

Issue Brief

FEDERAL ISSUE BRIEF



Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

November 5, 2025

Final CY 2026 Revisions to Payment Policies under the Medicare Physician Fee Schedule and Other Part B Payment and Coverage Policies Released

The Centers for Medicare and Medicaid Services (CMS) have issued a final rule, late on Friday October 31, to update the Medicare Physician Fee Schedule (MPFS) for CY 2026. The rule will become effective January 1, 2026.

A display copy of the 2,375-page rule is currently available at: <https://public-inspection.federalregister.gov/2025-19787.pdf>. Publication in the **Federal Register** is scheduled for November 5.

Comments

MPFS regulations are long and complex documents. Again, there is no table of contents. It is amazing that some of the CMS prospective payment systems contain a table of contents while others do not. It seems CMS is unable to improve its rulemaking to require all rules to employ consistent and simple tables of contents.

For this rule, CMS continues to provide the following list of items being addressed. And, once again, we are using such as a surrogate table of contents.

- Background (section II.A) (Page 8)
- Determination of PE RVUs (section II.B.) (Page 10)
- Potentially Misvalued Services Under the PFS (section II.C.) (Page 85)
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- Advancing Policies to Improve Care for Chronic Illness and Behavioral Health Needs (section II.I.) (Page 436)
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- Drugs and Biological Products Paid Under Medicare Part B (section III.A.) (Page 589)
 - Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (section III.B.) (Page 641)
 - Ambulatory Specialty Model (ASM) (section III.C.) (Page 680)
 - Medicare Diabetes Prevention Program (MDPP) (section III.D.) (Page 1,110)
 - Medicare Prescription Drug Inflation Rebate Program (section III.I.) (Page 1,146)
 - Medicare Shared Savings Program (section III.F.) (Page 1,214)
 - Changes to the Regulations Associated with the Ambulance Fee Schedule (section III.G.) (Page 1,427)
 - Updates to the Quality Payment Program and Medicare Promoting Interoperability Program (section IV.) (Page 1,431)
 - Collection of Information Requirements (section V.) (Page 1,658)
 - Regulatory Impact Analysis (section VI.) (Page 1,716)

Addenda Available Only Through the Internet on the CMS Website:

The PFS Addenda along with other supporting documents and tables referenced in this final rule are available on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html>. (However, this link takes you to the proposed rule.) Use this link to reference numerous items. <https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notice>

For the CY 2026 PFS final rule, refer to item CMS-1832-F.

As usual, we are providing page numbers (in red) identifying specific page locations in the rule.

Summary of Costs and Benefits (Page 6)

As required by section 1848(d)(1)(A) of the Act, beginning in 2026, there will be two separate conversion factors (CFs): one for items and services furnished by a qualifying APM participant as defined in section 1833(z)(2) of the Act (referred to as the qualifying APM conversion factor) and another for other items and services (referred to as the nonqualifying APM conversion factor), equal to the respective conversion factor for the previous year (or, for CY 2026, equal to the single conversion factor for CY 2025) multiplied by the update established under section 1848(d)(20) of the Act for such respective conversion factor for such year.

Payment Updates and Conversion Factors (CF) (Page 1,735)

Conversion Factor Calculations

To calculate the estimated CY 2026 PFS conversion factors, CMS took the CY 2025 conversion factor and multiplied it by a 1.0049 budget neutrality adjustment, then multiplied by the qualifying APM and

nonqualifying APM updates specified by section 1848(d)(20) of the Act, then applied the 1-year increase of 2.50 percent for CY 2026 established by statute.

PAYMENT PROVISIONS OF THE CY 2026 PFS RULE

Calculation of the CY 2026 PFS Qualifying APM Conversion Factor

CY 2025 Conversion Factor		32.3465
CY 2026 Qualifying APM Update Factor	0.75 percent (1.0075)	
CY 2026 RVU Budget Neutrality Adjustment	0.49 percent (1.0049)	
CY 2026 2.50 Percent Increase	2.50 percent (1.0250)	
CY 2026 Conversion Factor		33.5675

This represents an increase of 3.77 percent

Calculation of the CY 2026 PFS Non-Qualifying APM Conversion Factor

CY 2025 Conversion Factor		32.3465
CY 2026 Non-Qualifying APM Update Factor	0.25 percent (1.0025)	
CY 2026 RVU Budget Neutrality Adjustment	0.55 percent (1.0049)	
CY 2026 2.50 Percent Increase	2.50 percent (1.0250)	
CY 2026 Conversion Factor		33.4009

