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CMS' Calendar Year 2026 Medicare Physician Fee Schedule Final Rule

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On October 31, 2025, the Centers for Medicare and Medicaid Services (CMS) [released](#) the Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) Final Rule. The CMS press release can be found [here](#). A fact sheet from CMS can be found [here](#). The rule takes full effect on January 1, 2026.

CONVERSION FACTOR

For CY26, CMS will implement two separate conversion factors (CFs). For Alternative Payment Model (APM) participants, known as Qualifying Participants (QPs), the aggregate final CF is set at \$33.57, a 3.77% increase (\$1.22) from the CY25 CF of \$32.35. For non-qualifying participants (non-QPs), the aggregate final CF is \$33.40, reflecting a 3.26% increase (\$1.05) from the previous year. Notably, these aggregate updates represent a very slight reduction from the originally proposed updates (down from \$33.59 or 3.8% for qualifying APMs and \$33.42 or 3.3% for nonqualifying APMs – a \$0.02 cut in the proposed aggregate update for both categories).

A summary of the various components of those aggregate payment updates is below.

- The primary reason for the bifurcation of the CFs is the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, which reformed Medicare physician payments by replacing the outdated Sustainable Growth Rate (SGR) formula with the Quality Payment Program (QPP). Under MACRA, starting in CY26, a statutory update of 0.75% is provided for QPs that meet thresholds for participation in Advanced APMs (that emphasize quality and cost accountability) and 0.25% for non-QPs.
- In addition to the MACRA updates, the final rule includes a one-year increase of 2.50% applicable to both QPs and non-QPs, as included in this year's One Big Beautiful Bill Act (OBBBA). Enacted to address concerns over physician payment adequacy, the OBBBA's 2.50% adjustment helps offset inflation and other economic factors while Congress considers longer-term/systemic reforms to the PFS (which were considered during the development of the OBBBA but were ultimately dropped from the bill due to a combination of cost concerns and a lack of broad Republican consensus).
- Finally, the CF updates account for shifts in relative value units (RVUs), which are used to determine payment rates based on the resources required for services. CMS finalized a 0.49% adjustment to accommodate two broad-based changes in work and practice expense (PE) RVUs, as well ordinary shifts in RVUs (generally due to code values being revised). As discussed below, the broad-based modifications will have the practical effect of somewhat offsetting (in some instances, substantially) the positive CF update for certain specialties/services, particularly those delivered in the facility setting.

EFFICIENCY ADJUSTMENT

As noted above, CMS finalized two broad-based adjustments to RVUs as part of the CY26 rule. The first, an efficiency adjustment, will reduce the work component of the aggregate RVU calculations. The work RVU quantifies the physician's professional effort in providing a service, encompassing factors such as time, skill, physical and mental effort, and psychological stress due to potential risks to the patient.

As with the proposed rule, CMS used the final rule to criticize its historical dependency on survey data from the American Medical Association's Relative Value Scale Update Committee (AMA-RUC) for determining work RVUs. And the agency reiterated its concerns over the limited number of codes that undergo annual reevaluation and once again raised the notion that time assumptions in many PFS valuations are overstated.

CMS opted to largely finalize the efficiency adjustment as originally proposed. The adjustment will involve a broad-based -2.5% reduction to the intraservice physician time component of the work RVUs. The -2.5% is calculated as the sum of the Medicare Economic Index (MEI) productivity adjustments from the prior five years (CY21 through CY25). As with the proposed rule, the final rule does not apply the adjustment to time-based codes, such as evaluation and management (E/M) services, care management services, behavioral health services, services on the telehealth list, and maternity codes. However, in response to industry comments, CMS in the final rule opted to expand the list of exempt HCPCS codes, adding time-based physical medicine and rehabilitation (PM&R) services, remote therapeutic monitoring (RTM) services, time-based drug administration services (e.g., chemotherapy infusions), any new HCPCS codes for CY 2026, and certain codes involving high cost software inputs (e.g., CPT code 75577 for coronary atherosclerotic plaque assessment by CT).

