CY 2026 Medicare PFS Proposed Rule: What Providers Need to Know

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On July 16, 2025, the Centers for Medicare & Medicaid Services ("CMS") published the calendar year ("CY") 2026 Medicare Physician Fee Schedule ("PFS") proposed rule. The comment period closes on September 12, 2025, and the final rule is expected by November 1, 2025. If finalized, many of these policies would generally take effect on January 1, 2026.

This proposed rule represents a departure from the status quo regarding certain payment methodologies, including updates to practice expense ("PE") methodology and a new "efficiency adjustment." Further, CMS seems to be aligning its policies with CMMI's earlier announced "strategic direction,"—doubling down on alternative payment arrangements that take on more risk.

Conversion Factor

In 2026, there will be two conversion factors ("CFs")—one for eligible participants ("QPs") in Advanced Alternative Payment Models ("APMs") and one for all non-QP eligible clinicians and suppliers. The proposed CY 2026 qualifying APM CF is $33.5875 (3.8% higher than CY 2025) and the non-QP CF is $33.4209 (3.3% higher than CY 2025). The proposed CFs reflect statutory updates, such as the single 2.5% statutory update from the recently passed reconciliation bill and the 0.75% qualifying APM/0.25% non-QP update factor as well as a 0.55% budget neutrality adjustment. While the proposal represents an increase to the CF, Congress will still have to act to avoid a 4% across-the-board cut to Medicare stemming from Statutory PAYGO, or Pay-As-You-Go.

Practice Expense Methodology

CMS proposes to update its PE methodology to more accurately reflect relative resources involved in furnishing services paid under the PFS in facility and nonfacility settings. Since the implementation of the PE methodology, physician practice ownership trends have changed, causing CMS to reexamine assumptions embedded in payment methodology. For 2026, CMS proposes that when work RVUs are used to allocate indirect PE to facility RVUs, the amount allocated to the nonfacility PE RVUs for the same service will be reduced by one-half.

Efficiency Adjustment

As a result of CMS' concerns around low RUC survey response rates and to account for efficiencies gained in work RVUs for non-time-based services, CMS proposes to establish an "efficiency adjustment" which would use the Medicare Economic Index ("MEI") productivity adjustment. For 2026, the proposed efficiency adjustment would result in a 2.5% negative adjustment to certain codes. CMS estimates that almost all specialties will experience no more than +1 or -1%

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change in RVUs as a result of the proposed policy.

The proposed changes to PE and the new efficiency adjustment represent a departure from how CMS has long approached valuing physician work and office costs.

Telehealth

CMS proposes changes to the Medicare Telehealth Services List, including modifying the process to review requests for additions to the list, deleting HCPCS code G0136 from the list, and adding several codes to the list (HCPCS codes 90849, G0473, G0545, 92622, 92623). CMS also proposes to permanently remove frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultation services. CMS proposes to make permanent a COVID-19-era virtual direct supervision policy—a supervising professional can be immediately available through a virtual presence using real-time audio/video technology for the direct supervision of services and diagnostic tests. However, CMS is transitioning back to its pre-COVID-19 policy regarding the ability of teaching physicians to have a virtual presence for purposes of billing for services involving residents in teaching settings.

Enhanced Care Management and Behavioral Health

In the 2025 PFS final rule, CMS finalized coding and payment for Advanced Primary Care Management ("APCM") codes. For 2026, CMS proposes to create add-on codes for APCM services that would facilitate providing complementary behavioral health integration ("BHI") services (HCPCS codes GPCM1, GPCM2, GPCM3). CMS seeks comments on aspects of APCM codes, such as the application of cost sharing and the inclusion of additional preventative services in the APCM bundle.

In the 2025 PFS final rule, CMS also established payment for digital mental health treatment ("DMHT") devices furnished incident to behavioral health services used with an ongoing behavioral health treatment plan of care. CMS proposes to expand its payment policies to make these codes available for Attention Deficit Hyperactivity Disorder ("ADHD"). CMS continues to solicit comment on DMHT codes, including pricing information.