This reflects an increase of 3.26 percent

Calculation of the CY 2026 Anesthesia Qualifying APM Conversion Factor

CY 2026 National Average Anesthesia Conversion Factor		20.3178
CY 2026 Qualifying APM Update Factor	0.75 percent (1.0075)	
CY 2026 RVU Budget Neutrality Adjustment	0.49 percent (1.0049)	
CY 2026 2.50 Percent Increase	2.50 percent (1.0250)	
CY 2026 Anesthesia Fee Schedule Practice Expense and Malpractice Adjustment	-2.30 percent (0.9770)	
CY 2026 Conversion Factor		20.5998

Calculation of the CY 2026 Anesthesia Non-Qualifying APM Conversion Factor

CY 2026 National Average Anesthesia Conversion Factor		20.3178
CY 2026 Non-Qualifying APM Update Factor	0.25 percent (1.0025)	
CY 2026 RVU Budget Neutrality Adjustment	0.49 percent (1.0049)	
CY 2026 2.50 Percent Increase	2.50 percent (1.0250)	
CY 2026 Anesthesia Fee Schedule Practice Expense and Malpractice Adjustment	-2.30 percent (0.9770)	
CY 2026 Conversion Factor		20.4976

Impact

The table below shows the payment impact by specialty. (Page 1,738) Note, this year’s version is split between facility and non-facility locations. Overall, CMS is increasing payments in non-facilities and reducing same for those in facilities. CMS is trying to account for site-of-service differentials.

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
ALLERGY/IMMUNOLOGY	TOTAL	\$213	0%	7%	0%	7%
	Non-Facility	\$205	0%	8%	0%	8%
	Facility	\$8	0%	-11%	0%	-11%
ANESTHESIOLOGY	TOTAL	\$1,602	0%	-1%	0%	-1%
	Non-Facility	\$311	0%	7%	0%	7%
	Facility	\$1,290	0%	-3%	0%	-3%
AUDIOLOGIST	TOTAL	\$75	0%	-1%	-1%	-1%
	Non-Facility	\$72	0%	0%	-1%	0%
	Facility	\$3	0%	-13%	-1%	-14%
CARDIAC SURGERY	TOTAL	\$151	-1%	-3%	0%	-3%
	Non-Facility	\$27	0%	7%	0%	6%
	Facility	\$124	-1%	-5%	0%	-5%

(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
CARDIOLOGY	TOTAL	\$6,020	0%	1%	0%	1%
	Non-Facility	\$3,759	0%	6%	0%	5%
	Facility	\$2,261	-1%	-6%	0%	-7%
CHIROPRACTIC	TOTAL	\$631	-1%	-1%	0%	-2%
	Non-Facility	\$629	-1%	-1%	0%	-2%
	Facility	\$2	-1%	-15%	0%	-17%
CLINICAL PSYCHOLOGIST	TOTAL	\$733	3%	1%	-1%	3%
	Non-Facility	\$594	3%	3%	-1%	5%
	Facility	\$140	3%	-5%	-1%	-3%
CLINICAL SOCIAL WORKER	TOTAL	\$1,019	4%	2%	-1%	4%
	Non-Facility	\$879	4%	3%	-1%	6%
	Facility	\$141	4%	-5%	-1%	-2%
COLON AND RECTAL SURGERY	TOTAL	\$147	-1%	-2%	0%	-2%
	Non-Facility	\$53	0%	7%	0%	7%
	Facility	\$94	-1%	-7%	0%	-7%
CRITICAL CARE	TOTAL	\$338	0%	-5%	0%	-4%
	Non-Facility	\$55	0%	7%	0%	7%
	Facility	\$283	0%	-7%	0%	-7%
DERMATOLOGY	TOTAL	\$3,905	0%	-2%	0%	-2%
	Non-Facility	\$3,763	0%	-1%	0%	-1%
	Facility	\$142	-1%	-13%	0%	-14%
DIAGNOSTIC TESTING FACILITY	TOTAL	\$920	0%	2%	0%	0%
	Non-Facility	\$919	0%	2%	0%	0%
	Facility	\$2	-1%	\$0	1%	0%
EMERGENCY MEDICINE	TOTAL	\$2,422	0%	-3%	1%	-1%
	Non-Facility	\$221	0%	7%	0%	7%
	Facility	\$2,201	0%	-4%	1%	-2%

