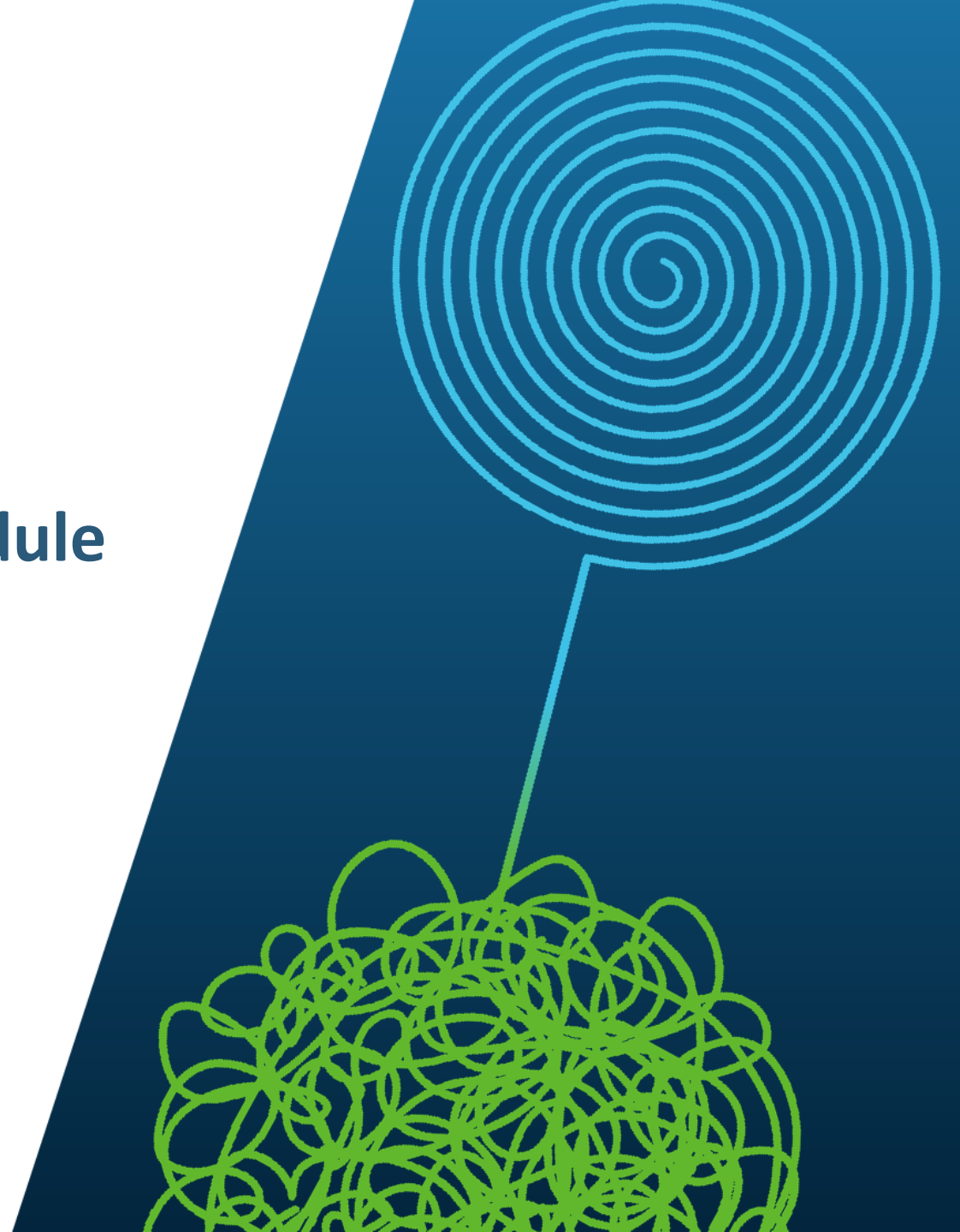
Healthcare Regulatory Roundup #98

2026 Medicare Physician Fee Schedule Proposed Rule – *Part 1*

July 30, 2025



Housekeeping

- Slides, handouts, and forms available in **Resources Panel**
- Enter questions in **Q&A Panel**
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Introductions