Specialties most directly impacted by this change include cardiac surgery (-1% cut to work RVUs), colon and rectal surgery (-1%), interventional radiology (-1%), neurosurgery (-1%), nuclear medicine (-1%), pathology (-1%), plastic surgery (-1%), radiation oncology (-1%), radiology (-1%), and thoracic surgery (-1%).

PRACTICE EXPENSE

As part of CY26 proposed rule, CMS announced its intention to implement a second broad-based adjustment targeting the PE RVU. The PE RVU quantifies the non-physician costs associated with providing a medical service, including staff time, supplies, equipment, and indirect expenses like rent and administrative overhead. As outlined in both the proposed and final rules, CMS believes an adjustment to the PE RVU is necessary to address distortions in payment allocation resulting from the significant shift in physician practices from independent, non-facility settings to hospital-based or facility settings.

CMS largely finalized the PE RVU adjustment as originally proposed. CMS will adjust the indirect PE allocation methodology by reducing the facility indirect PE to half of the non-facility indirect PE for applicable services, calculated using a revised formula that scales down the indirect PE allocator for

facility settings based on work RVUs or clinical labor inputs. This adjustment applies broadly to PFS services, excluding those without dual settings and those with specific exemptions, such as certain radiation oncology codes (which instead use Outpatient Prospective Payment System (OPPS) relative weights for PE valuation). In the aggregate, specialties most directly impacted by this change include cardiac surgery (-3% cut to aggregate PE RVUs), critical care (-5%), emergency medicine (-3%), gastroenterology (-3%), general surgery (-3%), infectious disease (-7%), neurosurgery (-5%), orthopedic surgery (-3%), and plastic surgery (-4%). Facility-based PE RVU cuts are, in some instances, much more dramatic (i.e., -10% or higher for many specialties).

SKIN SUBSTITUTES

Skin substitutes are currently reimbursed under the Medicare PFS in non-facility settings as separately payable items using the Average Sales Price (ASP) plus 6% methodology, with each product assigned a unique HCPCS Level II code and manufacturers required to report ASP data quarterly. Synthetic skin substitutes have been paid separately in physician offices since CY22, distinct from the application procedure codes (i.e., CPT 15271-15278). CMS has concerns with this approach, noting the increase in Medicare Part B spending on skin substitutes from \$250 million in CY19 to \$10 billion in CY24, while the beneficiary count has only doubled.

To address concerns about the potential overuse of skin substitute products, CMS finalized reclassifying skin substitutes as “incident-to” supplies rather than treating them as separately payable under the ASP + 6% methodology. In practice, “incident-to” classification means skin substitutes are considered integral but incidental components of the physician’s professional service during wound care. In place of the separate payment, the cost of such products will be “packaged” into the physicians’ PE RVU. As finalized, the PE RVU for such procedures will be adjusted to reflect a uniform OPPS-based rate of \$127.28 per cm² for skin substitute products for CY26, representing up to a -90% reduction in aggregate per-service costs. Notably, that figure represents an increase relative to the proposed rate of \$125.38 per cm².

In later years, CMS will differentiate the payment rates for skin substitute products in a manner consistent with their FDA regulatory status (i.e., distinct rates for products approved under the Human Cells, Tissues, and Cellular and Tissue-Based Products (HCT/P), Pre-Market Approvals (PMAs), or 510(k) pathways).

CHRONIC ILLNESS AND BEHAVIORAL HEALTH G-CODES

As part of the CY25 PFS final rule, CMS finalized three new G-codes for Advanced Primary Care Management (APCM) services. These codes – G0556 for non-complex APCM (requiring at least one serious condition and clinical staff time thresholds), G0557 for complex APCM (involving multiple conditions with significant staff involvement), and G0558 for APCM with direct physician or non-physician practitioner time thresholds - bundle elements from existing Chronic Care Management (CCM), Principal Care Management (PCM), and Communication Technology-Based Services (CTBS) into a single monthly payment structure.

