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CMS releases CY 2026 Physician Fee Schedule proposed rule

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POLICY UPDATE

CMS RELEASES CY 2026 PHYSICIAN FEE SCHEDULE PROPOSED RULE

On July 14, 2025, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2026 Revisions to Payment Policies Under the Physician Fee Schedule (PFS) and Other Revisions to Medicare Part B [CMS-13271] Proposed Rule, which includes proposals related to Medicare physician payment and the Quality Payment Program (QPP). For the first time, CMS proposes two separate PFS conversion factor (CF) updates: one for clinicians who participate in advanced alternative payment models (APMs) and are considered qualifying APM participants (QPs), and one for all other clinicians (referred to throughout as the QP CF and the non-QP CF). Both CFs for 2026 would incorporate a one-time payment increase of 2.5% provided by the One Big Beautiful Bill Act (OBBBA).

CMS also proposes significant changes to physician rate setting by incorporating an efficiency adjustment for non-time-based services and adjusting the practice expense (PE) methodology for allocating indirect PE relative value units (RVUs) based on the site of service. Other proposals include a new mandatory payment model related to heart failure and low back pain, telehealth updates, changes to the Merit-based Incentive Payment System (MIPS) program, and movement toward the MIPS Value Pathways.

Key takeaways from the CY 2026 PFS proposed rule:

- *CF update:* The proposed CY 2026 resource-based relative value scale CF is $33.5875 for physicians who meet certain participation thresholds in advanced APMs, and $33.4209 for other clinicians. These amounts represent an increase of 3.8% and 3.3%, respectively, from the final CY 2025 CF of $32.3465.
- *Efficiency adjustment:* CMS proposes an efficiency adjustment of -2.5% in CY 2026 to certain non-time-based services for procedures, radiology services, and diagnostic tests. CMS believes this negative adjustment would account for efficiencies accrued over time as services become more common, professionals gain more experience performing them, technology improves, and other operational improvements are implemented.
- *PE methodology:* CMS proposes to reduce the portion of indirect PE allocated to facility-based services beginning in CY 2026, citing outdated assumptions about physician practice patterns.
- *Global surgery package valuation:* CMS does not propose changes for CY 2026 but seeks public input on whether and how to revise global surgery package valuation.
- *Telehealth:* CMS proposes significant changes to the Medicare telehealth services list and to expand permanent flexibilities for virtual direct supervision.
- *MIPS:* CMS proposes policies aimed at providing stability to the program, including setting the MIPS performance threshold at 75 points through the CY 2028 performance period/2030 MIPS payment year.
- *Medicare Shared Savings Program (MSSP):* CMS proposes a suite of changes aimed at increasing participation and program integrity, including adjustments to beneficiary assignment thresholds, refinements to quality reporting requirements, protections against cyberattacks, and updated financial benchmarking and reconciliation methodologies.
- *New mandatory Ambulatory Specialty Model (ASM):* CMS proposes a new mandatory alternative payment model for heart failure and low back pain to start January 1, 2027, and run through December 31, 2031.
- *Requests for information:* CMS solicits feedback on future policy priorities and inquires whether the PFS adequately supports the prevention and management of chronic disease.

Comments on the proposed rule are due **September 12, 2025.**

- Proposed rule text
- CMS press release
- CMS fact sheet
- CMS fact sheet on MSSP
- CMS fact sheet on the ASM Model
- CMS fact sheet on the QPP, including MIPS

Read on for a topline summary of the major provisions in the proposed rule.

Our freshly updated, interactive **dashboard** shows proposed Medicare fee-for-service payment rates for 2026. You can use this dashboard to see for individual codes the top billing specialties, total RVUs, payment rates over time, and other key information.

MAJOR PAYMENT PROPOSALS

CONVERSION FACTOR

Key takeaway: The proposed CY 2026 CFs are $33.5875 for QPs and $33.4209 for all other clinicians. The QP CF is an increase of 3.8% over the CY 2025 CF and the non-QP CF is a 3.3% increase over CY 2025.

Medicare physician payment is based on the application of a dollar-based CF to geographically adjusted work, PE, and malpractice RVUs. Work RVUs account for the provider's time, effort, and level of clinical risk.PE RVUs capture the cost of supplies, equipment, and clinical personnel wages. Malpractice RVUs capture the cost of malpractice insurance.

The proposed CY 2026 anesthesia CF for physicians participating in qualifying Advanced APMs is $20.6754, and $20.5728 for those who do not participate in qualifying Advanced APMs. This represents an approximately 1.8% and 1.3% increase from the final CY 2025 anesthesia CF of $20.3178.

The proposed updates are primarily based on three factors:

1. A statutory 0.75% update scheduled for the PFS in CY 2026 for QPs and a 0.25% update for non-QPs.[1]
2. A 2.5% one-year increase provided by the OBBBA.
3. A 0.55% positive budget neutrality adjustment.

Medicare physician conversion factor (2017 – 2026)

Year	CF for QPs	CF for non-QPs	Actual update QPs (%)	Actual update non-QPs (%)
Jan 1, 2017	$35.8887	$35.8887	0.24	0.24
Jan 1, 2018	$35.9996	$35.9996	0.31	0.31
Jan 1, 2019	$36.0391	$36.0391	0.11	0.11
Jan 1, 2020	$36.0896	$36.0896	0.14	0.14
Jan 1, 2021	$34.8931	$34.8931	-3.32	-3.32
Jan 1, 2022	$34.6062	$34.6062	-0.82	-0.82
Jan 1, 2023	$33.8872	$33.8872	-2.08	-2.08
Jan 1, 2024	$33.2875	$33.2875	-1.77	-1.77
Jan 1, 2025	$32.3465	$32.3465	-2.83	-2.83
Jan 1, 2026	**$33.5875**	**$33.4209**	**3.84**	**3.32**

The positive budget neutrality adjustment is partly explained by the proposed efficiency adjustment, described in more detail below. This is the first time since 2021 that the CF update is positive. Overall physician payments have been cut during the previous five years and have not kept up with inflation. The OBBBA patch only applies to 2026 and would need to be extended to avoid future CF cuts.

SPECIALTY IMPACT

Key takeaway: Total impact by specialty ranges from -6% to +7%, with more significant decreases in the facility setting.

Proposed payment rates are affected by a range of proposed policy changes related to physician work, PE, and malpractice RVUs. CMS summarizes the aggregate impact of these changes in Table 92 of the

[1] Under the Medicare Access and CHIP Reauthorization Act of 2015, beginning in 2026, clinicians identified as QPs in an advanced APM will receive an annual 0.75% update and all other clinicians will receive a 0.25% annual update.

proposed rule. The specialty impact table, however, does not include the additional 2.5% relief from the OBBBA or the overall CF update.

Proposed policies in the rule are estimated to have significant differential effects depending on the site of service, especially the proposed changes to the allocation of indirect PE in the facility setting and the proposed efficiency adjustment. CMS also proposes updates to the geographic practice cost indices and malpractice RVUs, as statutorily required, and these updates would impact overall clinician reimbursement rates. The continued phase-in implementation of the previously finalized supply and equipment pricing updates also contributes to site of service variations.

As a result of these differential effects, CMS projects substantial variation between the facility and non-facility impacts across many specialties. All specialties are projected to experience negative impacts in the facility setting, while 47 specialties are projected to see a positive impact in the non-facility setting. The proposed rule's specialty impacts table lists each specialty's impact in the facility setting, non-facility setting, and in total.

Impact on individual practices would vary based on service mix, but in general, specialties that report more time-based services, such as family practice physicians and clinical social workers, would likely see an increase in RVUs, while specialties that report more procedures, diagnostic imaging, and radiology services would see a decrease in RVUs.

- Total specialty impacts range from -6% for infectious disease to +7% for allergy/immunology.
- Facility specialty impacts range from -17% for chiropractic to -1% for diagnostic testing facility and nurse anesthesiologist/anesthesiology assistant.
- Non-facility specialty impacts range from -2% for chiropractic and pathology to +10% for nurse anesthesiologist/anesthesiology assistant.

The proposed policies would have more positive impacts for allergy/immunology, vascular surgery, clinical social workers, and rheumatology relative to all other specialties. Specialties that would be negatively impacted by those same policies include infectious disease, neurosurgery, critical care, gastroenterology, and plastic surgery. Projected increases for some specialties, especially primary care and behavioral health, are driven by the redistributive effects of the proposed efficiency adjustment to work RVUs and the third year of the behavioral health work update.

Impact of proposed changes by selected specialties

Specialty	Setting	Allowed charges (M)	Impact of work RVU changes	Impact of PE RVU changes	Impact of malpractice RVU changes	Combined impact
Allergy/immunology	Total	$212	0%	7%	0%	7%
	Non-facility	$204	0%	8%	0%	8%
	Facility	$8	0%	-11%	0%	-11%
Chiropractic	Total	$626	-1%	-1%	0%	-2%
	Non-facility	$624	-1%	-1%	0%	-2%
	Facility	$2	-1%	-15%	0%	-17%
Diagnostic testing facility	Total	$913	0%	0%	0%	0%
	Non-facility	$911	0%	0%	0%	0%
	Facility	$2	-1%	0%	1%	-1%
Infectious disease	Total	$537	0%	-7%	0%	-6%
	Non-facility	$85	0%	7%	0%	7%
	Facility	$452	0%	-10%	0%	-9%

Note: Combined impact may not equal the sum of work, PE, and malpractice as a result of rounding. Source: Table 92, CY 2026 Proposed PFS, display copy.

EFFICIENCY ADJUSTMENT

Key takeaway: CMS proposes to apply an efficiency adjustment of -2.5% to work RVUs and intra-service physician time for certain non-time-based codes describing procedures, radiology services, and diagnostic tests.

CMS has historically relied on survey data provided by the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC) to estimate practitioner time, work intensity, and PE for the purpose of establishing RVUs. CMS regularly revalues codes as part of its potentially misvalued codes initiative, using RUC survey data that shows clinicians' estimates of how long a particular service takes to complete. However, CMS is concerned about the survey data's accuracy given "low response rates, low total number of responses, and a large range in responses, all of which may undermine the accuracy of recommendations relying on survey data." There also is often a lag between when the RUC revalues codes and when CMS decides to effectuate those new values.

For several years, CMS has also been concerned about not accounting for the efficiencies gained in work RVUs for non-time-based services. CMS believes that non-time-based services, such as those describing procedures, radiology services, and diagnostic tests, should become more efficient as they become more common, professionals gain more experience, technology improves, and other operational improvements are implemented.