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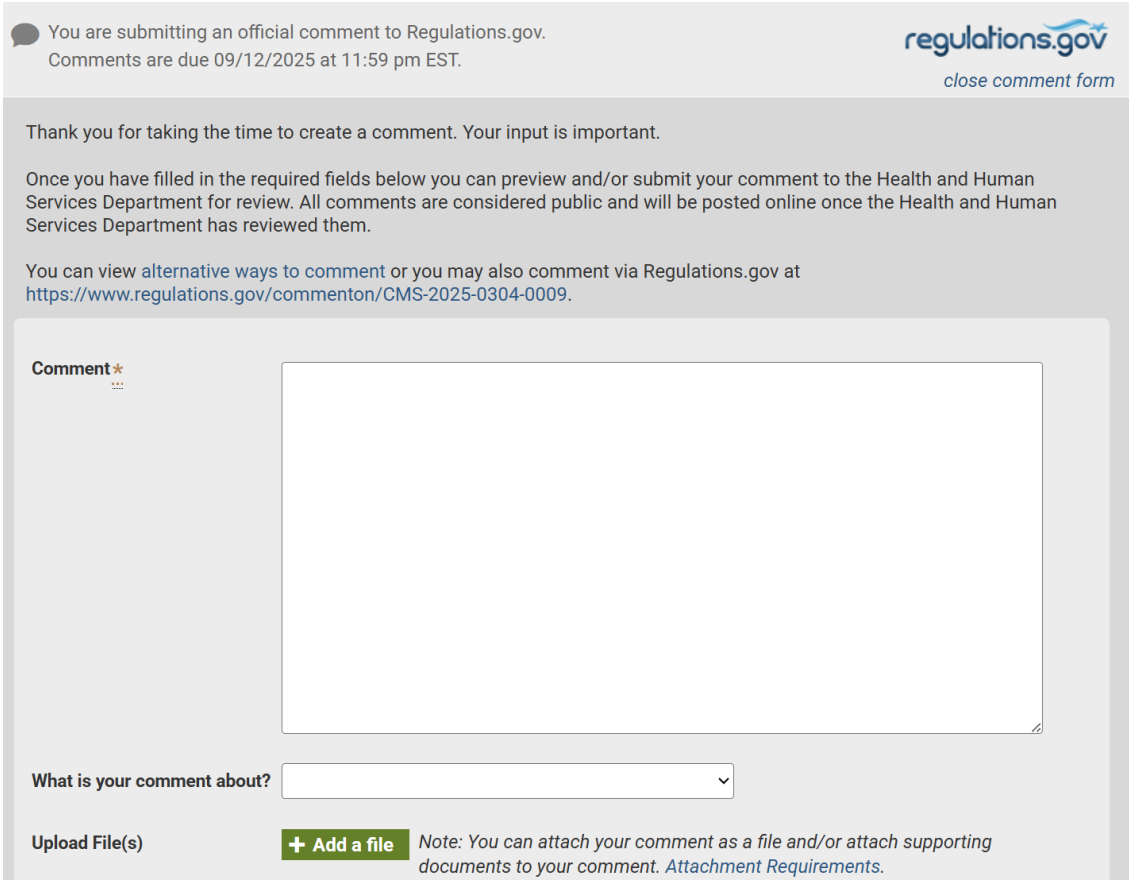
Comments Due September 12



https://www.federalregister.gov/documents/2025/07/16/2025-13271/medicare-and-medicaid-programs-cy-2026-payment-policies-under-the-physician-fee-schedule-and-other

Agenda

2026 Medicare Physician Fee Schedule Proposed Rule Parts 1 and 2

Part 1 – July 30

1. 2026 Payment Rate/Conversion Factor
2. Efficiency Adjustment
3. Practice Expense Methodology
4. Merit-Based Incentive Payment System (MIPS)
5. Ambulatory Specialty Model
6. Medicare Shared Savings Program (MSSP)