The intent was to reduce administrative burdens associated with fragmented billing requirements and increase access to coordinated care for beneficiaries with chronic or high-risk conditions.

In the CY26 PFS final rule, CMS built on that framework by finalizing three new add-on G-codes – GPCM1 (initial psychiatric Collaborative Care Model or CoCM, mirroring CPT 99492 for the first month of outreach, assessment, and treatment planning), GPCM2 (subsequent CoCM months, mirroring CPT 99493 for ongoing monitoring and adjustments), and GPCM3 (general Behavioral Health Integration or BHI services, mirroring CPT 99484 for at least 20 minutes of monthly care coordination) – which will be billed monthly alongside the base APCM codes.

TELEHEALTH

CMS finalized several updates to its PFS telehealth policies for CY 2026, including:

- CMS streamlined additions to the telehealth services list by eliminating the “provisional” versus “permanent” categories and concentrating evaluations only on whether the service can be adequately provided through interactive two-way audio-video technology.
- The agency permanently lifted limitations on the frequency of telehealth use for subsequent inpatient visits, subsequent nursing facility encounters, and critical care consultations.
- For services needing direct supervision, CMS permanently allows virtual supervision via real-time interactive audio-video communications (excluding audio-only). This covers “incident-to” billing, diagnostic testing, pulmonary rehab, and cardiac or intensive cardiac rehab services, but excludes services with a global surgery indicator of 010 or 090.
- In a change from the proposed rule, which did not extend the pandemic-era flexibility permitting teaching physicians to supervise residents virtually for billing purposes (instead proposing a return to the original mandate for physical presence during key parts of resident-delivered services), CMS finalized allowing teaching physicians to have a virtual presence in all teaching settings permanently, but only when the service is furnished virtually.

AMBULATORY SPECIALTY MODEL

CMS finalized the Ambulatory Specialty Model (ASM), a mandatory alternative payment model through the Innovation Center (CMMI) that targets beneficiaries with heart failure and low back pain. Starting January 1, 2027, the model holds specialists individually accountable through a two-sided risk payment adjustment on Medicare Part B fees, ranging roughly between –9% and +9% in the first payment year. Performance will be evaluated across four domains: quality (e.g., BP control, functional improvement), cost reduction, care-improvement activities (like patient engagement and social needs screening), and interoperability via certified EHRs. Specialists must treat at least 20 Medicare patients per condition

annually and operate within selected Core-Based Statistical Areas (CBSA). CMS finalized the ASM as proposed, without significant changes. The agency will announce selected geographic areas/participant lists in late 2025 and early 2026.

QUALITY PAYMENT PROGRAM

CMS finalized several refinements to the Quality Payment Program (QPP), including maintaining the Merit-based Incentive Payment System (MIPS) performance threshold at 75 points for the 2028-2030 payment years, adding five new quality measures (i.e., transplant waitlist ratios) while removing 10 others (i.e., social drivers of health), and introducing six new Value Pathways (MVPs) for specialties like diagnostic radiology and podiatry. CMS finalized these refinements as proposed, without modifications.

MEDICARE SHARED SAVINGS PROGRAM (MSSP)

The CY26 PFS final rule includes several updates to the Medicare Shared Savings Program (MSSP), including:

- Limiting participation in the BASIC track's one-sided risk level to a maximum of five performance years during an ACO's first agreement period in the glide path (if eligible), requiring ACOs to transition more quickly to two-sided risk models. This applies to periods beginning on January 1, 2027.
- Increasing flexibility in eligibility and financial reconciliation requirements by allowing ACOs to have fewer than 5,000 assigned beneficiaries in benchmark years 1 or 2, provided they have at least 5,000 in benchmark year 3. Such ACOs are restricted to the BASIC track with capped shared savings and losses. This applies to agreement periods beginning on or after January 1, 2027.
- Removing the health equity adjustment applied to an ACO's quality score, beginning in performance year 2026 (instead of 2025). CMS finalized the revised start date in response to comments and made terminology revisions for performance years 2023 through 2025 (instead of 2023-2024).
- Renaming the "health equity benchmark adjustment" to "population adjustment" for performance year 2025 and subsequent years, to better reflect its focus on beneficiaries enrolled in Medicare Part D low-income subsidy or dually eligible for Medicare and Medicaid.
- Updating the APM Performance Pathway (APP) Plus quality measure set for performance year 2025 and subsequent years, including removing Quality ID: 487 Screening for Social Drivers of Health.
- Expanding CAHPS survey modes to include a web-based option (web-mail-phone) beginning with performance year 2027, to increase response rates.
- Extending Extreme and Uncontrollable Circumstances (EUC) protections to include cyberattacks (e.g., ransomware/malware) for quality and financial evaluations from performance year 2025 onward.

- Revising the definition of a beneficiary eligible for Medicare Clinical Quality Measures (CQMs) for performance year 2025 and beyond, requiring one primary care service from specified providers.
- Requiring ACOs to report changes during the performance year to their ACO participant list (Change of Ownership scenarios resulting in a new TIN) and SNF affiliate list.
- Revising the definition of primary care services for beneficiary assignment to align with PFS changes, including new behavioral health integration and psychiatric collaborative care management add-on services when furnished with advanced primary care management, effective for performance year starting January 1, 2026. In a change from the proposed rule, CMS did not finalize the exclusion of HCPCS code G0136 (administration of a standardized, evidence-based Social Determinants of Health Risk Assessment tool), continuing to include it with its updated code descriptor.
- Revising quality monitoring policies to track whether ACOs meet both the quality performance standard and the alternative quality performance standard for performance years beginning January 1, 2026, with extended actions (prior to termination or immediate termination) if an ACO fails either.

AGENCY REPLIES TO REQUESTS FOR INFORMATION (RFIS)

In the proposed rule, CMS issued several RFIs on a variety of issues. For some those RFIs, the CY26 final rule contains a summary of the stakeholder comments and CMS feedback on industry's comments – a review of these specific RFIs is below. For most, however, CMS reiterated what it requested from stakeholders and noted that it had received significant feedback from industry but did not include a summary of those comments or feedback on the information it received (i.e., reducing regulatory burdens, enhancing payment for global surgeries, PDMP data integration, prevention and management of chronic disease, etc.).

- How to handle cost-sharing for APCM services, and whether waiving or adjusting cost-sharing requirements for APCM services could enhance access and utilization: Commenters recommended eliminating cost-sharing for APCM services, arguing that cost-sharing could limit uptake. CMS responded that APCM does not fully align with preventive service categories but acknowledged similarities with “personalized prevention plan services” (e.g., health risk assessments, self-management oversight). CMS noted the complexity of APCM bundling both preventive and treatment services, solicited further comments on application and inclusions (e.g., Annual Wellness Visits), and stated it would consider the input for future rulemaking without specific actions in this rule.
- Whether and how to standardize “core elements” within the MVP reporting requirements: Many commenters supported standardizing core elements to improve data comparability and reliability, but some expressed concerns that rigid standardization could limit flexibility for diverse patient populations. Suggestions included specific measures for core elements and mechanisms for updates. CMS reiterated its commitment to balancing standardization with flexibility and pledged to continue stakeholder engagement for future policy development without immediate changes.

- Input on transitioning to digital quality measurement within the QPP and MSSP: Most commenters supported changes aligning beneficiary definitions, noting reduced confusion and burden in reporting, which aids the dQM transition. Some raised concerns about technical challenges (e.g., EHR incompatibilities, data deduplication, vendor limitations). One encouraged integrating dQM into ACO requirements. CMS thanked commenters and stated it would not address RFI comments in this rule but would consider them for future rulemaking.

We trust you found this summary useful. Please reach out to [us](#) with any questions.

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