To account for changes in medical practice and better reflect the resources involved in furnishing services paid under the PFS, CMS proposes an efficiency adjustment to the work RVUs and the intra-service physician time (IST) for non-time-based services. CMS justifies this proposal by highlighting its authority under the Social Security Act to adjust RVUs to account for changes in medical practice. To calculate the efficiency adjustment, CMS proposes adding the last five years of the Medicare Economic Index (MEI) productivity adjustment, which equals a 2.5% reduction.

Thus, CMS would reduce the work RVU and IST for applicable codes by 2.5% in CY 2026. CMS offers the following examples to illustrate the impact at the code level:

CPT code	Description	Current IST (min)	Current wRVU	IST after efficiency adjustment (min)	wRVU after efficiency adjustment
11200	Rmvl skin tags up to&inc 15	7	0.82	6.83	0.8
63047	Lam facetectomy & foramotomy 1 vrt sgm lumbar	90	15.37	87.75	14.99

CMS proposes to apply this efficiency adjustment to all codes except time-based codes, including but not limited to evaluation and management (E/M) services, care management services, behavioral health services, services on the Medicare telehealth list, and maternity codes with a MMM global period. A table that lists all applicable codes is located here.

CMS proposes to update and apply this efficiency adjustment every three years. Under this schedule, the next efficiency adjustment after CY 2026 would be calculated and applied in CY 2029 PFS rulemaking, reflecting efficiency gains measured from 2027 through 2029.

PRACTICE EXPENSE

Key takeaway: CMS proposes revising the methodology for allocating indirect PE costs for facility-based services by reducing the portion of facility PE RVUs by half the amount allocated to non-facility-based services.

Under the PFS, many services are paid differently depending on where they are furnished. In a non-facility setting (*e.g.*, a physician's office), payment includes both the work RVU (reflecting the physician's time and effort) and a PE RVU that captures the full cost of operating the practice. This includes direct costs (such as clinical labor, supplies, and equipment) and indirect costs (such as administrative overhead), with indirect PE allocated based on the total direct costs and the greater of either clinical labor or the work RVU.

In a facility setting (*e.g.*, a hospital), payment still includes both work and PE RVUs. However, the PE RVU is typically lower because direct costs are paid separately to the facility under a different payment system such as the Hospital Outpatient Prospective Payment System (OPPS). As a result, indirect PE in the facility setting is allocated based solely on the work RVU, since the physician does not incur direct PE. Some indirect PE is still included in the facility setting payment to reflect assumptions built into the original PE methodology, which was developed at a time when most physicians maintained office-based practices even if they also furnished care in hospitals. Under that model, the PE methodology allocated the same amount of indirect cost per work RVU regardless of site of service.

Because the share of physicians in private practice has steadily declined, while hospital employment and facility-based practice have grown, CMS believes these assumptions may no longer accurately reflect how physicians incur PEs today. CMS is concerned that continuing to allocate the same amount of indirect PE in both facility and non-facility settings may overstate the costs borne by facility-based physicians, especially if they no longer maintain a separate office-based practice. CMS notes that the Medicare Payment Advisory Commission (MedPAC) and RAND have previously raised concerns that paying both the physician and the facility for the same indirect costs may result in duplicative payment. Because PFS payments are budget neutral, overstating indirect PE in the facility setting would reduce the pool of PE available for non-facility services, where physicians do incur full practice costs.

To address this potential inaccuracy, CMS proposes revising the methodology for allocating indirect PE costs for facility-based services. Beginning in CY 2026, CMS proposes to reduce the portion of PE RVUs allocated based on work RVUs in the facility setting to half the amount used in the non-facility setting. This change would affect step eight of the PE RVU methodology, where indirect cost allocators are assigned.

CMS offers the following example to illustrate the impact at the code level:

CPT code	Description	wRVU	Current indirect PE RVUs (full wRVU allocator)	Proposed indirect PE RVUs (half wRVU allocator)
33533	Coronary artery bypass, using arterial graft(s); single arterial graft	33.75	12.0	7.2

The proposed change in how indirect PE is allocated for facility-based services would result in significant increases in overall PFS spending for most office-based specialties and those furnishing highly technical services in non-facility settings, compared to the same specialties providing care in facility settings, as shown in Table 92.

CMS acknowledges that physicians practicing in facility settings may still incur indirect PE costs. In CY 2023 comments, the AMA noted that physicians may continue to incur certain indirect costs – such as coding, billing, and scheduling – even when they deliver care in a facility setting. Accordingly, CMS seeks comment on several key issues:

- The types and magnitude of indirect PE costs still incurred and attributable to physicians who practice in part or exclusively in a facility setting.
- Factors that may influence whether and to what extent a physician group continues to incur these costs, such as employment arrangements, specialty type, or practice structure.
- Whether the proposed 50% adjustment is appropriate, or whether CMS should consider a different percentage for CY 2026 or future years.
- Data sources that could better distinguish indirect PE costs in facility and non-facility settings.
- Whether this proposal should apply to services with MMM global periods (maternity care) and how it may impact access to those services.
- Whether certain service categories should be excluded from this policy change and if so, under what criteria.
- Alternative approaches to improving the allocation of indirect PE, including those outlined in Chapter 1 of MedPAC's June 2025 Report to Congress.

CMS emphasizes that this proposal is intended as a "starting point." The agency intends to further review the PE methodology and consider refinements based on public input and additional data.

Key takeaway: CMS proposes to maintain the current practice expense per hour (PE//HR) data and cost shares for CY 2026.

CMS has taken several actions in recent years to improve the PE methodology, including phased-in pricing updates for supplies and equipment (finalized in CY 2019) and clinical labor (finalized in CY 2022), aimed at increasing accuracy, predictability, and transparency. Unlike direct PE inputs, indirect cost data have not

been updated since the original 2007 – 2008 AMA physician practice information (PPI) survey based on 2006 data. CMS believes this gap should be addressed and has taken several actions in recent years, including issuing requests for stakeholder feedback, to explore potential updates. However, the agency has held off on making changes while the AMA completed its 2024 PPI survey – an effort that concluded in 2025.

For CY 2026, CMS does not propose implementing updated PE/HR data based on AMA's 2024 PPI survey. Instead, CMS proposes maintaining the current PE/HR data and cost shares because of concerns about the 2024 PPI survey's low response rate and the validity, reliability, and representativeness of the newly collected data—especially for facility-based practitioners—and the broader impact this could have on PFS ratesetting.

CMS also raises broader questions about relying on voluntary survey data alone and suggests that a more reliable and regularly updatable approach may involve using existing administrative data sources – such as Medicare claims, hospital cost reports, Internal Revenue Service Form 990 data, and the US Census Bureau's Service Annual Survey – with surveys used only to fill gaps where necessary. CMS states that an alternative to collecting survey data would be to modify the PE allocation system so that it only relies on data that can be measured accurately and on an ongoing basis.

These concerns reinforce CMS's view that a more robust approach may be necessary to ensure future PE methodology updates are accurate and sustainable, but for CY 2026, the agency continues to engage with stakeholders to determine the best path forward.

Key takeaway: Instead of AMA survey data, CMS proposes to use hospital data for several kinds of PFS services in an effort to promote price transparency and predictability.

As required under Section 1848(c)(2)(C)(ii) of the Social Security Act, CMS historically has used a resource-based system to establish PE RVUs for each physician service paid under the PFS. For CY 2026, CMS proposes to deviate from this statutory framework for a select set of services and instead value them based on hospital outpatient data from the OPPS. The services targeted under this proposal include radiation treatment delivery and superficial radiation therapy services, remote physiological monitoring (RPM) and remote therapeutic monitoring (RTM) services, and skin substitute services. Additional details on CMS's proposals for these three categories of codes are provided in subsequent sections of this +Insight.

The agency also seeks comment on whether a single standardized approach, such as a scaler, should be used instead, and how such a method could account for variation in practice costs, such as services driven by clinical staff time versus those driven by equipment costs.

Key takeaway: CMS proposes to continue implementing the supply pack pricing update and associated revisions as previously recommended by the RUC workgroup and others.

In recent years, interested parties have identified discrepancies in the pricing of several supply packs used as direct PE inputs under the PFS. CMS took initial steps to address these concerns in the CY 2025 PFS final rule, which updated pricing for several mispriced packs based on recommendations from the AMA RUC and others. In comments on the CY 2025 proposed rule, stakeholders flagged additional supply packs that were not proposed for repricing but were believed to be similarly misvalued. CMS deferred action on these packs to future rulemaking to ensure transparency and stakeholder input.

For CY 2026, CMS proposes to continue implementing the supply pack pricing updates recommended by the RUC workgroup, and to reprice the additional supply packs that were submitted too late for inclusion in the CY 2025 final rule. For three packs – the surgical instruments cleaning pack (SA043), moderate sedation pack (SA044), and small ortho drapes pack (SA081) – the proposed pricing updates are relatively modest. Accordingly, CMS proposes to finalize their new prices in full for CY 2026.

CMS proposes to incorporate the remaining 12 supply packs into the four-year phase-in that began in CY 2025, rather than starting a separate phase-in. CMS would implement one-third of the difference between the CY 2025 price and the fully updated price in each of CYs 2026, 2027, and 2028. According to CMS, this approach would preserve consistency across all supply pack updates.