Questions? Contact Andrew Wheeler, MHA's Vice President of Federal Finance, at 573-893-3700 | ext. 136 or awheeler@MoHospitals.org

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(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
ENDOCRINOLOGY	TOTAL	\$528	0%	2%	0%	3%
	Non-Facility	\$426	0%	6%	0%	6%
	Facility	\$102	0%	-11%	0%	-10%
FAMILY PRACTICE	TOTAL	\$5,461	0%	3%	0%	3%
	Non-Facility	\$4,394	0%	6%	0%	6%
	Facility	\$1,067	0%	-9%	0%	-9%
GASTROENTEROLOGY	TOTAL	\$1,397	0%	-3%	0%	-4%
	Non-Facility	\$505	0%	6%	0%	6%
	Facility	\$891	-1%	-9%	0%	-10%
GENERAL PRACTICE	TOTAL	\$378	0%	3%	0%	3%
	Non-Facility	\$304	0%	5%	0%	6%
	Facility	\$74	0%	-8%	0%	-7%
GENERAL SURGERY	TOTAL	\$1,536	0%	-3%	0%	-3%
	Non-Facility	\$449	0%	6%	0%	6%
	Facility	\$1,086	-1%	-7%	0%	-7%
GERIATRICS	TOTAL	\$201	1%	1%	0%	1%
	Non-Facility	\$129	1%	8%	0%	8%
	Facility	\$72	0%	-10%	0%	-9%
HAND SURGERY	TOTAL	\$261	0%	0%	0%	-1%
	Non-Facility	\$142	0%	5%	0%	5%
	Facility	\$119	-1%	-7%	0%	-7%
HEMATOLOGY/ONCOLOGY	TOTAL	\$1,549	0%	0%	0%	0%
	Non-Facility	\$995	0%	6%	0%	6%
	Facility	\$555	0%	-11%	0%	-11%
INDEPENDENT LABORATORY	TOTAL	\$551	0%	-1%	0%	-1%
	Non-Facility	\$537	0%	-1%	0%	-1%
	Facility	\$14	-1%	-1%	0%	-3%

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(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
INFECTIOUS DISEASE	TOTAL	\$541	0%	-7%	0%	-6%
	Non-Facility	\$86	0%	7%	0%	7%
	Facility	\$455	0%	-10%	0%	-9%
INTERNAL MEDICINE	TOTAL	\$9,446	0%	-2%	0%	-1%
	Non-Facility	\$4,686	0%	6%	0%	6%
	Facility	\$4,760	0%	-9%	0%	-8%
INTERVENTIONAL PAIN MGMT	TOTAL	\$829	0%	3%	0%	3%
	Non-Facility	\$647	0%	7%	0%	6%
	Facility	\$182	-1%	-8%	0%	-9%
INTERVENTIONAL RADIOLOGY	TOTAL	\$440	-1%	3%	0%	2%
	Non-Facility	\$260	0%	9%	0%	7%
	Facility	\$180	-2%	-5%	0%	-7%
MULTISPECIALTY CLINIC/OTHER PHYS	TOTAL	\$157	0%	-2%	0%	-2%
	Non-Facility	\$78	0%	5%	0%	5%
	Facility	\$78	0%	-9%	0%	-9%
NEPHROLOGY	TOTAL	\$1,633	0%	0%	0%	1%
	Non-Facility	\$976	1%	6%	0%	7%
	Facility	\$657	0%	-9%	0%	-9%
NEUROLOGY	TOTAL	\$1,319	0%	1%	0%	1%
	Non-Facility	\$836	0%	6%	0%	6%
	Facility	\$483	0%	-9%	0%	-9%
NEUROSURGERY	TOTAL	\$687	-1%	-5%	0%	-5%
	Non-Facility	\$116	0%	5%	0%	6%
	Facility	\$571	-1%	-7%	0%	-7%
NUCLEAR MEDICINE	TOTAL	\$48	-1%	0%	0%	-1%
	Non-Facility	\$21	0%	1%	0%	1%
	Facility	\$27	-1%	-1%	0%	-3%