Part 2 – August 13

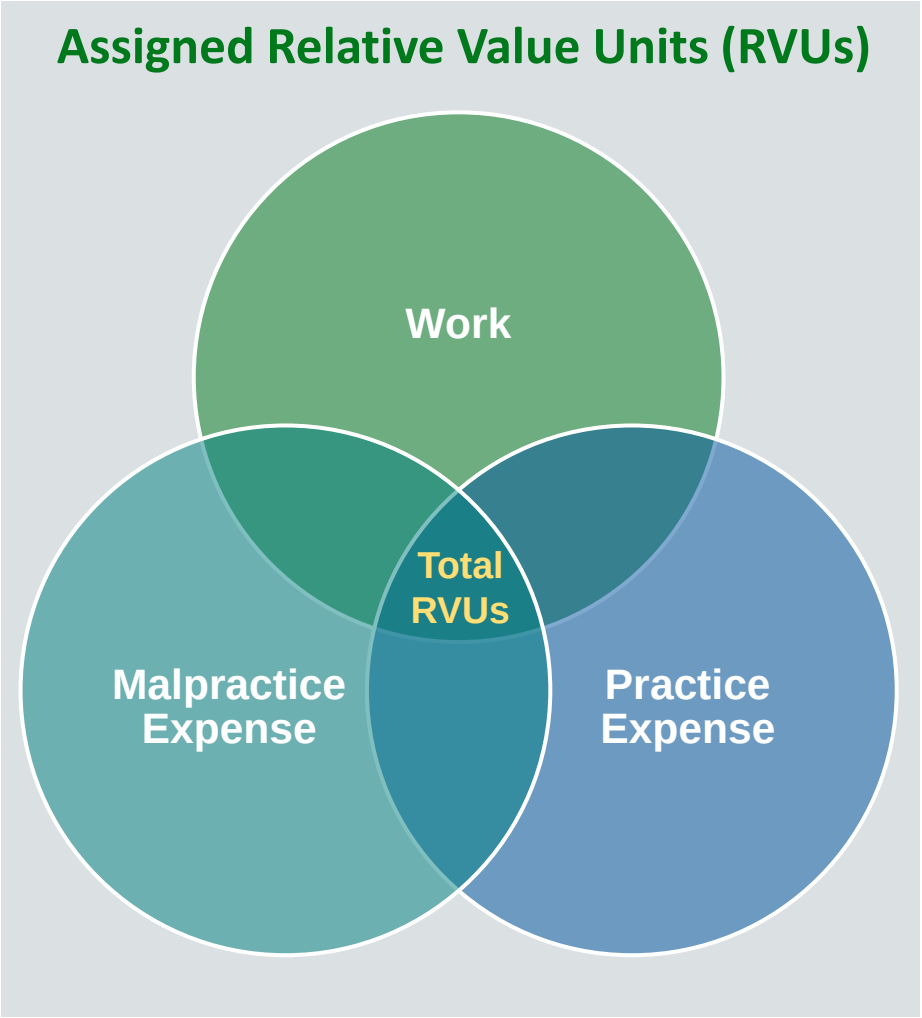
1. Telehealth changes
2. Global Payments Reforms
3. Skin Substitutes
4. Care Management
5. Prevention and Wellness

1. 2026 Payment Rate/Conversion Factor

Medicare Access and CHIP Reauthorization Act of 2015

- Passed with overwhelming bipartisan support
  - 392 to 37 in the House; 92 to 8 in the Senate
- Repealed existing Medicare physician payment formula
  - Sustainable Growth Rate (SGR) tied payments to gross domestic product, resulting in significant cuts (up to 25%) beginning in 2001 requiring annual Congressional intervention
- Replaced with specified annual payment increases
  - 2015 – 2019: 0.5% annual increase
  - 2020 – 2025: 0% annual increase
  - 2026 forward: 0.75% (qualifying APM conversion factor) or 0.25% (non-qualifying APM conversion factor) annual increase
- Established Quality Payment Program (performance-based payments/penalties)

Calculating Fee Schedule Payments



- **Conversion factor** (RVU x CF = national payment rate)*
  - Dollar amount based on statutory cap on MPFS spending
  - For 2026 and beyond, 0.75% increase in qualifying APM conversion factor, 0.25% increase in non-qualifying APM conversion factor
    - Unlike all other payment systems, no inflation adjustment
  - If any +/- in RVUs causes annual Part B expenditures to differ by > $20 million from what expenditures would have been, CF must be adjusted to preserve ***budget neutrality***
    - Coverage changes
    - RVU adjustments

*Different formula used to calculate anesthesia conversion factor

Brief History

Year	MPFS Final Rule	Congressional Fix	Final Cut	Final Amount
2021	-10.2%	+6.9%	-3.3%	$34.89
2022	-3.8%	+3%	-0.8%	$34.61
2023	-4.5%	+2.5%	-2.0%	$33.89
2024	-3.37%	+1.68%	-1.69%	$33.29
2025	-2.83%	NONE	-2.83%	$32.35

From **2021 to 2025**, conversion factor has been **reduced by $2.54** (**7.3% reduction**)