Supply Code	Description	HCPCS codes	CY 2024 price	New price	% Change	CY 2025 (year 1)	CY 2026 (year 2)	CY 2027 (year 3)	CY 2028 (year 4)
SA041	pack, basic injection	111	$ 10.45	$ 17.28	65%	$ -	$ 12.73	$ 15.00	$ 17.28
SA042*	pack, cleaning and disinfecting, endoscope	306	$ 19.43	$ 31.29	61%	$ 22.40	$ 25.36	$ 28.33	$ 31.29
SA043	pack, cleaning, surgical instruments	560	$ 12.61	$ 11.09	-12%	$ 11.09	$ -	$ -	$ -
SA044	pack, moderate sedation	3	$ 18.55	$ 19.20	4%	$ 19.20	$ -	$ -	$ -
SA048	pack, minimum multi-specialty visit	4568	$ 5.02	$ 1.98	-61%	$ -	$ 4.01	$ 2.99	$ 1.98
SA050	pack, ophthalmology visit (no dilation)	168	$ 2.72	$ 1.35	-50%	$ -	$ 2.26	$ 1.81	$ 1.35
SA051	pack, pelvic exam	239	$ 20.16	$ 2.81	-86%	$ -	$ 14.38	$ 8.59	$ 2.81
SA052	pack, post-op incision care (staple)	1079	$ 4.80	$ 9.90	106%	$ -	$ 6.50	$ 8.20	$ 9.90
SA053	pack, post-op incision care (suture & staple)	469	$ 5.47	$ 11.54	111%	$ -	$ 7.49	$ 9.52	$ 11.54
SA054	pack, post-op incision care (suture)	1708	$ 4.62	$ 10.34	124%	$ -	$ 6.53	$ 8.43	$ 10.34
SA055	pack, post-op incision care, craniotomy	12	$ 7.30	$ 18.18	149%	$ -	$ 10.93	$ 14.55	$ 18.18
SA056	pack, post-op incision care, neurosurgical	24	$ 6.20	$ 16.05	159%	$ -	$ 9.48	$ 12.77	$ 16.05
SA058*	pack, urology cystoscopy visit	38	$ 113.70	$ 37.63	-67%	$ 94.68	$ 75.67	$ 56.65	$ 37.63
SA080	pack, drapes, ortho, large	120	$ 37.30	$ 25.38	-32%	$ -	$ 33.33	$ 29.35	$ 25.38
SA081	pack, drapes, ortho, small	29	$ 2.25	$ 1.88	-16%	$ 1.88	$ -	$ -	$ -
SA082*	pack, ophthalmology visit (w-dilation)	145	$ 3.91	$ 2.33	-40%	$ 3.52	$ 3.12	$ 2.73	$ 2.33
SA083	pack, protective, ortho, large	119	$ 10.86	$ 14.75	36%	$ -	$ 12.16	$ 13.45	$ 14.75
SA084	pack, protective, ortho, small	27	$ 5.99	$ 8.15	36%	$ -	$ 6.71	$ 7.43	$ 8.15
SA089	kit, boston original system	100	$ 20.56	$ 41.15	100%	$ -	$ 27.42	$ 34.29	$ 41.15

Key takeaway: CMS does not intend to remove equipment items that fall under the $500 threshold.

Under the PE RVU methodology, CMS generally defines medical equipment as items with a price of $500 or more. Following publication of the CY 2025 PFS final rule, the AMA RUC asked CMS to remove all equipment inputs priced below the $500 threshold from the CMS ratesetting database.

For CY 2026, CMS does not propose to adopt this recommendation. The agency notes that these lower-cost items have been included as direct PE inputs for almost two decades, and given their relatively small valuation, the agency does not believe it is necessary to remove them at this time.

STRATEGIES FOR IMPROVING GLOBAL SURGERY PAYMENT ACCURACY

Key takeaway: CMS does not propose changes for CY 2026 but seeks input on whether and how to revise the portion of the global surgery package attributed to the procedure.

A global surgery package refers to a group of related services that Medicare pays for as a single unit, covering care before, during, and after a surgical procedure over a defined period (*e.g.*, 10 or 90 days). For example, Medicare's payment for a total knee replacement (CPT code 27447) includes six postoperative visits assumed to take place during the 90-day global period. These six visits are based on estimates of what a typical patient might need, not necessarily what is actually provided.

CMS and other stakeholders have long expressed concern that global surgery packages include more postoperative care than is typically delivered, leading to potential overvaluation (and, by extension, overpayment). In 2015, CMS finalized a policy to eliminate 10- and 90-day global periods in favor of zero-

day global periods, allowing postoperative visits to be billed separately. However, Congress blocked that policy through MACRA and directed CMS to collect data on actual postoperative visits to support more accurate valuation.

To comply with MACRA, in 2017 CMS began requiring certain practitioners to report postoperative visits using CPT code 99024. In the CY 2025 PFS final rule, CMS required broader use of transfer of care modifier -54 (surgical care only) whenever the operating surgeon does not intend to provide follow-up care and introduced HCPCS code G0559 to track postop visits furnished by other practitioners. These actions are part of CMS's larger stepwise strategy to improve how global surgery packages are valued and paid.

For CY 2026, CMS does not propose immediate policy changes but seeks comment on whether the "procedure shares" – the portion of the total RVU assigned to the surgical (or intraoperative) component – should be recalculated using a new methodology. Currently, procedure shares are based on historical assumptions. For example, many 90-day global surgery package codes assign 79% to 81% of the total work RVU to the surgery itself (the procedure share) and the remaining 19% to 21% to pre- and postop care. These values were originally developed using magnitude estimation and cross-specialty scaling, not current claims data.

CMS outlines and seeks comments on three potential methods for recalculating the procedure share for 90-day global surgery packages:

1. Procedure work RVUs would be calculated by subtracting the RVUs assigned to each postoperative visit listed in the physician time file from the total work RVUs for the global package.

2. Procedure work RVUs would be calculated by subtracting the work RVUs for postoperative visits actually reported to CMS using CPT code 99024. CMS would use the median number of reported 99024 visits for the procedure and multiply by the average RVU per visit, based on time and level in the physician time file.

3. Procedure work RVUs would be calculated by multiplying the total physician time (in minutes) by the proportion of that time spent on the procedure itself (*i.e.*, excluding time for post-op visits), based on the physician time file.

CMS favors the second approach because it reflects real-world practice patterns that can be updated more routinely and solicits input from the public.

CMS notes that a small number of codes do not have any percentages assigned even though these codes are identified as global packages. The agency seeks comment on whether these codes are appropriately categorized as 90-day global package codes, and if so, what the assigned percentages should be for each portion of the service.

Potential methods for recalculating the "procedure share" for 90-day global codes

Approach	Data source	What's subtracted	Purpose
1	Physician time file	wRVUs for assumed postop visits	Based on existing time/resource assumptions
2	99024 claims + physician time file	wRVUs for reported postop visits	Reflects claims-based reporting
3	Physician time file	Proportional time assigned to postop visits	Allocates work RVUs by share of total time spent

MODIFICATION TO THE NEW ADD-ON CODE FOR COMPLEXITY

Key takeaway: CMS proposes to allow the add-on code for complexity, G2211, to be billed as an add-on code with the home or residence E/M visits code family.

In the CY 2024 PFS final rule, CMS finalized a new office/outpatient E/M visit complexity add-on code, G2211. Some stakeholders have asked CMS to either establish separate payment for an E/M inherent complexity add-on code specific to home-based visits or expand use of G2211 to be reported alongside home and residence E/M visits furnished to beneficiaries in nursing facilities, assisted living facilities, and the beneficiary's home.

CMS agrees with stakeholder feedback that home visits involve developing and following through on a longitudinal care plan, which is critical to keeping patients stable and preventing exacerbation. CMS therefore proposes to allow HCPCS code G2211 to be billed as an add-on code with the home or residence E/M visits codes (CPT codes 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350).

POTENTIALLY MISVALUED CODES

Key takeaway: CMS received 11 potentially misvalued code (PMVC) requests but identified only two as potentially misvalued. CMS requests public comment on the proposed creation of a G-code for postoperative pain management and the assignment of national pricing for portable X-ray services.

The Affordable Care Act mandates regular review of fee schedule rates for physician services paid by Medicare, including services that have experienced high growth rates. CMS established the PMVC process to meet this mandate. Codes identified for review under this process may eventually have their values increased, decreased, or maintained.

For CY 2026, CMS received 11 PMVC requests and identified two as potentially misvalued. CMS seeks public comment on the proposed creation of a G-code for postoperative pain management and the assignment of national pricing for portable X-ray services. For the nine rejected requests, CMS cites reasons such as insufficient supporting evidence or recent RUC review with no significant changes since.

Request	Codes	Nominator reason
Maxillofacial prosthetic services **CMS proposal to nominate:** No	21076, 21077, 21079, 21080, 21081, 21082, 21083, 21084, 21085, 21086, 21087	PE inputs are missing, outdated, and undervalued.
Supervision of preparation and provision of antigens for allergen immunotherapy **CMS proposal to nominate:** No	95145, 95146, 95147, 95148, 95149	PE inputs may be outdated because labor and material costs have increased since the RUC last reviewed the codes in 2001.
Electronic analysis of implanted neurostimulator pulse generator/transmitter **CMS proposal to nominate:** No	95970, 95976, 95977	Clinical use has shifted and PE inputs for system analysis and programming are outdated.
Excimer laser treatment for	96920, 96921, 96922	The code descriptor has been modified and CMS used allegedly inaccurate data in valuing these

psoriasis **CMS proposal to nominate:** No		services.
Optical coherence tomography (OCT) of retina **CMS proposal to nominate:** No	0605T	Contractors' initial pricing was inaccurate and failed to account for the OCT device cost from the independent diagnostic testing facility.
Mechanical separation of plasma from blood **CMS proposal to nominate:** No	36514	The assigned clinical labor code undervalues the therapeutic apheresis nurse's wage, and the pricing and utilization assumptions for the cell separator system are inaccurate.
Remote interrogation device evaluation **CMS proposal to nominate:** No	93296	Service has experienced substantial changes in PE.
Fine needle aspiration **CMS proposal to nominate:** No	10021, 10004, 10005, 10006	These codes have been significantly undervalued since 2019, when they were subject to work RVU reductions.
Nasal sinus irrigation **CMS proposal to nominate:** No	31000, 31002	These codes are undervalued due to missing pricing data for essential lavage supplies that are not currently priced in the non-facility setting.
Portable X-ray (PXR) services **CMS proposal to nominate:** Yes	R0070, R0075	**CMS seeks comments** on whether to assign national pricing under the PFS for PXR transportation services, specifically for HCPCS codes R0070 and R0075.
Cryoablation therapy to treat postoperative pain **CMS proposal to nominate:** Yes	N/A – Nominator requested that CMS establish a code to describe the additional intraoperative time required by the surgeon to perform adjunctive cryoablation therapy for postoperative pain management. Currently there is no specific code to account for the additional physician work associated with intraoperative cryoablation therapy.	Procedure requires an additional 20 – 30 minutes of intraoperative time for the surgeon beyond the primary surgical procedure, and a new G-code for intraoperative cryoablation would support access to non-opioid pain relief by clarifying it is separate from Medicare anesthesia rules. **CMS seeks comments** on whether a new G-code is needed to account for the additional intraoperative time required to perform cryoablation therapy, including potential crosswalk codes.

