	% CHANGE PE GPCI	% CHANGE MP GPCI	% CHANGE GAF
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

STATE	LOC. CODE	STATE/LOCALITY NAME	WORK GPCI	PE GPCI	MP GPCI	GAF	% CHANGE WORK GPCI	% CHANGE PE GPCI	% CHANGE MP GPCI	% CHANGE GAF
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

STATE	LOC. CODE	STATE/LOCALITY NAME	WORK GPCI	PE GPCI	MP GPCI	GAF	% CHANGE WORK GPCI	% CHANGE PE GPCI	% CHANGE MP GPCI	% CHANGE GAF
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

STATE	LOC. CODE	STATE/LOCALITY NAME	WORK GPCI	PE GPCI	MP GPCI	GAF	% CHANGE WORK GPCI	% CHANGE PE GPCI	% CHANGE MP GPCI	% CHANGE GAF
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

STATE	LOC. CODE	STATE/LOCALITY NAME	WORK GPCI	PE GPCI	MP GPCI	GAF	% CHANGE WORK GPCI	% CHANGE PE GPCI	% CHANGE MP GPCI	% CHANGE GAF
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

STATE	LOCALITY CODE	STATE/LOCALITY NAME	INDEX - EMPLOYEE WAGES	INDEX - OFFICE RENTS	INDEX - PURCHASED SERVICES
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

STATE	LOCALITY CODE	STATE/LOCALITY NAME	INDEX - EMPLOYEE WAGES	INDEX - OFFICE RENTS	INDEX - PURCHASED SERVICES
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

STATE	LOCALITY CODE	STATE/LOCALITY NAME	INDEX - EMPLOYEE WAGES	INDEX - OFFICE RENTS	INDEX - PURCHASED SERVICES
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

STATE	LOCALITY CODE	STATE/LOCALITY NAME	INDEX - EMPLOYEE WAGES	INDEX - OFFICE RENTS	INDEX - PURCHASED SERVICES
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

8 Reference Tables

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

A. 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

CMS SPECIALTY	IMPACT SPECIALTY
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

CMS SPECIALTY	IMPACT SPECIALTY
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

B. 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%

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
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%

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
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%

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
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

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
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.

C. 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)

CMS SPECIALTY/SERVICE RISK GROUP	CMS SPECIALTY/SERVICE RISK GROUP USED AS SOURCE FOR IMPUTATION
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).

D. 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

OCCUPATION CODE	OCCUPATION TITLE
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

OCCUPATION CODE	OCCUPATION TITLE
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

OCCUPATION CODE	OCCUPATION TITLE
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

OCCUPATION CODE	OCCUPATION TITLE
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

E. 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

COUNTY NAME	IMPUTED VALUE: MEDIAN GROSS RENT FOR 2- BEDROOMS
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

COUNTY NAME	IMPUTED VALUE: MEDIAN GROSS RENT FOR 2- BEDROOMS
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)

F. 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

CURRENT LOCALITY CODE	CURRENT STATE/LOCALITY NAME	PRIOR LOCALITY CODE	PRIOR STATE/LOCALITY NAME	TRANSITION AREA?
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

G. 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 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 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%

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.

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.

LEGACY COUNTY	PLANNING REGION	TOTAL LEGACY COUNTY POP	TOTAL PLANNING REGION POP	SHARED POPULATION	% TOTAL LEGACY COUNTY POP	% TOTAL PLANNING REGION POP
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%

9 Acquiring Publicly Available Data for GPCI Development

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

A. 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 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 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](#).

B. 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:

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

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

³⁹ The OEWS May 2023 data can be found here: <https://www.bls.gov/oes/#data> <https://www.bls.gov/oes/tables.htm>

⁴⁰ At the time of the GPCI data collection, May 2023 was the most recently available OEWS data.

C. 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
Total US Population by County Subdivision	2022 American Community Survey 5-Year Estimates (2018-2022)	https://data.census.gov/table ⁴²
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.

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.

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.

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

A. 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 GPICs was minimal but resulted in a more complete set of codes based on the current methodology.⁴³

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

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).

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.

B. 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

1. 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 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

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.

⁴⁵ BLS Employment Projections; Table 5.3 [Educational attainment for workers 25 years and older by detailed occupation : U.S. Bureau of Labor Statistics](#)

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.

2. 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.

C. 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.

D. Comparison of Changes in the WORK GPICs

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

OCCUPATION CODE	OCCUPATION TITLE
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/Technical
25-2032	Career/Technical Education Teachers, Secondary School
25-2052	Special Education Teachers, Kindergarten and Elementary School
25-2057	Special Education Teachers, Middle School
25-2058	Special Education Teachers, Secondary School
25-3041	Tutors
25-4022	Librarians and Media Collections Specialists

OCCUPATION CODE	OCCUPATION TITLE
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 $\geq 75\%$ Bachelors' Degrees (or Higher) and Data Existence for $\geq 75\%$ 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

OCCUPATION CODE	OCCUPATION TITLE
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 GPICs 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 $\geq 75\%$, WAGE DATA FOR $\geq 50\%$ OF U.S. COUNTIES	BACHELOR'S DEGREE OR HIGHER $\geq 75\%$, WAGE DATA FOR $\geq 75\%$ 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.

E. 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 “ $\frac{1}{4}$ 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

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 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.

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.

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.