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(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
NURSE ANES / ANES ASST	TOTAL	\$1,064	0%	-2%	0%	-1%
	Non-Facility	\$20	0%	9%	0%	10%
	Facility	\$1,044	0%	-2%	0%	-1%
NURSE PRACTITIONER	TOTAL	\$7,750	0%	0%	0%	1%
	Non-Facility	\$5,104	0%	5%	0%	5%
	Facility	\$2,647	0%	-9%	0%	-9%
OBSTETRICS/GYNECOLOGY	TOTAL	\$543	0%	-1%	0%	-1%
	Non-Facility	\$371	0%	4%	0%	4%
	Facility	\$172	-1%	-10%	1%	-10%
OPHTHALMOLOGY	TOTAL	\$4,457	0%	-1%	0%	-2%
	Non-Facility	\$3,153	0%	3%	0%	3%
	Facility	\$1,304	-1%	-12%	0%	-13%
OPTOMETRY	TOTAL	\$1,365	0%	2%	0%	2%
	Non-Facility	\$1,301	0%	3%	0%	3%
	Facility	\$64	0%	-13%	0%	-13%
ORAL/MAXILLOFACIAL SURGERY	TOTAL	\$45	0%	0%	0%	0%
	Non-Facility	\$34	0%	4%	0%	4%
	Facility	\$11	-1%	-10%	0%	-11%
ORTHOPEDIC SURGERY	TOTAL	\$3,283	0%	-3%	0%	-3%
	Non-Facility	\$1,450	0%	5%	0%	5%
	Facility	\$1,833	-1%	-9%	0%	-9%
OTHER	TOTAL	\$55	0%	-1%	0%	0%
	Non-Facility	\$43	0%	1%	0%	3%
	Facility	\$11	0%	-9%	0%	-9%
OTOLARNGOLOGY	TOTAL	\$1,129	0%	1%	0%	0%
	Non-Facility	\$895	0%	3%	0%	3%
	Facility	\$233	-1%	-11%	0%	-12%

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(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
PATHOLOGY	TOTAL	\$1,178	-1%	-2%	0%	-2%
	Non-Facility	\$624	-1%	-1%	0%	-2%
	Facility	\$554	-1%	-2%	0%	-3%
PEDIATRICS	TOTAL	\$54	0%	1%	0%	2%
	Non-Facility	\$35	0%	5%	0%	7%
	Facility	\$19	0%	-8%	0%	-7%
PHYSICAL MEDICINE	TOTAL	\$1,142	0%	-2%	0%	-2%
	Non-Facility	\$543	0%	6%	0%	6%
	Facility	\$600	0%	-9%	0%	-9%
PHYSICAL/OCCUPATIONAL THERAPY	TOTAL	\$6,205	0%	-1%	0%	-1%
	Non-Facility	\$6,205	0%	-1%	0%	-1%
	Facility	\$	-1%	-6%	-1%	-7%
PHYSICIAN ASSISTANT	TOTAL	\$3,938	0%	0%	0%	1%
	Non-Facility	\$2,720	0%	4%	0%	4%
	Facility	\$1,218	0%	-8%	0%	-8%
PLASTIC SURGERY	TOTAL	\$290	-1%	-4%	0%	-4%
	Non-Facility	\$128	0%	3%	0%	4%
	Facility	\$161	-1%	-9%	0%	-10%
PODIATRY	TOTAL	\$1,875	0%	1%	0%	2%
	Non-Facility	\$1,663	0%	3%	0%	3%
	Facility	\$211	0%	-8%	0%	-9%
PORTABLE X-RAY SUPPLIER	TOTAL	\$80	0%	-1%	0%	-1%
	Non-Facility	\$77	0%	-1%	0%	-1%
	Facility	\$3	-1%	-1%	0%	-2%
PSYCHIATRY	TOTAL	\$835	1%	0%	0%	0%
	Non-Facility	\$505	1%	6%	0%	6%