SKIN SUBSTITUTES

Key takeaway: CMS proposes to change its methodology for paying for skin substitutes in an effort to curb significant growth in spending over the last five CYs.

Under the PFS, CMS pays for skin substitutes as biologicals, with payment based on average sales price (ASP) plus 6% (or wholesale acquisition cost or invoices in the absence of ASP). Under the OPPS, CMS unconditionally packages skin substitutes with their accompanying surgical procedure. In doing so, CMS divides the skin substitutes into a high-cost group and a low-cost group, in order to meet the agency's stated goal of ensuring "adequate resource homogeneity among APC assignments for the skin substitute application procedures."

In the proposed rule, CMS discusses "unprecedented growth" in skin substitute payments, at a rate that CMS attributes, at least in part, to the price of the products. The growth in spending is not commensurate with the increase in the volume of patients.

For several years, CMS has proposed payment policies in the PFS or OPPS rules but has not finalized meaningful changes. For CY 2026, CMS proposes a substantive change in its approach to payment for skin substitutes. The proposal is driven by a set of policy objectives that CMS outlined in the CY 2023 rulemaking cycle:

- Ensuring a consistent payment approach for skin substitute products across the physician office and hospital outpatient department setting.
- Ensuring that all skin substitute products are assigned an appropriate HCPCS code.
- Using a uniform benefit category across products within the physician office setting, regardless of whether the product is synthetic or composed of human- or animal-based material.
- Maintaining clarity on skin substitute policies and procedures.

CMS proposes to pay for skin substitute products (excluding biological products licensed under Section 351 of the Public Health Service Act) as incident-to supplies when they are used as part of a covered application procedure paid under the PFS in the non-facility setting or under the OPPS in the hospital outpatient department setting. In determining the payment rate, CMS proposes to categorize skin substitutes into three groupings based on their US Food and Drug Administration (FDA) regulatory status:

1. Premarket approvals.
2. 510(k)s and de novo authorizations.
3. 361 human cells, tissues, and cellular and tissue-based products (HCT/P)

The vast majority of products (196) fall under the 361 HCT/P category, with 53 and seven falling in the 510(k) and premarket approvals categories, respectively.

For 2026, CMS proposes to set a single payment rate across all three categories but states that in future years, payment rates would differ by category. To arrive at the proposed national unadjusted payment rate for CY 2026 ($125.38/cm2), CMS uses volume-weighted ASPs as reported by the manufacturer and hospital outpatient utilization data from Q4 2024. CMS proposes to use hospital outpatient utilization data rather than physician office utilization data because of the perception that physician office utilization may be skewed by the seeming incentives that this proposed policy is seeking to address.

CMS proposes to apply this proposed payment rate while maintaining the existing HCPCS codes for skin substitutes to allow for reporting of costs and to track applicable skin substitutes for relevant coverage policies, including the collaborative local coverage determinations established by the Medicare administrative contractors that have an implementation date of January 1, 2026.

CMS seeks comments on several aspects of the proposal:

- Initial value for the three categories.
- Methodology used to arrive at the initial value, including the use of the most recent Q4 data.
- Whether to create subcategories for the three categories based on FDA regulatory framework.
- Methods for recognizing new, innovative products in the initial years under PFS (e.g., separate payment for products with transitional pass through in the hospital outpatient setting or new technology add-on payment in the inpatient setting).

Specifics of how the policy will be implemented in the outpatient setting are discussed in the CY 2026 OPPS proposed rule.

ACCESS TO BEHAVIORAL HEALTH SERVICES

INTEGRATING BEHAVIORAL HEALTH INTO ADVANCED PRIMARY CARE MANAGEMENT

Key takeaway: CMS proposes to create optional add-on codes for advanced primary care management (APCM) services that would facilitate the delivery of behavioral health integration (BHI) services.

In the CY 2025 PFS final rule (89 FR 97859 through 97902), CMS finalized separate coding and payment for APCM services (HCPCS codes G0556, G0557, and G0558). CMS believes that patients with chronic health conditions are more likely to have related behavioral health concerns and find it easier to improve chronic conditions when these concerns are also addressed. Integrating behavioral health with primary care has been shown to improve outcomes, for example by reducing depression severity and enhancing patients' care experience. In CMS's view, physicians and practitioners who furnish APCM services should be able to provide BHI and collaborative care model (CoCM) services without documenting their time spent performing the service, because doing so would help facilitate a more holistic, team-based approach to care coordination and reduce burden.

For CY 2026, CMS proposes to create optional add-on codes for APCM services that would facilitate providing complementary BHI services by removing the time-based requirements of the existing BHI and CoCM codes. The proposed new codes are:

- HCPCS code GPCM1, an add-on code based on CPT code 99492.
- HCPCS code GPCM2, an add-on code based on CPT code 99493 for CoCM services delivered to patients also receiving APCM services.
- HCPCS code GPCM3, an add-on code for general BHI services based on CPT code 99484.

CMS also seeks comments on how the agency should consider the application of cost sharing for APCM services. CMS asks for suggestions for other potential changes to APCM or additional coding to further recognize the work of advanced primary care practices in preventing and managing chronic disease.

DIGITAL MENTAL HEALTH TREATMENT

Key takeaway: CMS proposes expanding coverage for additional digital mental health treatment devices and seeks feedback on digital device policies.

In the CY 2025 PFS final rule, CMS finalized Medicare payment to billing practitioners for digital mental health treatment (DMHT) devices cleared by the FDA that are furnished incident to or integral to professional behavioral health services and used in conjunction with ongoing behavioral health care treatment under a behavioral health treatment plan of care. The billing practitioner must diagnose the patient with a mental health condition and prescribe or order the DMHT device.

In the CY 2026 PFS proposed rule, CMS clarifies that while the patient must have a diagnosed mental health condition, the billing practitioner does not have to be the one who made the diagnosis. The patient can use the DMHT device in settings allowed by the FDA—such as at home, in a doctor's office, or other outpatient locations—depending on how the device is classified. Medicare will only pay for the use of DHMT devices if they are used as the FDA has approved under classification §882.5801.

CMS also proposes to expand Medicare payment for certain DHMT services to include devices that are FDA-cleared or authorized for treating attention deficit hyperactivity disorder (ADHD) and classified under § 882.5803. These devices are software-based therapies used alongside care from a clinician to help manage ADHD or its symptoms. Like other DHMT devices CMS already covers (classified under § 882.5801), these ADHD devices must be supported by clinical data showing they use a validated therapy model and are effective. CMS believes adding coverage for these devices will better reflect the range of FDA-authorized behavioral health treatments. The same rules that were finalized in CY 2025 for HCPCS codes G0552, G0553, and G0554 would apply. CMS is also asking for public feedback on whether to add coverage for other digital therapy devices for conditions like gastrointestinal symptoms, sleep disturbance, or fibromyalgia.

CMS also asks stakeholders for input on the possibility of establishing additional separate coding and payment for a broader set of services describing digital tools used by practitioners to maintain or encourage a healthy lifestyle as part of a mental health treatment plan of care, including recommendations on how these services should be priced.

Finally, CMS seeks feedback on related digital device policies for consideration in future rulemaking. The agency received a request to create a new add-on G code that could be used with certain psychological and neuropsychological testing services (CPT codes 96112, 96113, 96116, 96121, 96130, 96131, 96132, and 96133) when clinicians use an FDA-approved eye-tracking device to help diagnose autism spectrum disorder in children. The agency is seeking public comments on whether it should create a temporary G code with contractor pricing for this purpose, or whether it would be more appropriate to pursue a Category III CPT code through the AMA's CPT Editorial Panel process.

MODIFICATIONS TO SOCIAL DETERMINANTS OF HEALTH, COMMUNITY HEALTH INTEGRATION SERVICES, AND PRINCIPAL ILLNESS NAVIGATION SERVICES

Key takeaway: CMS proposes to modify language in community health integration (CHI) service codes and delete social determinants of health (SDOH) code G0136 because of overlapping resource costs with existing services. CMS also clarifies "certified or trained auxiliary personnel" for CHI and principal illness navigation (PIN) codes.

In CY 2024, CMS added several new codes to the PFS to support integrated care:

- Coding for PIN services (G0023, G0024, G0140, G0146) to support care navigation following an initiating E/M visit addressing a serious high-risk condition/illness/disease expected to last longer than three months (e.g., cancer, chronic obstructive pulmonary disease, congestive heart failure).

PIN services can be furnished by auxiliary personnel under the general supervision of the provider who furnished the PIN initiating visit.

- Two G codes (G0019 and G0022) to pay for CHI services, which reimburse services aimed at addressing particular SDOH needs that interfere with or present barriers to diagnosis or treatment of the patient's problems addressed in the CHI initiating visit. These services can be delivered by trained auxiliary personnel, such as community health workers, under general supervision.

- Standalone G code (G0136) for administering an SDOH risk assessment as part of a comprehensive social history when medically reasonable and necessary in relation to an E/M visit (beneficiary cost sharing may apply when the assessment is not conducted as part of the annual wellness visit). Assessments can be conducted by auxiliary personnel under the general supervision of the provider who performs the underlying visit.

For CY 2026, CMS proposes to replace the term "social determinants of health" with "upstream driver(s)," which CMS considers more comprehensive. CMS states that it will make conforming revisions to codes describing similar services to reflect the updated terminology, including services furnished by rural health clinics (RHCs), federally qualified health centers (FQHCs), and Opiod Treatment Programs (OTPs).

In the CY 2026 proposed rule, CMS clarifies that "certified or trained auxiliary personnel" for HCPCS codes G0019, G0022, G0023, G0024, G0140, and G0146 include marriage and family therapists (MFTs) and mental health counselors (MHCs) along with clinical social workers (CSWs). Similar to CSWs, MFTs and MHCs can bill Medicare directly for CHI and PIN services they personally perform related to mental illness diagnosis or treatment. CMS clarifies that if CSWs, MFTs, or MHCs perform these services under the general supervision of a billing practitioner and there are no state certification or training requirements, they must have the necessary training or certification to perform all parts of the CHI and PIN services.

For CSWs, MFTs, and MHCs to bill Medicare directly for CHI services personally performed for the diagnosis or treatment of mental illness, CMS proposes to allow CPT code 90791 (psychiatric diagnostic evaluation) or the health behavior assessment and intervention (HBAI) services CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168 (and any subsequent HBAI codes) to serve as initiating visits for CHI. CMS believes that these codes are the most analogous to the E/M codes currently used for CHI initiating visits by practitioners in specialties whose covered services are limited by statute to the diagnosis and treatment of mental illness.