Medicare Economic Index: +2.5% in 2021, +4.6% in 2022, +4.1% in 2023, +4.6% in 2024, +3.6% in 2025

Calculation of 2026 Conversion Factor

- Start with 2025 conversion factor = $32.35
- Apply MACRA update
  - Qualifying APM conversion factor (0.75% increase) = $32.59
  - Non-qualifying APM conversion factor (0.25% increase) $32.43
- Apply OBBBA's one-time 2.5% increase
  - Qualifying APM conversion factor = $33.40
  - Non-qualifying APM conversion factor = $33.24
- Apply positive budget neutrality adjustment of 0.55%
  - Qualifying APM conversion factor = **$33.59**
  - Non-qualifying APM conversion factor = **$33.42**

Positive Budget Neutrality Adjustment

- Proposed 0.55% positive adjustment significantly higher than prior years
  - 0.05% positive adjustment proposed for CY 2025
  - 2.17% negative adjustment proposed for CY 2024
  - 1.55% negative adjustment proposed for CY 2023
- Primary drivers:
  - Efficiency adjustment to work RVUs for non-time-based services
  - Behavioral health work update (Year 3)
  - Re-valuation of specific codes
  - Supply and equipment pricing updates
- Winners and losers:
  - Almost all specialties between -1% and +1% change in allowed charges
    - Distinguish between facility-based and non-facility-based, with latter more likely to see negative impact
      - E.g., facility-based interventional radiologists and radiologists at -2% non-facility-based at 0%
    - Clinical psychologists, social workers at 3-4% increase

Geographic Practice Cost Indices

- Payment adjustments to account for cost variations across 108 localities
  - 1.0 = national average
  - 3 separate adjustments
    - Physician work GPCI reflects relative cost of physician labor in different areas using salary information from individuals with higher education
    - Practice expense (PE) GPCI accounts for employee compensation, office rent, purchased services, equipment & supplies
    - Malpractice (MP) GPCI adjusts for geographic differences in malpractice insurance premiums
- CMS updating data on which adjustments based with changes to be phased in over 2 years
  - Adjustments by locality listed in Addendum E*
  - Seeks comment on future reforms to PE GPCI cost share weights
- "Temporary" 1.0 floor for work GPCI set to expire 9/30/2025 impacting 46 localities

https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1832-p

2. Efficiency Adjustment

Basis For Adjustment

- Historically, CMS relied on AMA Relative Value Scale Update Committee (AMA RUC) estimates (time, work intensity, and practice expense) to establish values under MPFS
  - Pre
  - Intra
  - Post
- Proposes efficiency adjustment to counteract potentially overstated values and changes that have occurred in practices over time
  - Applied to work RVU
  - Intra-service portion of physician time for non-time-based services expected to become more efficient over time
    - Periodically apply to (almost) all codes (>8,900)
    - Excluded services: E/M, care management, behavioral health, telehealth services, maternity codes with a “MMM” global period

Efficiency Adjustment Methodology

- Calculated based on the sum of the past five years of the Medicare Economic Index (MEI) productivity adjustment percentage
  - MEI – metric to measure practice cost inflation (non-physician employee compensation, rent, medical equipment, etc.)
- Assumes a 5-year lookback period, proposed efficiency adjustment of -**2.5%** for CY **2026**
- CMS proposing to move away from survey data (bias, low response rates, etc.)
  - Requests comments regarding sources for valid, reliable empiric data collection (electronic health record logs, operating room logs, and time motion data)
  - Over time, CMS expects this to provide more accurate value for services under MPFS
- Additional adjustments applied every three years (CY 2029 PFS rulemaking)

3. Practice Expense Methodology

Practice Expense Methodology

- Current methodology relies on the AMA's Physician Practice Information (PPI) survey data
  - Measures specialty specific practice costs (2008)
  - Additional survey efforts conducted in 2024
  - Due to limitations, not using the survey data for 2026
- Significant change proposed for 2026
  - Current methodology does not take into account the increase in physician employment and decline in privately practicing physicians
    - RAND and MedPAC reports
  - Proposing to recognize greater indirect costs for office-based practices vs. facility setting

Additional Practice Expense Considerations

- Proposes to rely on auditable, routinely updated hospital data to understand cost assumptions for some technical services paid under MPFS
  - "Promotes price transparency across settings, offers more predictable rate setting outcomes, and limits the influence of limited survey"
- Facility services will have PE RVUs allocated at half the non-facility amount
- Hospital (facility) based procedural specialties decrease
- Office based specialties and those relying on time-based codes for billing may see an increase (family practice, psychiatry, geriatrics, etc.)
- CMS estimates almost "all specialties" will experience no more than +/- 1%
  - Individual service impacts may vary