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(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
	Facility	\$330	1%	-9%	0%	-9%
PULMONARY DISEASE	TOTAL	\$1,233	0%	-2%	0%	-1%
	Non-Facility	\$538	0%	7%	0%	7%
	Facility	\$695	0%	-8%	0%	-8%
RADIATION ONCOLOGY AND RADIATION THERAPY CENTERS	TOTAL	\$1,507	-1%	-1%	0%	-1%
	Non-Facility	\$1,009	0%	-1%	0%	-1%
	Facility	\$498	-1%	-1%	0%	-2%
RADIOLOGY	TOTAL	\$4,515	-1%	-1%	0%	-2%
	Non-Facility	\$1,972	0%	0%	0%	1%
	Facility	\$2,543	-2%	-2%	0%	-3%
RHEUMATOLOGY	TOTAL	\$525	0%	4%	0%	4%
	Non-Facility	\$470	0%	6%	0%	6%
	Facility	\$55	0%	-12%	0%	-12%
THORACIC SURGERY	TOTAL	\$290	-1%	-2%	0%	-3%
	Non-Facility	\$55	0%	9%	0%	8%
	Facility	\$235	-1%	-5%	0%	-5%
UROLOGY	TOTAL	\$1,605	0%	0%	0%	0%
	Non-Facility	\$1,127	0%	5%	0%	5%
	Facility	\$479	-1%	-9%	0%	-10%
VASCULAR SURGERY	TOTAL	\$934	0%	6%	0%	5%
	Non-Facility	\$659	0%	11%	0%	9%
	Facility	\$275	-1%	-7%	0%	-6%
TOTAL	TOTAL	\$91,035	0%	0%	0%	0%
	Non-Facility	\$57,776	0%	4%	0%	4%
	Facility	\$33,259	0%	-7%	0%	-7%

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II. PROVISIONS OF THE RULE

DETERMINATION OF PE RVUS (Section II.B.) (Page 8)

This section explains how CMS develops PE RVUs by considering the direct and indirect practice resources involved in furnishing each service.

For the CY 2026 final rule, CMS has incorporated the available utilization data for one new specialty, Epileptologists. (Page 11)

Facility and Non-facility Costs (Page 14)

CMS is establishing two PE RVUs: facility and non-facility. The methodology for calculating PE RVUs is generally the same for both the facility and non-facility RVUs but is applied independently to yield two separate PE RVUs. In calculating the PE RVUs for services furnished in a facility, CMS does not include resources that would generally not be provided by physicians when furnishing the service. **For this reason, the facility PE RVUs are generally lower than the non-facility PE RVUs.**

CMS did not make any proposals associated with the list of expected specialty assignments for low volume services. (Page 15)

CMS did not make any proposals associated with the allocation of indirect PE for some office based services policy for CY 2026. (Page 19)

CMS did not propose any changes to the equipment interest rates for CY 2026. (Page 25)

For CY 2026, CMS proposed to update the price of 35 supplies and 7 equipment items in response to the public submission of invoices following the publication of the CY 2025 PFS final rule. The 42 supply and equipment items with updated prices are listed in the valuation of specific codes section of the rule under Table A-B6, CY 2026 Invoices Received for Existing Direct PE Inputs. (Page 46)

CMS is finalizing the removal of 11 equipment items priced below \$500 from the rate setting database and their associated CPT and HCPS codes as shown in Table A-B7 (Page 49)

CMS is finalizing its proposal to reduce the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs beginning in CY 2026. (Page 81)

Comments

This is a relatively long section amounting to approximately 75 pages. It is evident that CMS continues to struggle with data to allocate direct and indirect PE expenses.

POTENTIALLY MISVALUED SERVICES UNDER THE PFS (SECTION II.C.) (Page 85)

Section 1848(c)(2)(K) of the Act requires the Secretary to periodically identify potentially misvalued services using certain criteria and to review and make appropriate adjustments to the relative values for those services.

For CY 2026, CMS now says it received 12 requests concerning potentially misvalued codes (PMVC). The nominations are as follows: CMS is not proposing to nominate 10 of these codes as potentially misvalued. (Numbers 1-10)

- 1) Maxillofacial Prosthetic Services (CPT codes 21076, 21077, 21079, 21080, 21081, 21082, 21083, 21084, 21085, 21086, 21087) (Page 90)
- 2) Supervision of preparation and provision of antigens for allergen immunotherapy (CPT codes 95145, 95146, 95147, 95148, 95149). (Page 94)
- 3) Electronic Analysis of Implanted Neurostimulator Pulse Generator/Transmitter (CPT codes 95970, 95976, 95977). (Page 99)
- 4) Excimer Laser Treatment for Psoriasis (CPT codes 96920, 96921, 96922) (Page 101)
- 5) Optical Coherence Tomography (OCT) of Retina (CPT code 0605T) (Page 108)
- 6) Mechanical Separation of Plasma from Blood (CPT code 36514). (Page 111)
- 7) Remote Interrogation Device Evaluation (CPT code 93296) (Page 114)
- 8) Fine Needle Aspiration (FNA) (CPT codes 10021, 10004, 10005, 10006) (Page 118)
- 9) Nasal Sinus Irrigation (CPT codes 31000 and 31002) (Page 121)
- 10) Portable X-ray Services (HCPCS codes R0070, R0075) (Page 123)
- 11) Cryoablation Therapy to Treat Postoperative Pain -- finalizing the creation of a new add-on G code, HCPCS code G0571 (Intraoperative nerve(s) cryoablation for post-surgical pain relief (list separately in addition to code for primary service)) to be billed with a surgical procedure to account for additional time and resources required to perform cryoablation. (Page 103)
- 12) Sleep Study (CPT code 95800) -- based on the information provided by commenters regarding the outdated nature of the code and supply input pricing, and the additional information provided in public comments, CMS is finalizing an update to the PE inputs as described in Table A-C3 for CY 2026. (Pages 129 & 133)

