Summary of the CY 2026 Medicare Physician Fee Schedule Proposed Rule

On Monday, July 14, the Centers for Medicare & Medicaid Services (CMS) released the CY 2026 Medicare Physician Fee Schedule and Quality Payment Program proposed rule. CMS also release an accompanying a press release, MPFS Fact Sheet, QPP fact sheet, and MSSP fact sheet. Comments on the proposed rule are due by September 12, 2025. The AAFP will thoroughly review the proposed rule and provide comments to CMS. The final rule will be released around November 1, 2025, and will take effect on January 1, 2026, except where specified otherwise in the final rule.

2026 Conversion Factor and Impact on Family Medicine

As statutorily required, in 2026 the MPFS will feature two conversion factors: one for qualifying alternative payment model participants (the APM CF) and one for all other clinicians (the non-APM CF). The CY 2026 APM CF of $33.59 represents a projected increase of $1.24 (+3.83%) from the current CF of $32.35. The proposed CY 2026 non-APM CF of $33.42 represents a projected increase of $1.07 (+3.3%) from the current conversion factor of $32.35. The increase to both CFs is due to three factors:

- A 2.5% increase to both CFs attributable to the passage of H.R. 1;
- The statutorily required update of 0.75% for the APM CF and 0.25% to the non-APM CF; and
- An additional 0.55% increase necessary to account for proposed changes in relative value units (RVUs) for some services (i.e., a positive budget-neutrality adjustment).

CMS estimates that the impact on total allowed charges by family physicians will be a positive 3% total in 2026. However, this represents an increase of 6% for services billed by family physicians in non-facility settings (the majority of family physicians) and a decrease of 9% for family physicians practicing in facility settings. This shift is

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largely due to practice expense (PE) methodology updates related to site of service (see below). This estimate also does not include the 2.5% increase to both CFs attributable to H.R. 1. Accordingly, non-facility family physicians can expect significant increases in payment in 2026 under both CFs if the rule is finalized as proposed.

Determination of Practice Expense Relative Value Units (PE RVUs)

CMS proposes multiple technical refinements to its PE RVU methodology and pricing of specific supply and equipment items and supply packs. CMS is proposing not to implement the per hour PE recommendations (PE/HR) or cost shares from the AMA's Physician Practice Information (PPI) and Clinician Practice Information (CPI) survey data. Instead, CMS proposes to maintain the current PE/HR and 2006-based MEI cost shares for CY 2026 MPFS rate setting while introducing new adjustments to the PE methodology

CMS proposes to modify the indirect practice expense methodology to change the allocation of indirect practice costs based on site of service. The proposed change in methodology, only recognizing 50% of the physician's work of facility-based services in the indirect cost method, results in a shift of payment from facility-based services to non-facility-based services. Facility-based physician payments will decrease overall by -7 percent while non-facility-based physician payments will increase by 4 percent. CMS seeks comments on multiple aspects of this proposal and on the question of whether separate coding and payment is needed for evaluation and management visits furnished at urgent care centers.

Efficiency Adjustment

CMS proposes to apply an "efficiency adjustment" of -2.5% to work relative value units (RVUs) and the corresponding intra-service portion of physician time of non-time-based services that CMS believes accrue gains in efficiency over time. This new efficiency adjustment is intended to mitigate the effects of the current and historical valuation of services which may be overstating the actual time necessary to provide

many services, as CMS notes research has suggested. The proposed efficiency adjustment mostly impacts procedurally focused specialties, including surgery, radiology, and pathology. CMS notes that the proposed adjustment does not reduce payment by more than 1 percent for most specialties. This change in methodology contributes to a positive 0.55 percent budget neutrality adjustment in the proposed 2026 conversion factor.

Telehealth Services under the MPFS

CMS proposes to simplify the Medicare Telehealth Services List review process from its current five-step process to a three-step process, including eliminating Step 4 and Step 5 and removing the distinction of "provisional" and "permanent" status. CMS is not proposing to add the telemedicine evaluation and management (E/M) services (CPT codes 98000-98015) to the Medicare Telehealth Services List. The agency states that since these services are not considered separately payable under MPFS when rendered in person – having an assigned status indicator I ("Not valid for Medicare purposes") – they also would not be separately payable when rendered via telehealth.

CMS is proposing to permanently remove frequency limitations for Subsequent Inpatient Visits (CPT codes 99231-99233), Subsequent Nursing Facility Visits (CPT codes 99307-99310), and Critical Care Consultation Services (HCPCS codes G0508 and G0509).