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2026-medicare-physician-fee-schedule-pfs-proposed-rule-cms-1832-p

Impact – Allowed Charges By Specialty

TABLE 92: CY 2026 PFS ESTIMATED IMPACT ON TOTAL ALLOWED CHARGES BY SPECIALTY

(A) Specialty	(B) Total: Non-Facility/Facility	(C) Allowed Charges (mil)	(D) Impact of Work RVU Changes	(E) Impact of PE RVU Changes	(F) Impact of MP RVU Changes	(G) Combined Impact
FAMILY PRACTICE	*TOTAL*	$5,426	0%	3%	0%	3%
	Non-Facility	$4,367	0%	6%	0%	6%
	Facility	$1,059	0%	-9%	0%	-9%
HEMATOLOGY/ONCOLOGY	*TOTAL*	$1,537	0%	0%	0%	0%
	Non-Facility	$984	0%	6%	0%	6%
	Facility	$552	0%	-11%	0%	-11%
RADIOLOGY	*TOTAL*	$4,492	-1%	-1%	0%	-2%
	Non-Facility	$1,964	0%	1%	0%	1%
	Facility	$2,528	-2%	-2%	1%	-3%
TOTAL	***TOTAL***	**$90,545**	**0%**	**0%**	**0%**	**0%**
	Non-Facility	$57,482	0%	4%	0%	4%
	Facility	$33,064	0%	-7%	0%	-7%

4. Merit-Based Incentive Payment System (MIPS)

MIPS Quality

- Data completeness
  - 2026: 75% as finalized in previous rulemaking
  - 2027 – 2028: proposed to hold at 75% (no change)
- 190 quality measures
  - Adding 5 measures, including 2 eCQMs
  - Substantive changes to 32 existing measures
  - Removal of 10 measures from inventory
  - QCDR measures are approved outside of rulemaking - not included in this count

MIPS Quality

- Topped Out Measures
  - Measures in specialty set with limited choices and high % of topped out measures that lack measure development which limits meaningful participation
  - Identified each year through rulemaking
  - 19 measures proposed to meet topped-out status (including 4 claims measures)
- Definition of High Priority Measure
  - Revision to remove “health equity” from the definition – now reads as follows
    - “An outcome (including intermediate-outcome and patient-reported outcome), appropriate use, patient safety, efficiency, patient experience, care coordination, or opioid quality measure.”

MIPS Quality

- Scoring for Administrative Claims-Based Quality Measures
  - Proposing to align with benchmarking methodology for cost measures beginning with performance year (PY) **2025**/payment year **2027 (i.e., current year adjustment)**
  - Median performance rate would be set at score derived from performance threshold and standard deviations applied for scoring ranges

Points	Cut Offs for Admin Claims-based Measures. *(adjust admin claims scoring methodology)*
1 – 1.9	Median + (2.75 x standard deviation)
2 – 2.9	Median + (2.5 x standard deviation)
3 – 3.9	Median + (2.25 x standard deviation)
4 – 4.9	Median + (2 x standard deviation)
5 – 5.9	Median + (1.5 x standard deviation)
6 – 6.9	Median + (1 standard deviation)
7 – 7.9	Median + (0.5 x standard deviation)
8 – 8.9	Median - (0.5 x standard deviation)
9 – 9.9	Median - (1 x standard deviation)
10	Median - (1.5 x standard deviation)

MIPS Quality

- APP Plus Quality Measure Set
  - Optional for MIPS eligible clinicians, groups, and APM entities
  - Required for MSSP (ACOs required to report measure set)
  - If reporting, all measures in APP Plus Quality Measure set are required
  - If MIPS quality measure changes are approved as proposed, APP Plus Quality Measure Set will be aligned accordingly
    - Screening for Social Drivers of Health (487) also would be removed

MIPS Cost

- No proposed expansion or reduction to existing inventory of 35 cost measures
- Proposed informational-only feedback period of 2 years for new cost measures before they impact cost scoring
  - Example: new cost measure effective for PY 2027 would not impact scoring until PY 2029/payment year 2031
- Proposed modification to Total Per Capita Cost (TPCC) Measure
  - "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;
  - Require the second service used to initiate a second candidate event to 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; and
  - Require 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."