CMS proposes deleting SDOH HCPCS code G0136 and remove it from the Medicare telehealth services list because the agency believes that the associated resource costs are already included in other services, such as E/M visits.

TELEHEALTH AND OTHER REMOTE SERVICES

CMS proposes to change how codes are categorized on the Medicare telehealth services list and eliminate steps in the review process for adding new codes to the list. CMS also proposes to expand the ability for virtual presence to meet certain direct supervision requirements.

Payment and coverage of telehealth services will be significantly impacted if Congress does not extend the Medicare telehealth flexibilities beyond September 30, 2025. CMS does not discuss this scenario in much detail in the proposed rule, however.

UPDATES TO THE TELEHEALTH SERVICES LIST

Key takeaway: CMS proposes to no longer list codes as "provisional" on the Medicare telehealth services list.

CMS currently uses a five-step process to review changes to the Medicare telehealth services list, which includes "permanent" and "provisional" codes.[2] If all five steps are passed, the code is placed on the permanent list. If only steps one through three are met, the code is placed on the provisional (or temporary) list.

CMS proposes to eliminate review steps four and five, which would obviate the need for a provisional list entirely. Under this proposal, all codes currently on the provisional list would be added to the permanent list. CMS would maintain its ability to review and subsequently remove codes from the permanent list. The agency believes this proposal would reduce administrative burden and allow patients and providers to determine the most effective modality of care, including in-person.

Because of this proposal, CMS is not considering any formal requests to move codes from the provisional to the permanent list. If CMS does not move forward with the proposed changes, the agency will undertake a comprehensive review and analysis of all codes on the current provisional list.

Of the new codes submitted for addition to the Medicare telehealth services list, CMS proposes to add:

- CPT code 90849 (Multiple-family group psychotherapy).
- CPT code G0473 (Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes).
- CPT code G0545 (Visit complexity inherent to hospital inpatient or observation care associated with a confirmed or suspected infectious disease by an infectious diseases consultant, including disease transmission risk assessment and mitigation, public health investigation, analysis, and testing, and complex antimicrobial therapy counseling and treatment (add-on code, list separately in addition to hospital inpatient or observation evaluation and management visit, initial, same day discharge, or subsequent)).
- CPT codes 92622 (Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes) and 92623 (Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes (list separately in addition to code for primary procedure)).

CMS declines to add the following codes to the Medicare telehealth services list:

- CPT codes 90935 (Hemodialysis procedure with single evaluation by a physician or other qualified healthcare professional); 90937 (Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription); 90945 (Dialysis procedure other than hemodialysis (for example, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single evaluation by a physician or other qualified healthcare professional); and 90947 (Dialysis procedure other than hemodialysis (for example, peritoneal dialysis, hemofiltration,

[2] The five steps are:
1. Determine whether the service is separately payable under the PFS.
2. Determine whether the service at issue is, in whole or in part, inherently a face-to-face service.
3. Review the elements of the service as described by the HCPCS code and determine whether each of them is capable of being furnished using an interactive telecommunications system.
4. Consider whether the service elements of the requested service map to the service elements of a service on the list that has a permanent status described in previous final rulemaking.
5. Consider whether there is evidence of clinical benefit analogous to the clinical benefit of the in-person service when the patient, who is located at a telehealth originating site, receives a service furnished by a physician or practitioner located at a distant site using an interactive telecommunications system.

or other continuous renal replacement therapies) requiring repeated evaluations by a physician or other qualified healthcare professional, with or without substantial revision of dialysis prescription).

  - CMS seeks additional data from stakeholders on whether elements of this service can be delivered via an interactive telecommunication system.

- HCPCS code G0248 encompassing a face-to-face demonstration of the use and care of the INR monitor, obtaining at least one blood sample, providing instructions for reporting home INR test results, and documenting the patient's ability to perform testing and report results.

  - CMS states this does not meet step 2 of the review process.

- CPT codes 98000 – 98015, telemedicine E/M services.

  - CMS states that these do not meet step 1 of the review process.

OTHER CHANGES TO CODES

Key takeaway: CMS proposes permanent changes to frequency limitations.

During the COVID-19 public health emergency (PHE) and through rulemaking for CY 2025, CMS suspended frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultation services. CMS proposes to permanently suspend the frequency limitations beginning in CY 2026.

PROVIDER HOME ADDRESS

Key takeaway: CMS does not propose to extend flexibilities related to a provider's home address.

In CY 2025, CMS permitted distant site practitioners to continue to use their currently enrolled practice location instead of their home address when providing telehealth services from their home through December 1, 2025. The agency does not discuss this policy in the proposed rule and, as a result, the flexibility would not be further extended.

DIRECT SUPERVISION

Key takeaway: CMS proposes permanent changes to allow more flexibility in virtual presence.

In CY 2025, CMS continued to allow the virtual presence flexibility for certain services valued under the PFS given that these services typically are performed in their entirety by auxiliary personnel:

- Services furnished incident to a physician or other practitioner's service when provided by auxiliary personnel employed by the billing practitioner and working under their direct supervision, and for which the underlying HCPCS code has been assigned a PC/TC indicator of '5'.

- Services described by CPT code 99211 (Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified healthcare professional).

For CY 2026, CMS seeks to expand this flexibility to more services by permanently adopting a definition of direct supervision that allows "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only) for all services described as incident-to a physician's professional services, except for services that have a global surgery indicator of 010, signifying a

minor surgical procedure with a 10-day postoperative period, and 090 indicating a major surgical procedure with a 90-day postoperative period.

As a result of this proposed change, the definition of direct supervision applicable to cardiac, pulmonary, and intensive cardiac rehabilitation services would be modified to include virtual presence through audio/video real-time communications technology (excluding audio-only) for services without a 010 or 090 global surgery indicator.

For CY 2026, CMS proposes to end the temporary policy that allowed teaching physicians to have a virtual presence during the key portion of the Medicare telehealth service for which payment was sought, through audio/video real-time communications technology, in all residency training locations. The policy is currently set to end December 31, 2025. CMS proposes to transition back to the pre-PHE policy, which would maintain the rural exception established in the CY 2021 PFS final rule that recognize the unique challenges and importance of expanding medical education opportunities in rural settings.

TELEHEALTH ORIGINATING SITE FACILITY FEE PAYMENT

Key takeaway: CMS would update the originating site facility fee schedule to $31.8.

Every year, CMS increases the payment for the telehealth originating site facility fee based on the MEI. For CY 2026, CMS is proposing a 2.7% increase, reflecting the expected rise in practice costs based on historical data through the second quarter of 2025. Therefore, the proposed payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is $31.85.

REMOTE MONITORING SERVICES

Key takeaway: CMS proposes new and revised payment rates for new and existing RPM and RTM services.

In recent years, CMS has expanded payment for remote monitoring services, which generally use digital technologies (primarily medical devices, together with software) to collect medical and other forms of health data from patients in one location and electronically transmit the information to the patient's healthcare provider in a different location for assessment and care management. Beginning in 2019, with the introduction of CPT codes for RPM, CMS has gradually established payment rates and provided guidance on requirements and appropriate utilization for remote monitoring services. CMS established payment policies for RTM effective in 2022 and allows payment using the RTM codes for services that support an episode of therapy where the clinical issue ties to musculoskeletal, respiratory, or cognitive behavioral therapy.

During the COVID-19 PHE, CMS waived the 16-day data collection requirement for the RPM and RTM codes, allowing the services to be eligible for reimbursement following at least two days of data for a patient in a month. This flexibility ended with the conclusion of the PHE. Since then, stakeholders have engaged with both CMS and the AMA to seek coding and payment policies that would allow for payment where RPM or RTM devices captured data for less than 16 days in a calendar month. At the September 2024 CPT Editorial Panel meeting, the AMA accepted the creation of new types of RPM and RTM codes:

- Codes for device supplies for two to 15 days in a month (99XX4, 98XX4 – 98XX6).
- Treatment management services for the first 10 minutes in a month (as opposed to requiring 20 minutes in a month) (99XX5, 98XX7).

Full code descriptors can be found in Table 18 in the proposed rule.

CMS details several proposals specific to these codes, including the following:

- For the new treatment management codes for 10 minutes per month (99XX5 and 98XX7), CMS proposes a work RVU that is about one-half the work RVU for the 20-minute codes, given the similar level of intensity but less time.

- For the PE-only codes for both RPM and RTM, CMS does not accept invoices submitted by the RUC. CMS proposes to calculate the PE RVU for these codes by dividing the geometric mean cost under the OPPS by the CF.

- For 98986, CMS proposes to change from national pricing in 2025 to contractor pricing in 2026.

- CMS proposes to have these codes resurveyed in one (RPM) and three (RTM) years following availability of CY 2026 claims data.

While CMS has sought to maintain similarities in the two sets of codes, it seeks feedback on whether that is appropriate and requests evidence and data from stakeholders on whether these remote monitoring services are similar or if there are meaningful differences.

MEDICARE DIABETES PREVENTION PROGRAM

Key takeaway: CMS seeks to expand participation in the Medicare Diabetes Prevention Program (MDPP) by allowing MDPP suppliers to deliver MDPP services online through December 31, 2029.

The MDPP is an evidenced-based behavioral intervention that aims to prevent or delay the onset of type 2 diabetes for eligible Medicare beneficiaries diagnosed with prediabetes. Although CMS made changes to the MDPP in recent years, it believes additional modifications are necessary since uptake of the MDPP remains low. According to CMS, less than 1% of eligible beneficiaries participate in the program (about 5,000 out of 9.3 million eligible enrollees). To increase participation in the program, CMS proposes the following:

- Testing the inclusion of an asynchronous delivery modality that will allow MDPP suppliers to deliver the set of MDPP services online through December 31, 2029; clarifying that MDPP suppliers are not required to maintain in-person delivery capability through December 31, 2029; and introducing a new G-code and payment for online sessions.

    - CMS would add definitions for “live coach interaction,” “online delivery period,” and “online session,” and would modify the definition of “online.” These terms pave the way for the MDPP benefit to be delivered virtually.

    - CMS proposes that MDPP suppliers be permitted to deliver MDPP in-person, via distance learning, in-person with a distance learning component, or using online modalities. While MDPP suppliers may offer synchronous and asynchronous modalities, they may not intermingle asynchronous (for example, online) and synchronous (in-person, in-person with a distance learning component, and distance learning) delivery modalities for individual beneficiaries. The set of MDPP services, inclusive of make-up sessions, must be delivered to individual beneficiaries fully synchronously or fully asynchronously.