CMS is proposing to permanently adopt a definition of "direct supervision" that permits the virtual presence of a supervising physician to include using audio/video real-time communications technology — though not audio-only — for an expanded set of services. CMS is not proposing to extend current policy that permits a distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services from their home. This policy will expire on January 1, 2026, at which time distant site practitioners will be required to use their home address when providing telehealth services from that location.

CMS is proposing not to extend the current policy that allows teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings through December 31, 2025. Instead, the agency is

proposing to transition back to pre-public health emergency policy, which would require teaching physicians to be in-person with their residents in all teaching settings. CMS does propose to maintain the rural exception established in the CY 2021 MPFS final rule, which permits teaching physicians in specific rural settings to continue utilizing audio/video real-time communications technology to fulfill the presence requirement, so long as they maintain active, real-time observation and participation in the service.

Valuation of Specific Codes

In addition to this broad adjustment in the valuation of codes, CMS proposes some adjustments to specific codes. Among those most relevant to family physicians are codes for combination COVID-19 vaccine administration, immunization counseling in the absence of vaccine administration, and remote monitoring services.

Evaluation and Management (E/M) Visits and G2211

In response to stakeholder feedback, CMS is proposing to expand the use of G2211 to be reported alongside home or residence services. Beginning January 1, 2026, CMS will allow G2211 to be reported with office/outpatient E/M services (CPT codes 99202-99215) and home or residence E/M services (CPT codes 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350). CMS proposes to update the descriptor to read as follows: *"Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to home or residence or office/outpatient evaluation and management service, new or established)."*

Enhanced Care Management

When CMS finalized the advanced primary care management (APCM) service codes in the 2025 MPFS final rule, they noted that they view behavioral health integration (BHI) services as complementary to APCM. CMS believes an option that eliminates

the time-based requirements of the existing BHI codes could facilitate providing BHI services to patients also receiving APCM services.

To that end, CMS is proposing to establish three optional add-on codes describing collaborative care management (CoCM) and BHI services that may be reported when the APCM base code is reported by the same practitioner in the same month. The new codes would be considered "designated care management services," meaning they can be provided by auxiliary personnel under the general supervision of the billing practitioner. GPCM1 would be based on CPT code 99492, GPCM2 would be based on CPT code 99493, and GPCM3 would be based on CPT code 99484. They propose to crosswalk to the corresponding work RVUs (wRVUs) and a direct crosswalk to the current PE amounts.

In addition, CMS is issuing a request for information on how they should consider the application of cost-sharing to APCM services, and whether they should incorporate preventive services (e.g., annual wellness visit, depression screening) into the APCM bundle.

Advancing Access to Behavioral Health Services

CMS is proposing to expand payment eligibility under the existing HCPCS codes G0552, G0553, and G0554 to include digital mental health treatment (DMHT) devices for ADHD that have received FDA clearance and are classified as digital therapy devices for ADHD. Also, CMS is seeking public input on whether to create new, broad-based codes and payment structures in 2026 for digital tools used in mental health care management that promote healthy lifestyles but may not require FDA authorization.

CMS is seeking public input on how Medicare can better support services that promote chronic disease management, reduce social isolation, and improve physical activity and nutrition. This includes exploring new payment and coding options for intensive lifestyle interventions, medically tailored meals, and FDA-authorized digital therapeutics. CMS is also considering ways to boost the use of the Annual Wellness Visit and is requesting feedback on creating standalone codes for motivational interviewing and health coaching, including the potential for health coaches to deliver these services under physician supervision.

CMS is proposing to delete HCPCS code G0136, which covers Social Determinants of Health (SDOH) risk assessments, effectively removing it from the Medicare Telehealth Services list and the Annual Wellness Visit. Additionally, CMS plans to replace the term 'social determinants of health' with 'upstream driver(s)' in related code descriptors, including those used in rural health clinics (RHCs), federally qualified health centers (FQHCs), and opioid treatment programs (OTPs), aiming for terminology that better reflects root causes of health outcomes.