MIPS Improvement Activities (IA)

- Reminder: 8 activities were suspended on 05/06/2025 for PY 2025
  - Clinicians advised to select other improvement activities to complete
  - However, if any suspended improvement activities have already been completed or were in process of being completed, clinicians will still be able to attest to completing them and receive credit
- Changes to current inventory of 104 IAs
  - 3 additions
  - 7 modifications
  - 8 removals (previously suspended)
- Proposed removal of “Achieving Health Equity (AHE)” subcategory and addition of “Advancing Health and Wellness (AHW)”

MIPS Promoting Interoperability

- Protect Patient Health Information Objective, Security Risk Analysis Measure – proposed modification to include second attestation (Yes/No) as to having conducted a security risk assessment; no = zero points for the category
- High Priority Practices Safety Assurance Factors for Electronic Health Record (EHR) Resilience (SAFER) Guide Measure – proposes requiring meeting 2025 SAFER Guides
- Public Health and Clinical Data Exchange objective – new optional bonus measure, Public Health Reporting Using the Trusted Exchange Framework and Common Agreement (TEFCA) measure
- Proposing to adopt measure suppression policy for MIPS Promoting Interoperability performance category and Medicare Promoting Interoperability Program
- Proposed suppression of Electronic Case Reporting for PY 2025 (current PY) due to CDC pausing onboarding of new healthcare organizations

MIPS Value Pathways (MVPs)

- Goal = 80% of MIPS eligible clinicians have relevant MIPS pathway
- Continuing to pursue sunsetting of traditional MIPS
- 6 newly proposed MVPS
  - Diagnostic radiology, interventional radiology, neuropsychology, pathology, podiatry, vascular surgery
- Modifications to all 21 currently finalized MVPs
- Groups to attest to specialty composition during registration (even single specialty groups)
- Multispecialty small practices would still be able to report as group for PY 2026 (optional but not required to form subgroups)
- Qualified Clinical Data Registries (QCDRs) and Qualified Registries would have one year after new MVP is finalized before required to fully support that MVP

Quality Payment Program Requests for Information

- Core elements in an MVP
- Well-being and nutritional measures
- Procedure codes for MVP assignment
- Transition toward Digital Quality Measurement (FHIR-based eCQMs)
- Potential changes to Query of Prescription Drug Monitoring Program Measure (performance based from Y/N)
- Performance-based Measures in the Public Health and Clinical Data Exchange Objective
- Data quality

More information for all MIPS updates can be found at https://qpp.cms.gov/resources/resource-library
"Quality Payment Program (QPP) Fact Sheet and Policy Comparison Table"

5. Ambulatory Specialty Model

Chronic Condition Episode-Based Cost Measures

- Existing measures
  - Asthma/Chronic Obstructive Pulmonary Disease
  - Depression
  - Diabetes
  - **Heart Failure**
  - **Low Back Pain**
  - Chronic Kidney Disease
  - End-Stage Renal Disease
  - Kidney Transplant Management
  - Rheumatoid Arthritis
  - Prostate Cancer

- Enables CMS to test whether adjusting specialists' payment based on **quality**, **cost**, **care coordination**, and **meaningful use** improves quality and reduces costs associated with chronic conditions