- Making changes to address operational questions and barriers related to weight collection requirements. CMS proposes to allow weight measurements used to determine the achievement or maintenance of the required minimum weight loss to be based on weight documented in the beneficiary’s medical record within two days of the completion of the MDPP session. Currently, beneficiaries must weigh in during their in-person MDPP session or self-report weight measurements on the date associated with the billable MDPP session. CMS would also allow beneficiaries to self-report weight from a reasonable location other thsm an in-person delivery site.

- Extending flexibilities allowed during the COVID-19 PHE through December 31, 2029, including the option to deliver MDPP sessions via distance learning and for beneficiaries to virtually self-report weight for MDPP distance learning sessions.

QUALITY PAYMENT PROGRAM

Under the QPP, eligible clinicians can be subject to payment adjustments based on performance under MIPS, or they can participate in the advanced APM track. Eligible clinicians in MIPS will have payments increased, maintained, or decreased based on relative performance in four categories: quality, cost, promoting interoperability, and improvement activities. CMS has implemented the MIPS Value Pathways (MVPs) as a voluntary alternative to traditional MIPS but signals efforts to move towards this reporting pathway in the future.

MERIT-BASED INCENTIVE PAYMENT SYSTEM

Key takeaway: CMS proposes to maintain the performance threshold required to avoid a penalty and receive a positive payment adjustment through the 2028 performance period.

To avoid a negative adjustment and be eligible for a positive payment adjustment, a provider's MIPS total score must reach a performance threshold. CMS proposes to maintain the MIPS performance threshold of 75 points not only for 2026 but through the CY 2028 performance period. Historically, CMS had increased the MIPS performance threshold, but during the COVID-19 PHE, the agency maintained a 75 point threshold for several consecutive years, allowing MIPS participants to avoid additional quality reporting challenges.

CMS recently released performance data for the CY 2023 performance period/2025 MIPS payment year. Overall performance has remained stable over the last few years, with mean and median scores above 80 points. The median score for the CY 2023 performance period/2025 MIPS payment year was 85 points, well above the 75 point threshold. Most clinicians (81%) surpassed the 75 point threshold and received positive MIPS payment adjustments. Only 14% of clinicians received negative MIPS payment adjustments, and 5% received neutral MIPS payment adjustments. MIPS is a budget neutral program, meaning that CMS must use negative payment adjustments to fund positive adjustments. The fact that a large proportion of clinicians continue to avoid negative adjustments has limited the potential for large positive adjustments. Although the law allowed for positive payment adjustments up to 9% (or even higher), the maximum positive payment adjustment in the CY 2023 performance period/2025 MIPS payment year was only 2.15% because of the budget neutrality requirement.

The MIPS performance category weights are specified in statute, are not open for comment, and have not changed from CY 2024.

Performance category	PY 2024 weight	PY 2025 proposed weight
Quality	30%	30%
Cost	30%	30%
Promoting interoperability	25%	25%
Improvement activities	15%	15%

CMS estimates that 84.04% of eligible clinicians would receive a positive MIPS adjustment for the CY 2026 performance period. The median payment adjustment is estimated to be 1.3%.

Quality category

CMS proposes changes that would result in a total of 190 quality measures (a reduction from the current 195).[3] Specific measure changes are outlined in more detail in the QPP fact sheet. In line with the Trump administration's focus, CMS proposes to remove health equity from the definition of a high-priority measure and solicits feedback on adding potential well-being and nutrition measures.

The rule proposes to update the benchmarking methodology for administrative claims quality measures to align with the benchmarking methodology for cost measures beginning with the CY 2025 performance period/2027 MIPS payment year. Scoring methodology would be based on the standard deviation, the median, and an achievement point value derived from the performance threshold. For a MIPS-eligible clinician whose performance rate under an administrative-claims-based measure was equal to the median performance rate for all MIPS-eligible clinicians scored on that measure, CMS would assign an achievement point value equal to 10% of the performance threshold.

While CMS revised its "topped out" policy for quality measures in last year's rulemaking, the agency proposes to remove the scoring cap and adjust measure benchmarks for 19 measures in the CY 2026 performance period. These measures belong to specialty sets and MVPs with limited measure choice and in areas that lack measure development, which precludes meaningful participation.

Cost category

Cost measures are largely based on claims data and typically calculated by CMS. This often leaves clinicians without much insight into how their performance is scored. CMS proposes a two-year informational-only feedback period for new cost measures, allowing clinicians to receive feedback and find opportunities to improve performance before a new cost measure affects their MIPS final score.

CMS proposes to update rules for the total per capita cost (TPCC) measure that had historically been cited for concerns tied to incorrect attribution. CMS proposes to exclude any candidate events initiated by an advanced care practitioner taxpayer identification number-national provider identifier (TIN-NPI) if all other non-advanced-care practitioner TIN-NPIs in their group are excluded based on the specialty exclusion criteria. CMS would also require that:

- The second service used to initiate a second candidate event be an E/M service or other related primary care service provided within 90 days of the initial candidate event service by a TIN-NPI within the same TIN.

- The second service used to initiate a candidate event be provided by a TIN-NPI that has not been excluded from the measure based on specialty exclusion criteria.

More details on these changes are available on the total per capita cost measure information form on the CMS website.

CMS does not propose to expand or reduce the existing inventory of 35 cost measures for the CY 2026 performance period.

[3] Qualified clinical data registry measures are approved outside the rulemaking process and are not included in this total.

Improvement activities

Improvement activities are no longer weighted, based on final policies from last year. The CY 2026 proposed rule would remove the achieving health equity subcategory and add an advancing health and wellness subcategory to align with the Trump administration's priorities.

CMS also proposes the following changes to the improvement activities inventory for the 2026 performance period:

- Addition of three new activities (see Appendix D). One of the new improvement activities highlights patient safety related to artificial intelligence (AI). The measure would involve developing a new data-collection field with patient safety reporting systems for AI-attributable events, including where actual harm is caused to a patient because of AI technology.
- Modification of seven existing activities.
- Removal of eight activities, many tied to health equity (see Appendix E).

Promoting interoperability

In the past, CMS allowed certain participants to not be scored in the promoting interoperability category and re-weighted the other MIPS categories, especially where interoperability may have been outside of certain clinicians' control or where clinicians experienced barriers to technical advances. Automatic reweighting now only applies to MIPS-eligible clinicians, groups, and virtual groups with the following special statuses: ASC-based, hospital-based, non-patient facing, or small practice.

To address situations where promoting interoperability measures may still be challenging, CMS proposes to adopt a measure suppression policy. This new policy would establish criteria for determining circumstances in which a measure could be suppressed and subsequently not scored for MIPS-eligible clinicians and eligible hospitals and critical access hospitals participating in the Medicare Promoting Interoperability Program, respectively. The proposed policy would be effective starting with the CY 2026 performance period/2028 MIPS payment year and the electronic health record (EHR) reporting period in CY 2026. As an example, CMS proposes to suppress the electronic case reporting measure so that it would not be scored for the public health and clinical data exchange objective. Because the Centers for Disease Control and Prevention temporarily paused the onboarding of new healthcare organizations, CMS believes this policy is warranted and would prevent undue penalties for MIPS-eligible clinicians because of circumstances that are outside of their control.

The rule proposes to modify the public health and clinical data exchange objective by adopting a new optional bonus measure: the public health reporting using the Trusted Exchange Framework and Common Agreement (TEFCA) measure. For this measure, MIPS-eligible clinicians would attest that they are in active engagement (validated data production) with a public health agency to transfer health information using TEFCA. The measure would be one of four available bonus measures under the public health and clinical data exchange objective, in which a maximum of five points could be earned if reporting one, more than one, or all optional bonus measures. The rule would also add a second attestation component to the security risk analysis measure and modify the high priority practices SAFER Guide measure by requiring use of the 2025 SAFER Guides.

MIPS VALUE PATHWAYS

Key takeaway: CMS proposes six new MVPs, includes a specialty attestation requirement during MVP registration, and includes three separate requests for information (RFIs).

The MVPs are a participation option to motivate clinicians to move away from reporting on self-selected activities and measures (traditional MIPS) and towards an aligned set of measure options designed to be meaningful to patient care, better connect measures across MIPS categories, and be more relevant to a clinician's scope of practice. Over the years, participation in traditional MIPS has been criticized as expensive and time consuming with low positive payment adjustments as a reward, and as having an uncertain impact on patient care. At the same time, some stakeholders have raised concerns about sunsetting MIPS because MVPs are untested and it is unclear whether there will be MVP options for all participants. In the CY 2022 final rule, CMS finalized a proposal to launch the MVPs in 2023, set an implementation timeline, and defined MVP criteria. CMS launched the option for MVPs with 12 different pathways[4] reflecting various specialties and care settings in 2023 and added new MVPs in both 2024 and 2025. Currently, 21 MVPs are available for the CY 2025 performance period/2027 MIPS payment year.

CMS has released results from the first year of MVP reporting, the 2023 performance period. Nearly 42,000 clinicians (7.7% of all clinicians in MIPS) registered for an MVP, and almost half (20,484) submitted MVP data. Clinicians who reported MVP data also had the option of reporting through traditional MIPS, and CMS took the highest score. Nearly all (98%) clinicians who reported through an MVP also reported through traditional MIPS. Only 16% of clinicians (6,790) received a final MIPS score based on their MVP participation, because the clinician's MVP scores on average were lower than their traditional MIPS scores. Thus, 84% of clinicians who reported through an MVP received a score based on their reporting through traditional MIPS. While MVP participation could have increased in 2024, based on the data available MVP participation appears low, and clinicians who report through MVPs continue to rely on traditional MIPS to ensure they receive the highest possible scores.

New MVPs

CMS proposes six new MVPs for the CY 2026 performance period/2028 MIPS payment year, for a total of 27 MVPs. The new MVPs focus on diagnostic radiology, interventional radiology, neuropsychology, pathology, podiatry, and vascular surgery.

Transition to mandatory program

The MVP program remains a voluntary option to provide time for MIPS-eligible clinicians to familiarize themselves with MVPs and begin preparing their practices for participation. CMS has suggested that it will eventually sunset MIPS and move clinicians to MVPs but has not specified a date for this transition to occur. In the CY 2025 PFS proposed rule, CMS sought comment on, but did not propose, the 2029 performance period as the potential timeline for completing the transition to MVPs (and sunsetting traditional MIPS).