CMS solicits comment on software as a service ("SaaS"). Specifically, what factors CMS should consider when paying for SaaS, have risk-based payment arrangements reflected the underlying value of SaaS, and what alternative pricing strategies should CMS use to accurately pay for SaaS and artificial intelligence devices.

Skin Substitutes

Due to an increase in Part B spending for skin substitutes in recent years, CMS proposes a new framework for reimbursement, which the agency expects will reduce Medicare spending. Currently, most skin substitutes are paid under the average sales price ("ASP")-based payment methodology. Beginning in 2026, CMS would instead reimburse skin substitutes as "incident-to" supplies by applying a single payment rate (initially, approximately $125.38/sq.cm. before accounting for geographic adjustments) for all skin substitutes associated with three FDA regulatory statuses (361 HCT/P, 510(k) and Pre-Market Approvals). Skin substitutes licensed based on an FDA biologics license application (also known as the 351 HCT/P) would continue to be paid as biologicals under the ASP methodology.

Ambulatory Specialty Model

CMS proposes a new mandatory alternative payment model that would be implemented and tested under the Center for Medicare and Medicaid Innovation ("CMMI"). The Ambulatory Specialty Model ("ASM") would run for five years, beginning on January 1, 2027. The model would focus on heart failure and lower back pain, meaning the specialties involved would likely include anesthesiology, neurosurgery, orthopedic surgery, pain management, interventional pain management, and cardiology.

Medicare Shared Savings Program

CMS proposes significant modifications to the Medicare Shared Savings Program ("MSSP"), which is a voluntary program that allows healthcare providers to form or participate in Accountable Care Organizations ("ACOs"). One major proposal would be to limit participation in the BASIC track's glide path to an ACO's first agreement period, for a maximum of 5 performance years instead of 7 performance years. Another proposal would be to modify the eligibility and financial reconciliation requirements to allow an ACO that does not meet the 5,000 minimum assigned beneficiary threshold in the first and/or second of the ACO's benchmark years to participate in MSSP.

Additional MSSP proposals include requiring limited mid-year modifications to an ACO's participant list and skilled nursing facility affiliate list due to a change of ownership,
revising the extreme and uncontrollable circumstances policies to explicitly include cyberattacks as qualifying events, and renaming the "health equity benchmark adjustment" (HEBA) the "population adjustment."

Quality Payment Program

CMS proposes updates to the Merit-based Incentive Payment System ("MIPS"). The proposal adds five new quality measures, including three that are high-priority and patient-reported. The performance threshold would stay at 75 points for the CY 2026 performance period/2028 MIPS payment year through the CY 2028 performance period/2030 MIPS payment year.

MIPS Value Pathways

CMS proposes six new MIPS Value Pathways ("MVPs") for the CY 2026 performance period/2028 MIPS payment year. There would be 27 MVPs, should these be finalized. The proposed MVPs include the following areas: neuropsychology, pathology, podiatry, diagnostic radiology, interventional radiology, and vascular surgery.

In the proposed rule, CMS notes that it is considering sunsetting traditional MIPS, and highlights that in the CY 2025 PFS proposed rule, it discussed that CMS may be ready to fully transition to MVPs by the CY 2029 performance period/2031 MIPS payment year. Finally, CMS seeks comment on the development of certain key quality measures within each MVP, which are referred to as "Core Elements."

Requests for Information

The proposed rule includes several requests for information ("RFIs"), including on:

• Prevention and management of chronic disease, including on whether additional services should be covered and how to improve the uptake of currently covered services;
• Payment for services in urgent care centers, including whether or not an add-on code would be appropriate or if a new set of visit codes would be more practical;
• Cost sharing for APCM services, particularly, if they were to include preventive services within the APCM bundles;
• Enhancing healthcare data quality and monitoring systems, including potential future modifications to the Query of Prescription Drug Monitoring Program ("PDMP") measure, potential modifications to the Promoting Interoperability performance category's objectives and measures, and potential improvements to enhance health information MIPS eligible clinicians are exchanging across systems; and
• Potential Core Elements MVP reporting requirements and functions utilizing Medicare procedural codes to further facilitate more MVP specialty reporting.

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