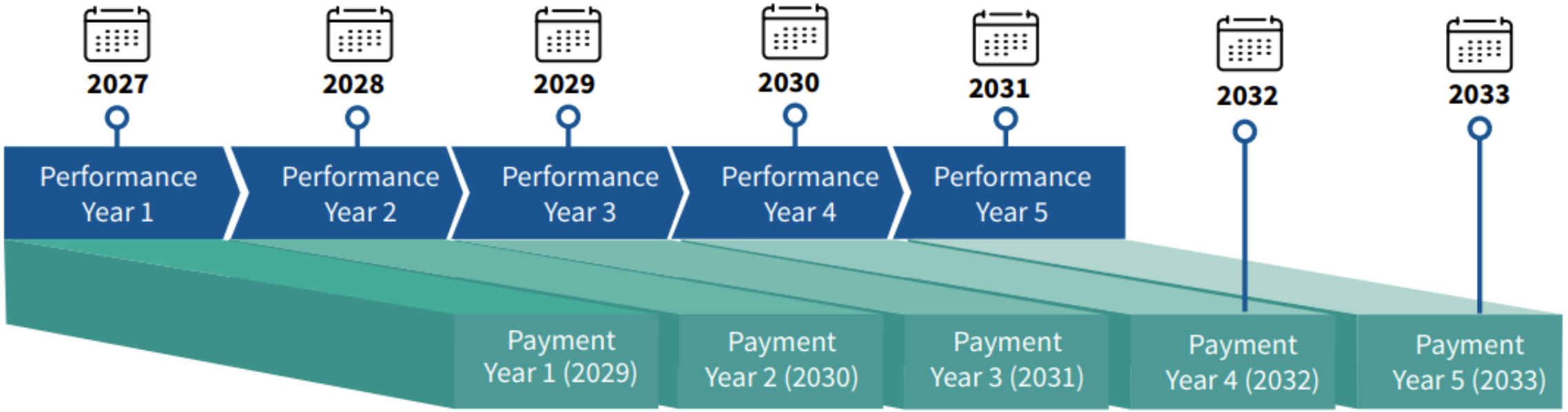
New Mandatory Alternative Payment Model

- 5 performance years beginning January 1, 2027
  - Mandatory for selected participants, i.e., individual physician (NPI + TIN) who:
    - Is a specialist treating lower back pain or congestive heart
      - Low back pain: anesthesiology, pain management, interventional pain management, neurosurgery, orthopedic surgery, and physical medicine and rehabilitation
      - Congestive heart failure: cardiologists
    - Practices in one of selected core-based statistical area or metropolitan division
      - ~25% of all CBSAs/MDs identified using stratified random selection
    - Has 20+ attributed episodes under MIPS low back pain episode-based cost measure (EBCM) or heart failure EBCM in the calendar year 2 years prior to performance year (20+ episodes in 2025 = 2027 participant)
      - EBCMs included in Advancing Care for Heart Disease MVP and Rehabilitative Support for Musculoskeletal Care MVP since 2024
      - Episode initiated when physician submits professional claim for at least two separate services provided to single beneficiary related to low back pain/heart failure
  - Will release preliminary list of selected participants by end of 2025, final list by late July 2026

Methodology

- ASM Participant reports on specified measures across 4 domains
  - Quality
  - Cost Performance (applicable EBCM)
  - Improvement Activities
  - Interoperability
- ASM Participant's performance compared to benchmarks calculated using all ASM Participants' performance
- ASM Participant's MPFS payments for professional services adjusted based on relative performance score
  - For Performance Year 2027 / Payment Year 2029, adjustments range from plus 9% to negative 9% (budget neutral); risk levels increase in performance year 3-5 by 1% per year
  - ASM Participant exempted from any MIPS reporting requirements

ASM Timeline



https://www.cms.gov/priorities/innovation/files/asm-model-infographic.pdf

Quality Measures

Domain	Prevention Category	Measure	Collection Type(s)
Heart Failure			
Excess Utilization	Adverse events and acute care utilization	Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with HF (MIPS Q492)	Claims
Evidence-based Care and Outcomes	Reduction of disease progression	HF: Beta-Blocker Therapy for LVSD (MIPS Q008)	eCQM MIPS CQM
Evidence-based Care and Outcomes	Reduction of disease progression	HF: ACE Inhibitor or ARB or ARNI Therapy for LVSD (MIPS Q005)	eCQM MIPS CQM
Evidence-based Care and Outcomes	Reduction of disease progression	Controlling High Blood Pressure (MIPS Q236)	eCQM MIPS CQM
Patient Reported Outcomes and Experience	Function/health status/wellbeing	Functional Status Assessments for Heart Failure (MIPS Q377)	eCQM
Low Back Pain			
Excess Utilization	Risk reduction/absence of disease	MRI Lumbar Spine for LBP (measure in development)	Claims
Evidence-based Care and Outcomes	Adverse events and acute utilization	Use of High-Risk Medications in Older Adults (MIPS Q238)	eCQM MIPS CQM
Evidence-based Care and Outcomes	Risk reduction/absence of disease	Preventive Care and Screening: Screening for Depression and Follow-Up Plan (MIPS Q134)	eCQM MIPS CQM
Evidence-based Care and Outcomes	Risk reduction/absence of disease	Preventive Care and Screening: BMI Screening and Follow-Up Plan (MIPS Q128)	eCQM MIPS CQM
Patient Reported Outcomes and Experience	Function/health status/wellbeing	Functional Status Change for Patients with Low Back Impairments (MIPS Q220)	MIPS CQM