In the CY 2026 proposed rule, CMS does not indicate a timeline but does propose policies aimed at facilitating the transition to MVP reporting. CMS proposes to require clinicians who register for MVPs to attest to their group's specialty composition as a single specialty or multispecialty. This designation, and whether a group is considered a small group (15 clinicians or fewer) or a large group, will dictate whether the group must participate in an MVP as a subgroup. Multispecialty groups will no longer be able to report MVP as a single group.

CMS previously established that beginning with the CY 2026 MIPS performance period/2028 MIPS payment year, MIPS-eligible clinicians in multispecialty groups must divide into and report as subgroups, or must each report to an MVP as individuals. Alternatively, MIPS-eligible clinicians in multispecialty groups may continue to participate in traditional MIPS reporting. Under the proposed attestation policy, a multispecialty

[4] The 12 MVPS previously established by CMS are advancing cancer care; optimal care for kidney health; optimal care for patients with episodic neurological conditions; supportive care for neurodegenerative conditions; promoting wellness; advancing rheumatology patient care; coordinating stroke care to promote prevention and cultivate positive outcomes; advancing care for heart disease; optimizing chronic disease management; adopting best practices and promoting patient safety within emergency medicine; improving care for lower extremity joint repair; patient safety and support of positive experiences with anesthesia.

group practice consisting of 15 or fewer clinicians that chooses to report an MVP would be exempt from the requirement to participate as subgroups. A group practice consisting of 16 or more clinicians who are involved in a single focus of care would attest as a single specialty group and register as a single group for MVP reporting. If a group practice consists of 16 or more clinicians and the clinicians within the group are involved in multiple specialties, the group practice could not register for MVP reporting as a single group. MIPS-eligible clinicians in such groups would need to divide into subgroups or, if applicable, participate as individuals for reporting an MVP.

Requests for information

CMS seeks feedback on:

- The development of a subset of quality measures within each MVP, referred to as "core elements," that would represent the foundation and focus of the MVP. An MVP participant would be required to report one core element. CMS believes this would enable more accurate comparisons of similar clinicians and would give patients the best information available about clinicians so they can make informed decisions about their care.

- The identification of Medicare Part B procedural billing codes that align with each MVP to encourage specialists to report the relevant MVP based on their use of the procedural billing codes.

- Well-being and nutrition tools and measures that "assess overall health, happiness, and satisfaction in life."

Qualified clinical data registry policies

CMS proposes to allow qualified clinical data registries (QCDRs) and qualified registries additional time to fully support finalized MVPs. Currently, QCDRs and qualified registries must immediately support MVPs that are applicable to their customers once an MVP is approved. CMS proposes that, beginning with the CY 2026 performance period/2028 MIPS payment year, QCDRs and qualified registries can have a one-year grace period after a new MVP is finalized before they must be able to support it.

ADVANCED APM TRACK

Key takeaway: CMS proposes a comprehensive overhaul of the QP determination process to increase APM participation, particularly among specialists.

To become a QP, clinicians must receive at least 75% of payments or see at least 50% of patients through an advanced APM. Given stakeholders' reported challenges meeting this statutorily mandated threshold, CMS proposes changes to better align with modern advanced APM designs, including:

- Adding QP determinations at the NPI level in addition to existing APM entity-level calculations. This change would ensure that clinicians who actively participate in an advanced APM can achieve QP status even if their APM entity does not.

- Broadening the definition of "attribution-eligible beneficiary" to include beneficiaries receiving any covered professional services (not just E/M services) from a participating clinician. This change would begin with the 2026 QP performance period and is designed to support greater recognition of specialists' contributions to value-based care.

MEDICARE SHARED SAVINGS PROGRAM

CMS proposes changes to advance MSSP's long-term sustainability and encourage participation from a broader range of providers, including those serving underserved and rural populations. As of January 1,

2025, MSSP has 477 accountable care organizations (ACOs) with more than 650,000 healthcare providers and organizations providing care to more than 11.2 million beneficiaries. Major proposed changes to the MSSP are outlined below.

Key takeaway: CMS proposes to limit participation in the BASIC track's glide path to an ACO's first agreement period only.

Currently, the BASIC track's glide path policy allows an ACO inexperienced in Medicare ACO initiatives to begin in a one-sided risk model (BASIC level A or B) and transition to two-sided risk over time or remain in a one-sided risk model for the entirety of its first agreement period. When renewing or re-entering the program in a subsequent agreement period, the ACO is able to restart in a one-sided risk model before being required to progress to higher levels of risk.

Under CMS's proposal, an ACO inexperienced in Medicare ACO initiatives would still be allowed to participate in the BASIC track's glide path for its first agreement period, but it would be required to enter BASIC level E or the ENHANCED track when it applies for a subsequent agreement period. This change would apply program-wide, including to ACOs that previously joined the MSSP under earlier policies that allowed restarting the glide path in subsequent agreement periods.

Key takeaway: CMS proposes to permit limited mid-year modifications to an ACO's participant list and skilled nursing facility (SNF) affiliate list due to change of ownership (CHOW).

To address administrative disruptions that occur during ownership transitions, CMS proposes to permit limited mid-year modifications to an ACO's participant list and SNF affiliate list when specific criteria are met:

- CMS proposes to allow an ACO to add a new participant TIN mid-year when a CHOW results in a new Medicare-enrolled TIN with no Medicare billing claims history. This ensures continuity, particularly where benchmark year (BY) claims history is necessary for MSSP operations.

- CMS proposes to allow mid-year changes when a CHOW of an SNF affiliate results in a change to the SNF's Medicare-enrolled TIN and the new TIN continues to meet all SNF three-day rule waiver requirements.

ACOs would be required to notify CMS within 30 calendar days of the CHOW's effective date.

Key takeaway: CMS proposes changes to allow an ACO that does not meet the 5,000 minimum assigned beneficiary threshold in BY1 and/or BY2 to still participate in MSSP.

Under current policy, an ACO must meet and maintain a 5,000 minimum assigned beneficiary threshold for each BY to enter and remain in MSSP. For agreement periods starting on or after January 1, 2027, CMS proposes to allow ACOs with fewer than 5,000 assigned beneficiaries in either BY1 or BY2 to enter MSSP, as long as they meet the beneficiary threshold in BY3. If an ACO with fewer than 5,000 assigned beneficiaries in BY1 or BY2 enters the program, CMS proposes that it be restricted to the BASIC track.

CMS also proposes alternative performance payment limits (*i.e.*, the cap on shared savings) and loss recoupment limits (*e.g.*, the cap on shared losses) for ACOs that fall below the 5,000 beneficiary threshold during any BY. Under current policy, these limits are set as a fixed percentage of the ACO's BY3 expenditures, based on the track and level of risk. CMS proposes to compare the existing limits to alternative limits calculated using the BY with the lowest number of assigned beneficiaries, and to apply the lesser value.

Under current policy, certain low-revenue ACOs participating in the BASIC track qualify for shared savings even if they do not meet established minimum savings ratio requirements. CMS proposes to exclude these ACOs from receiving shared savings if they have fewer than 5,000 assigned beneficiaries in any BY.

Key takeaway: CMS proposes to revise the definition of primary care services used for beneficiary assignment.

CMS proposes to include new HCPCS add-on codes in the definition of primary care services: the new enhanced care model management services codes proposed to support BHI and psychiatric CoCM services when furnished with APCM services.

CMS proposes to delete G0136 (Social determinants of health risk assessment) from the definition of primary care services, because the agency believes that the resource costs are already captured in other services, such as E/M visits. CMS also proposes to allow CPT or HCPCS codes that replace previously listed codes to be automatically included in assignment logic if they become effective during the assignment window.

Key takeaway: CMS proposes to retroactively revise the definition of "beneficiary eligible for Medicare clinical quality measures (CQMs)" beginning in performance year 2025 and onward.

To better align with the ACO assignment methodology, CMS proposes to revise the definition to require a "primary care service" during the applicable "performance year" from an ACO professional, replacing the current standard of a "claim" during the "measurement period." This change is expected to increase alignment between the Medicare CQM-eligible population and assignable beneficiaries, reducing patient matching complexity for ACOs. Even though the proposal would not be finalized until later this year, CMS plans to flag beneficiaries that meet the proposed criteria in its quarterly lists to ACOs, starting with the Q2 2025 beneficiary list.

Key takeaway: CMS proposes several changes to MSSP quality reporting requirements.

CMS proposes several updates to ACO quality reporting requirements to streamline terminology, align with evolving digital quality measurement standards, and refine the APP Plus quality measure set. Key proposed changes include:

- Terminology revisions: CMS would replace "health equity adjusted quality performance score" with "quality score" and revise related terms across MSSP regulations to avoid confusion and clarify that race and ethnicity are not included in scoring methodologies.
- Measure set updates: CMS proposes removing Quality ID: 487 (Screening for social drivers of health) from the APP Plus quality measure set, reducing it to 10 required measures starting in performance year 2028 or one year after the electronic CQM (eCQM) for Quality ID: 493 becomes available.
- Survey mode expansion: Beginning in 2027, Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey must be administered using a web-mail-phone protocol to improve response rates and reduce burden, based on successful field testing and strong stakeholder support.
- Digital quality measurement: CMS issued an RFI on transitioning to digital quality measures using eCQMs based on Fast Healthcare Interoperability Resources.
- Enhanced monitoring: CMS proposes revising monitoring regulations starting in performance year 2026 to address ACOs failing both the quality performance standard and the alternative quality performance standard.

Key takeaway: CMS proposes to revise the extreme and uncontrollable circumstances (EUC) policies to explicitly include cyberattacks as qualifying events.

Beginning in performance year 2025, if an ACO is affected by a cyberattack, such as ransomware and malware, it may submit a MIPS EUC exception application at the legal entity level. If its application is successful, the following relief would apply:

- Quality reporting relief: ACOs would have their quality performance score set to the higher of their actual score or the 40th percentile of MIPS scores, preserving eligibility for shared savings.
- Loss mitigation: Shared losses would be prorated based on the duration of the cyberattack, and 100% of the ACO's assigned beneficiaries would be considered affected.
- Operational flexibility: If an end date is not specified for the cyberattack, CMS would apply a default 90-day duration (or until December 31 if within 90 days of year-end).