Payment for Skin Substitutes

CMS believes the current approach to paying for skin graft technology is unsustainable and proposes to pay for skin substitute products as incident-to supplies in non-facility and hospital outpatient department (HOPD) settings. CMS proposes three groups of substitutes: premarket approval (PMA), 510(k), and human cells, tissues, and cellular and tissue-based products (HCT/P), based on how the FDA reviews the product. (Products licensed under section 351 of the Public Health Services Act keep the existing payment methodology.) For products across the three categories, initial payment rates will be based on ASP as submitted by manufacturers. For existing products, a site-neutral payment based on hospital outpatient rates will be set, with a fixed PE/MP RVU for each category. Rates will be updated manually.

Strategies for Improving Global Surgery Payment Accuracy

As part of an iterative process towards improving the accuracy of global surgical service valuation and payment, CMS solicits public comment to ascertain what next steps it could take. Specifically, CMS seeks comments related to what the “procedure shares” should be based on when a transfer of care modifier is applied to a code with a 90-day global surgical package. CMS also seeks comments regarding current practice standards and division of work between surgeons and others who provide post-operative care.

Geographic Practice Cost Indices (GPCIs)

CMS is conducting its regular three-year update of the GPCIs, as required by statute. This update reflects changes in the relative costs of physician work, practice expenses, and malpractice insurance across geographic areas. CMS is also refining its methodology to better reflect current market conditions. Additionally, the GPCI work floor for certain rural areas is set to expire absent congressional intervention. Accordingly, GPCIs in the proposed rule do not reflect the work floor.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

CMS proposes adopting APCM add-on codes that would allow RHCs and FQHCs an easier billing process when providing BHI and CoCM services. The agency believes doing so is aligned with the broader MPFS and would support the goal of RHCs and FQHCs providing increased BHI and other advanced primary care services. CMS thus proposes requiring RHCs and FQHCs to bill the individual CPT and HCPCS codes that comprise CoCM HCPCS code G0512 and to use the same codes as are billed under the MPFS. Subsequently, the agency proposes removing the requirement for RHCs and FQHCs to report HCPCS code G0512. Payment rates would be updated annually based on total MPFS amounts and would be paid at the national non-facility MPFS payment rate. Similarly, CMS proposes to unbundle HCPCS code G0071 and to instead require RHCs and FQHCs that provide advanced primary care services through Remote Evaluation and Communication Technology-Based Services (CTBS) instead report the individual codes that comprise G0071.

CMS proposes care management services that are designated and paid for under the MPFS also be adopted as care coordination services for RHCs and FQHCs, which the agency believes will facilitate a more efficient and transparent payment process. Going forward, CMS proposes that any new care management/coordination services added to the MPFS would also be added to the list of services that can be rendered by RHCs and FQHCs for payment under this framework.

CMS proposes to permanently adopt a definition of “direct supervision” for RHCs and FQHCs that permits the virtual presence of a supervising physician to include using

audio/video real-time communications technology — though not audio-only — for an expanded set of services. The agency believes doing so will support continued patient access to care and preserve workforce capacity. CMS proposes to continue using the same payment methodology as in recent years for the same list of RHC and FQHC services that are provided via telecommunication technologies in these settings.

Ambulatory Specialty Model (ASM)

CMMI is proposing a new mandatory alternative payment model to test whether adjusting payment for specialists based on their performance on targeted measures of quality, cost, care coordination, and meaningful use of certified electronic health record technology (CEHRT) results in enhanced quality of care and/or reduced costs through more effective upstream chronic condition management. The Ambulatory Specialty Model will run for five years, beginning January 1, 2027, and concluding on December 31, 2031.

The model will focus on care provided by select specialists to Medicare beneficiaries with the chronic conditions of heart failure and low back pain. Clinicians with the cardiology specialty code on the plurality of their Medicare Part B claims will be included in the heart failure cohort. Clinicians with the specialty type of anesthesiology, interventional pain management, neurosurgery, orthopedic surgery, pain management, and physical medicine and rehabilitation on the plurality of their Medicare Part B claims will be included in the low back pain cohort.

To promote preventive care, the model will incentivize participants to ensure that their patients have a regular source of primary care and are screened to help identify risks and early signs of chronic conditions.

Medicare Shared Savings Program (MSSP)

CMS is making relatively few changes to the Medicare Shared Savings Program. The changes are designed to encourage greater participation in the program and align with the administration's goals to promote better chronic disease management and prevention, more efficiently use resources, promote innovation, and drive increased savings for the Medicare Trust Fund.