PAYMENT FOR MEDICARE TELEHEALTH SERVICES UNDER SECTION 1834(M) OF THE ACT (SECTION II.D.) (Page 135)

CMS will, as proposed, beginning for the CY 2026 Medicare Telehealth Services List, revise the 5-step review process for reviewing requests to the Medicare Telehealth Services List. (Page 136)

CMS will remove Step 4 (Consider whether the service elements of the requested service map to the service elements of services on the list that has a permanent status described in previous final rulemaking) and Step 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) from CMS’ review criteria and retain Steps 1 through 3.

Services on the Medicare Telehealth Services List would no longer be designated “permanent” or “provisional”. All services listed or added on the Medicare Telehealth Services List would be considered included on a permanent basis.

Requests to Add Services to the Medicare Telehealth Services List for CY 2026 (Page 143)

The rule’s table A-D1: CY 2026 Requests For Addition To The Medicare Telehealth Services List identifies requests for additions to the telehealth services for CY 2026.

CY 2026 Requests for Addition to the Medicare Telehealth Services List

Category	HCPCS	Short Descriptor
Multiple-Family Group Psychotherapy	90849	Multiple family group psytx
Group Behavioral Counseling for Obesity	G0473	Group behave couns 2-10
Infectious Disease Add-On	G0545	Inherent visit to inpt
Auditory Osseointegrated Sound Processor	92622	Dx aly aud oi snd prcsr 1st
	92623	Dx aly aud oi snd prcsr each
Dialysis	90935	Hemodialysis one evaluation
	90937	Hemodialysis repeated eval
	90945	Dialysis one evaluation
	90947	Dialysis repeated eval
Telemedicine E/M	98000	Synch audio-video new sf 15
	98001	Synch audio-video new low 30
	98002	Synch audio-video new mod 45

Category	HCPCS	Short Descriptor
	98003	Synch audio-video new hi 60
	98004	Synch audio-video est sf 10
	98005	Synch audio-video est low 20
	98006	Synch audio-video est mod 30
	98007	Synch audio-video est hi 40
	98008	Synch audio-only new sf 15
	98009	Synch audio-only new low 30
	98010	Synch audio-only new mod 45
	98011	Synch audio-only new high 60
	98012	Synch audio-only est sf 10
	98013	Synch audio-only est low 20
	98014	Synch audio-only est mod 30
	98015	Synch audio-only est high 40
Home INR Monitoring	G0248	Demonstrate use home INR mon

CMS is adding only the following from the above table. (Page 154)

Category	HCPCS	Short Descriptor
Multiple-Family Group Psychotherapy	90849	Multiple family group psytx
Group Behavioral Counseling for Obesity	G0473	Group behave couns 2-10
Infectious Disease Add-On	G0545	Inherent visit to inpt
Auditory Osseointegrated Sound Processor	92622	Dx aly aud oi snd prcsr 1st
	92623	Dx aly aud oi snd prcsr each

CMS is permanently removing frequency limitations via telehealth for the following codes relating to Subsequent Inpatient Visits, Subsequent Nursing Facility Visits, and Critical Care Consultation Services: (Page 156)

1. Subsequent Inpatient Visit CPT Codes: 99231, 99232, 99233
2. Subsequent Nursing Facility Visit CPT Codes: 99307, 99308, 99309, 99310
3. Critical Care Consultation Services: HCPCS Codes G0508, G0509

Direct Supervision via Use of Two-way Audio/Video Communications Technology (Page 158)

CMS is revising the regulation at § 410.26(a)(2) to state that the presence of the physician (or other practitioner) required for direct supervision may include virtual presence through audio/video real-time communications technology (excluding audio-only) for services without a 010 or 090 global surgery indicator.