Key takeaway: CMS proposes renaming the health equity benchmark adjustment (HEBA) to the population adjustment.

CMS's proposal would not alter how the adjustment is calculated and would apply to agreement periods beginning on or after January 1, 2025.

DRUGS AND BIOLOGICAL PRODUCTS PAID UNDER MEDICARE PART B

Key takeaway: CMS proposes new guidance on price concessions and bona fide service fees (BFSFs) in calculating ASP.

CMS proposes to define the term "bundled arrangement" and provide clarity to manufacturers on how to account for bundled price concessions when calculating ASP. CMS also proposes new regulations specifying the circumstances in which certain fees must be considered price concessions.

CMS proposes revisions to the definition of BFSF. CMS proposes to specify the methodologies that should be used to calculate fair market value in certain circumstances and to require verification from manufacturers that a BFSF is not passed on. CMS also proposes that reasonable assumptions for the calculation of ASP be required as a part of the quarterly ASP data submissions to CMS.

Key takeaway: CMS clarifies ASP calculations for units of selected drugs sold at the maximum fair price and for autologous cell-based immunotherapy and gene therapies.

In the proposed rule, CMS clarifies that units of selected drugs sold at the maximum fair price are included in the calculation of the manufacturer's ASP (described in Section 1847A(c) of the Social Security Act) effective January 1, 2026.

CMS proposes that preparatory procedures for tissue procurement required for manufacturing an autologous cell-based immunotherapy or gene therapy be included in the payment for the product itself and that, beginning January 1, 2026, any such preparatory procedures that were paid for by the manufacturer be included in the calculation of the manufacturer's ASP.

PRESCRIPTION DRUG INFLATION REBATE PROGRAMS

Key takeaway: CMS specifies how it would calculate the Part B payment amount and payment amount benchmark quarter when certain data are unavailable, and proposes to establish a claims-based methodology to remove 340B units from Part D rebate calculations.

The Inflation Reduction Act of 2022 (IRA) established requirements under which drug manufacturers must pay inflation rebates if they raise their prices for certain drugs payable under Part B or covered under Part D

faster than the rate of inflation. CMS proposes new policies for the Medicare Part B Drug Inflation Rebate Program and the Medicare Part D Drug Inflation Rebate Program, including a proposal to establish a claims-based methodology to remove 340B units from Part D rebate calculations starting on January 1, 2026, and establishing a Medicare Part D claims data 340B repository.

MEDICARE PART B

CMS proposes several new policies:

- If data necessary to calculate the payment amount in the payment amount benchmark quarter are not available in the calendar quarter beginning July 1, 2021, or the third full calendar quarter after the drug's first marketed date, whichever is later, CMS will use the third full calendar quarter after the Part B rebatable drug is assigned a billing and payment code as the payment amount benchmark quarter.

- If a published payment limit is not available for the applicable payment amount benchmark quarter, CMS proposes to calculate the payment amount using positive ASP or positive wholesale acquisition cost (WAC) data reported by manufacturers to the ASP data collection system.

- If neither positive ASP nor positive WAC data are available in the ASP data collection system for the applicable quarter, CMS proposes to use WAC data from other public sources for the applicable quarter to calculate the payment amount.

MEDICARE PART D

Drugs purchased through the 340B Program are excluded from the calculation of the rebate amounts. CMS has previously required that 340B drugs billed to Medicare Part B including a modifier (TB) to exclude them from the calculations. Because of the way in which 340B drugs are billed to Part D, CMS has acknowledged that requiring a claim-level modifier for Part D claims is not practicable.

To exclude Medicare Part D claims for 340B drugs from the rebate calculations, CMS proposes two different approaches, both of which would allow for claim-level identification of Medicare Part D claims for 340B drugs:

- Data driven claims-based methodology: CMS would use existing data sources to associate prescriber NPIs with 340B covered entities and 340B contract pharmacies. CMS would use this data to identify 340B drugs billed to Part D based on two criteria: the prescriber (determined by NPI) provides care at a 340B covered entity, and the pharmacy (determined by NPI) is a contract pharmacy for that same 340B covered entity.

- Claims data repository: CMS also proposes to implement an initially voluntary process for 340B covered entities to submit claim-level data to CMS to identify 340B claims billed to Part D. Although this option would initially be voluntary, CMS encourages 340B covered entities to submit the data to get used to making submissions and strongly suggests that the agency might make reporting mandatory in the future.

These two proposals represent CMS's first efforts to identify 340B drugs billed to Medicare Part D.

RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS

Key takeaway: CMS proposes policies to facilitate advanced primary care and care coordination services provided by RHCs and FQHCs.

CMS proposes to adopt the optional add-on codes for APCM that would facilitate billing for BHI and CoCM services when RHCs and FQHCs provide advanced primary care. CMS also proposes to adopt services that are established and paid under the PFS and are designated as care coordination services for purposes of separate payment for RHCs and FQHCs. CMS states that this proposal would better align Medicare policy across care settings and would improve transparency and predictability for RHCs and FQHCs.

Key takeaway: CMS proposes to permanently adopt real-time audio/visual supervision and proposes policies for services furnished through audio-only communications.

For RHC and FQHC services and supplies requiring direct supervision, CMS proposes to permanently adopt a definition of direct supervision that allows the physician (or supervising practitioner) to provide such supervision through real-time audio and visual interactive telecommunications (excluding audio-only). CMS also proposes policies that would allow RHCs and FQHCs to bill for non-behavioral-health services furnished using telecommunication technology by reporting HCPCS code G2025 on the claim, including services furnished using audio-only communications technology, through December 31, 2026.

AMBULATORY SPECIALTY MODEL

Key takeaway: CMS proposes to launch a new mandatory alternative payment model for heart failure and low back pain.

The CMS Innovation Center plans to launch a new mandatory, five-year APM beginning January 1, 2027. The ASM aims to improve quality and reduce costs by holding individual specialists (not at the organizational level) accountable for performance on targeted quality, cost, care coordination, and EHR use metrics when managing heart failure and low back pain, which together account for about 6.2% of Medicare Part A and B spending. CMS will adopt the MVP framework used in MIPS to streamline reporting. ASM would adjust Part B payments (positively, neutrally, or negatively) based on clinician performance compared to peers in the same specialty and condition. Like MIPS, these payment adjustments would take place two years after the performance year in which the physician reported quality measures (*e.g.*, 2027 performance year/2029 payment year). In the first payment year, these adjustments would range from -9% to +9%. All participants would be subject to this risk. The payment approach would ensure that the total positive adjustments for high performers do not exceed the total negative adjustments for low performers. Similar to other CMS Innovation Center models, CMS would apply a discount to provider payments to ensure savings to the Medicare program.

MEDICARE PARTS A AND B PAYMENT FOR DENTAL SERVICES INEXTRICABLY LINKED TO SPECIFIC COVERED MEDICAL SERVICES

Key takeaway: CMS does not propose to expand the clinical scenarios under which fee-for-service Medicare payment may be made for dental services inextricably linked to covered services.

In the CY 2023 PFS final rule, CMS clarified and codified that Medicare Payment under Parts A and B could be made when dental services are furnished in either the inpatient or outpatient setting when the dental services are inextricably linked to, and substantially related and integral to the clinical success of, other covered services. CMS also established a process whereby the agency accepts and considers submissions from the public to assist with identifying additional such dental services.

For CY 2026, CMS received seven submissions, mostly focused on dental care's role in managing diabetes-related complications such as retinopathy and nephropathy, highlighting how untreated dental infections might worsen these conditions. CMS ultimately decided not to propose any changes for CY 2026, but noted that it will consider the information submitted for future rulemaking.

OTHER PROPOSALS AND REQUESTS FOR INFORMATION

The CY 2026 rule also addresses several other proposals, including the following:

- *An RFI on payment for services in urgent care centers:* Building on a comment solicitation in the CY 2025 rule about the role that urgent care centers can play in addressing emergency department capacity issues, CMS seeks comments on whether separate coding and payment is needed for E/M visits furnished at urgent care centers, including whether an add-on code would be appropriate or if a new set of visit codes would be more practical. CMS points to a request from a stakeholder to adopt a new place of service code for "enhanced" urgent care centers, and to create a new add-on G-code to describe the resource costs involved when practitioners furnish certain services in enhanced urgent care centers that offer extended hours and certain diagnostic and therapeutic services. CMS also seeks comment on how practice costs vary among different non-facility settings of care. While this rule includes a proposal to "better recognize variations in indirect costs between facility and nonfacility settings of care," CMS also aims to improve the PE methodology going forward and better recognize relative resources involved in furnishing services across different kinds of non-facility settings.

- *A RFI on prevention and management of chronic disease:* Building on President Trump's executive order related to "making America healthy again," CMS seeks feedback on expanded treatment options and flexibility for insurance coverage and benefits around lifestyle changes and disease prevention. The RFI seeks stakeholder input on whether the PFS adequately captures services that address causes of chronic diseases, including social isolation and loneliness; care that improves physical activity and exercise prescription; intensive lifestyle interventions; medically-tailored meals; FDA-cleared digital therapeutics; and technical enhancements to the annual wellness visit. The RFI solicits specific feedback on creating separate coding and payment for motivational interviewing and use of health coaches.

- *A comment solicitation on payment policy for software as a service (SaaS):* CMS discusses the challenges in accounting for services that include innovative technology, such as software algorithms and AI, in the agency's PE methodology. CMS is concerned about the rapidly changing nature of technology and the difficulty in obtaining verifiable and consistent costs from manufacturers. CMS seeks feedback on how the use of SaaS and AI technology affects management of chronic disease and primary care services, and how to incorporate these costs into the current strategy for paying for evolving models of care delivery, such as APCM and risk-based payment arrangements generally. CMS notes that the CY 2026 OPPS proposed rule includes a comment solicitation regarding SaaS devices furnished in hospital outpatient departments and ASCs.

CONCLUSION

The 2026 PFS proposed rule includes more substantial policies, especially regarding payment, compared to recent regulations. The significant proposed changes to PE and the proposed adjustments and consideration of new data sources suggests physician Medicare payment may undergo significant changes. The new administration has outlined a shift in policy focus toward chronic diseases, wellness, and future uses of technology through several RFIs, suggesting additional reforms could be underway.

For more information, contact: Jeffrey Davis, Deborah Godes, Kayla Holgash, Lauren Knizner, Marie Knoll, Anthony Livshen, Kristen O'Brien, Rachel Stauffer, Simeon Niles or Devin Stone