Improvement Activities

- Attest to completing 2 improvement activities
  - Connecting to primary care and ensuring completion of health-related social needs screening – evidence of processes, workflows, and/or technology that require participant to
    - Confirm ASM beneficiary has access to primary care services and, if not, assist beneficiary in securing services
    - Communicate relevant information back to ASM beneficiary's PCP following visits
    - Determine whether ASM beneficiary has received annual HRSN screening in primary care setting and, if not, encourage PCP to do so or allow ASM participant to do so
  - Establishing communication and collaboration expectations with primary care using collaborative care arrangements
    - Enter into at least one CCA with PCP that includes at least 3 of the following: data sharing, co-management, transitions in care planning, closed-look connections, and care coordination
- Both activities equally weighted

Promoting Interoperability

Objectives	Measures		Available Points (based on performance)	Redistribution if exclusion is claimed
e-Prescribing	e-Prescribing		1-10 points	10 points to HIE objective
	Query of PDMP		10 points	10 points to the e-Prescribing measure
Health Information Exchange (HIE)	Option 1	Support Electronic Referral Loops by Sending Health Information	1-15 points	15 points to Provide Patients Electronic Access to Their Health Information measure
		Support Electronic Referral Loops by Receiving and Reconciling Health Information	1-15 points	15 points to the Support Electronic Referral Loops by Sending Health Information measure
	Option 2	HIE Bi-Directional Exchange	30 points	No exclusion
	Option 3	Enabling Exchange under TECFA	30 points	No exclusion
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information		1-25 points	No exclusion
Public Health and Clinical Data Exchange	Report to the following public health or clinical data registries: 1. Immunization Registry Reporting 2. Electronic Case Reporting		25 points for the objective	25 points to the Provide Patients Electronic Access to their Health Information measure if an exclusion is claimed for both measures.
	Option to report one of the following public health agency or clinical data registry measures: • Public Health Registry Reporting, OR • Clinical Data Registry Reporting, OR • Syndromic Surveillance Reporting		No bonus points	Not applicable

Final Score

- Assign number 1-100 based on following:

ASM Performance Category	Weight or Scoring Adjustment in Final Score
Quality	50 percent weight
Cost	50 percent weight
Improvement Activity	Scoring adjustment of zero, -10, or -20 points
Promoting Interoperability	Scoring adjustment of zero to -10 points

- Apply complex patient scoring adjustment
  - Calculated based on two risk indicators: HCC scores and proportion of beneficiaries with dual eligible status
  - Similar to MIPS adjustment, but reference median for each risk indicator calculated based on ASM Participant data
- Apply solo/small practice scoring adjustment
  - 15 or fewer clinicians in practice at time APM participants identified for upcoming performance year = 10 pts
  - Solo practitioner at time APM participants identified for upcoming performance year = 15 pts

6. Medicare Shared Savings Program

MSSP Changes

- Limit upside-only participation to 5 years (currently 7 years) for agreement periods beginning on or after 01/01/2027
- Remove 5,000 attributed beneficiary requirement for first two years of participation for agreement periods beginning on or after 01/01/2027
  - Related changes to financial reconciliation
- Effective PY 2026, expand definition of ‘primary care services’ for purposes of beneficiary attribution
- Effective 01/01/2026, require updates to ACO participant list outside annual change request cycle to reflect certain changes in ownership
- Effective PY 2025, expand Extreme and Uncontrollable Circumstance (EUC) policy to include cyberattacks

MSSP Changes – Quality Reporting

- Effective PY 2025:
  - Revise definition of beneficiary eligible for Medicare CQMs to improve overlap with beneficiaries assignable to an ACO
  - Remove Health Equity Adjustment applied to ACO's quality score
    - Revise regulations to change 'Health Equity Adjustment' to 'Population Adjustment' for PY 2023 and 2024
- Effective PY 2026, remove Screening for Social Drivers of Health measure from APP Plus quality measure set
- Effective PY 2027, require CMS-approved survey vendors to administer the CAHPS for MIPS Survey via a web-mail-phone protocol

Our Next Healthcare Regulatory Roundup Webinars

August 13, 2025; 11 am – 12 pm ET
Healthcare Regulatory Roundup #99:
CY 2026 Medicare Physician Fee Schedule Proposed Rule, Part 2

August 27, 2025; 11 am – 12 pm ET
Healthcare Regulatory Roundup #100:
FY 2026 Hospital Inpatient PPS Final Rule

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