Changes to Teaching Physicians' Billing for Services Involving Residents with Virtual Presence (Page 165)

CMS did not propose to extend its current policy to allow teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings, which had been in effect through December 31, 2025. However, in response to public comments highlighting the extent to which this flexibility has been integrated into clinical practice, CMS is finalizing allowing teaching physicians to have a virtual presence in all teaching settings, only in clinical instances when the service was furnished virtually, on a permanent basis.

Telehealth Originating Site Facility Fee Payment Amount Update (Page 170)

The payment amount for HCPCS code Q3014 for CY 2026 (Telehealth originating site facility fee) is \$31.85.

Comments

With the government shut down on October 1 and without Congress extending a number of expiring telehealth payment items, it is unclear how telehealth claims will be adjudicated. If and when Congress resumes work, many expect a number of expiring payment issues, including telehealth, will be extended. Let's hope CMS is not reacting too soon by extending telehealth services.

VALUATION OF SPECIFIC CODES (SECTION II.E.) (Page 173)

The work RVUs, work time and other payment information for all CY 2026 payable codes is available on the CMS website at:

<https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/PhysicianFeeSched/index> .(This is another link that does not work – brings you to an error page.)

Efficiency Adjustment (Page 182)

CMS historically has relied on survey data primarily provided by the AMA Relative Value Scale Update Committee (AMA RUC) to estimate practitioner time, work intensity, and aspects of practice expense, which are often reflected in the valuation of codes paid under the PFS. Only a small portion of the total codes are considered for revaluation annually, and this process relies primarily on subjective information

from surveys that have low response rates, with respondents who may have inherent conflicts of interest (since their responses are used in setting their payment rates). Research has demonstrated that the time assumptions built into the valuation of many PFS services are, as a result, very likely overinflated. In order to mitigate these effects and take into account changes in medical practice, CMS is finalizing application of an efficiency adjustment to the work RVUs and corresponding intra-service portion of physician time for non-time-based services that the agency expects to accrue gains in efficiency over time. This would periodically apply to all codes except time-based codes, such as evaluation and management (E/M) services, care management services, behavioral health services, services on the Medicare telehealth list, and maternity codes with a global period of MMM.

To determine this efficiency adjustment, CMS is finalizing its proposal to use the Medicare Economic Index (MEI) productivity adjustment percentage. The MEI productivity adjustment is calculated by the CMS Office of the Actuary (OACT) each year, and CMS is finalizing a look-back period of five years, which results in a final efficiency adjustment of -2.5 percent for CY 2026. In response to public comments, CMS is finalizing an updated list of HCPCS codes that will be exempt from the efficiency adjustment. CMS is also finalizing that, going forward, CMS may give preference to empiric studies of time to incorporate into service valuation, compared to survey data, and solicit comment on the types of empiric data that CMS should consider. CMS expects that moving away from survey data would lead to more accurate valuation of services over time and help address some of the distortions that have occurred in the PFS historically.

Specific Codes (Page 216)

CMS explains changes to the specific CPT codes identified below.

In red, is the rule’s display copy page number on which the code(s) discussions begin. If you scroll down to the next numbered item, the paragraphs just above contain CMS final actions.

1	Tympanostomy (CPT code 0583T) (Page 216)
2	Temporary Female Intraurethral Valve-Pump (CPT codes 0596T and 0597T) (Page 218)
3	Skin Cell Suspension Autograft (Page 218)
4	Limb Lengthening-Shortening – Femur (CPT codes 27465, 27466, 27468, and 27458) (Page 219)
5	Limb Lengthening-Shortening – Tibia (CPT codes 27715 and 27713) (Page 220)
6	Arthrodesis Great Toe (CPT codes 28750 and 28755) (Page 220)
7	Closure Left Atrial Appendage with Endocardial Implant (CPT code 33340) (Page 222)
8	Thoracic Branch Endograft Services (CPT codes 33880, 33881, 33883, 33886, 33882, and 35602) (Page 223)
9	Lower Extremity Revascularization (CPT codes 37254, 37255, 37256, 37257, 37258, 37259, 37260, 37261, 37262, 37263, 37264, 37265, 37266, 37267, 37268, 37269, 37270, 37271, 37272, 37273, 37274,