CMS currently allows accountable care organizations (ACOs) inexperienced with Medicare performance-based risk initiatives to participate in a one-sided model for up to seven performance years before being required to assume downside risk. Based on their analysis, CMS believes most ACOs are interested in and prepared to participate in two-sided models after five or fewer years under a one-sided model. Therefore, they are proposing to limit the amount of time an ACO inexperienced with Medicare performance-based risk initiatives can spend in a one-sided model to up to five years under the ACO's first agreement period. CMS also proposes to require such ACOs to progress to a two-sided risk model by their second or subsequent agreement period through participating in either the BASIC track Level E or the ENHANCED track. CMS proposes to make these changes effective for agreement periods beginning on or after January 1, 2027.

CMS is proposing modifications to the 5,000-beneficiary threshold. Specifically, they are proposing to allow ACOs who have fewer than 5,000 assigned beneficiaries in benchmark year (BY) one, BY2, or both to enter into an agreement period in the BASIC track. Under current policy, an application for an ACO with fewer than 5,000 assigned beneficiaries is denied.

CMS also proposes to cap shared savings and shared losses at a lower amount for ACOs with fewer than 5,000 assigned beneficiaries in any benchmark year. CMS proposes these changes for agreement periods beginning on or after January 1, 2027.

Finally, CMS proposes ACOs that fall below the 5,000 assigned beneficiary threshold for any benchmark year would not be eligible to leverage existing policies that provide alternative shared savings opportunities to low revenue ACOs participating in the BASIC track that do not meet the minimum savings rate but do meet the quality standards.

CMS proposes revising the list of primary care service codes used for assignment to include Enhanced Care Model Management Services (HCPCS codes GPCM1, GPCM2, GPCM3) and to remove Social Determinants of Health Risk Assessment Services (HCPCS code G0136), if finalized.

Beginning with the 2025 performance year, CMS proposes to revise the definition of "beneficiaries eligible for Medicare clinical quality measures" (CQMs) to better align

with the beneficiaries that are assignable to the ACO. This proposal is in response to stakeholder feedback that the current definitions conflict with each other, causing confusion and increased burden for ACOs.

CMS believes the health equity adjustment is duplicative of the eCQM/MIPS CQM reporting incentive and the Complex Organizational Adjustment. They are proposing to eliminate the health equity adjustment and propose to retroactively apply this change so that it applies to the 2025 performance year.

CMS proposes to revise the APM Performance Pathway (APP) Plus measure set to remove Quality ID 487: Screening for Social Drivers of Health.

Beginning with the 2027 performance year, CMS proposes that CMS-approved survey vendors must administer the CAHPS for MIPS Survey via a web-mail-phone-protocol. The cost of adding the web survey mode must be included in the overall costs for CAHPS for MIPS Survey administration that are publicly reported by vendors.

CMS proposes to revise the extreme and uncontrollable circumstances policy for ACOs to include ACOs affected by a cyberattack, including ransomware/malware, as determined by the Quality Payment Program. CMS proposes to implement this policy starting with the 2025 performance year.

Updates to the Quality Payment Program (QPP) and Medicare Promoting Interoperability Program

CMS is proposing changes to the Quality Payment Program to promote the use of connected measures and activities, continue awarding clinicians for providing high-value care, and use data-driven information to help all clinicians improve care and engage patients.

CMS continues to encourage participation in MIPS Value Pathways (MVPs) and is making proposals to increase adoption. CMS proposes adding six new MVPs for the 2026 performance period. These include diagnostic radiology, interventional radiology, neuropsychology, pathology, podiatry, and vascular surgery. They are also proposing modifications to all existing MVPs.

CMS is proposing an exception to the policy that requires multispecialty groups to register as a subgroup, individual, or APM Entity to report an MVP. CMS will allow multispecialty groups that are small practices (15 or fewer eligible clinicians) to register to report an MVP as a group.

CMS is issuing several requests for information, including RFIs related to MVP elements, well-being and nutrition measures, transitioning toward digital quality measurement, promoting interoperability measures, and evaluating how clinicians exchange health information.

In the cost category, CMS proposes to modify the total per capita cost measure. They are also proposing to make new cost measures informational-only for the first two years they are used in the program. They are not proposing any new cost measures for implementation in the 2026 performance period.

CMS is proposing to replace the Achieving Health Equity improvement activities subcategory with a new Advancing Health and Wellness subcategory.

CMS proposes to maintain the performance threshold at 75 points through the 2028 performance year/2030 payment year. The data completeness threshold will remain 75%, as finalized through previous rulemaking.