	37275, 37276, 37277, 37278, 37279, 37280, 37281, 37282, 37283, 37284, 37285, 37286, 37287, 37288, 37289, 37290, 37291, 37292, 37293, 37294, 37295, 37296, 37297, 37298, and 37299) (Page 235)
10	Irreversible Electroporation of Tumors (CPT codes 47384 and 55877) (Page 246)
11	Endoscopic Sleeve Gastroplasty (CPT code 43899) (Page 248)
12	Transurethral Robotic-assisted Resection of Prostate (CPT codes 52500, 52601, 52630, 52648, 52649, and 52597) (Page 250)
13	Cystourethroscopy (CPT code 52443) (Page 257)
14	Prostate Biopsy Services (CPT codes 55705, 55706, 55707, 55708, 55709, 55710, 55711, 55712, 55713, 55714, 55715, and 76872) (Page 262)
15	Laparoscopic Prostatectomy (CPT codes 55840, 55842, 55845, 55866, 55867, 55868, and 55869) (Page 263)
16	Endovascular Therapy with Imaging (CPT codes 61624, 61626, 75894, and 75898) (Page 266)
17	Guided High Intensity Focused Ultrasound (CPT code 61715) (Page 274)
18	Percutaneous Interlaminar Lumbar Decompression (CPT codes 62330 and 62331) (Page 279)
19	Percutaneous Decompression of Median Nerve (CPT code 64728) (Page 280)
20	Baroreflex Activation Therapy (CPT codes 64654, 64655, 64656, 64657, 64658, 64659, 93145, and 93146) (Page 285)
21	Percutaneous Electrical Nerve Field Stimulation (CPT code 64567) (Page 289)
22	Laminotomy – Repair of Disc Defect (CPT code 63032)) (Page 289)
23	Cerebral Perfusion & CT Angiography-Head & Neck (CPT codes 70496, 70498, 70471, 70472, and 70473) (Page 291)
24	Coronary Atherosclerotic Plaque Assessment (CPT code 75577) (Page 292)
25	Use of the Relationship Between OPSS APC Relative Weights to Establish PE RVUs for Radiation Oncology Treatment Delivery (CPT codes 77387, 77402, 77407, 77412, and 77417), Superficial Radiation Treatment (CPT codes 77X05, 77X07, 77X08, and 77X09), and Proton Beam Treatment Delivery (CPT codes 77520, 77522, 77523, and 77525) (Page 294)
26	Combination COVID-19 Vaccine Administration (CPT codes 90480 and 90481) (Page 318)
27	Immunization Counseling (CPT codes 90482, 90483, and 90484) (Page 319)
28	Colon Motility Services (CPT codes 91124 and 91125) (Page 321)
29	Dark Adaptation Diagnostic and Screening Services (CPT codes 92284 and 92288) (Page 324)

30	Coronary Therapeutic Services and Procedures (CPT codes 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92973, 92930, 92945, 93571, and 93572) (Page 327)
31	RSV Monoclonal Antibody Administration (CPT codes 96380 and 96381) (Page 329)
32	Remote Monitoring (CPT codes 98975, 98976, 98977, 98978, 98980, 98981, 98984, 98985, 98986, 98979, 99091, 99453, 99454, 99457, 99458, 99473, 99474, 99445, and 99470) (Page 330)
33	Hearing Device Services (CPT codes 92628, 92629, 92631, 92632, 92634, 92635, 92636, 92637, 92638, 92639, 92641, and 92642). (Page 356)
34	Scalp Cooling Services (CPT codes 97007, 97008, and 97009) (Page 359)

This section also contains the following tables;

TABLE A-E12: CY 2026 work RVUs for new, revised, and potentially misvalued codes (Page 362)

TABLE A-E13: CY 2026 Direct PE Refinements (Page 386)

TABLE A-E14: CY 2026 Direct PE Refinements – Equipment Refinements Conforming To Changes In Clinical Labor Time (Page 406)

TABLE A-E15: CY 2026 Invoices Received For Existing Direct Pe Inputs (Page 407)

TABLE A-E16; CY 2026 New Invoices

TABLE A-E17: CY 2026 NO PE Refinements (Page 411)

EVALUATION AND MANAGEMENT (E/M) Visits (SECTION II.F.) (Page 414)

CMS proposed to allow HCPCS code G2211 to be billed as an add-on code with the home or residence evaluation and management visits code family (CPT codes 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350).

The HCPCS code G2211 refined descriptor would 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))".

CMS is finalizing as proposed, to allow HCPCS code G2211 to be billed as an add-on code with the home or residence E/M visits code family (CPT codes 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350).

ENHANCED CARE MANAGEMENT (SECTION II.G.) (Page 419)

1. Integrating Behavioral Health into Advanced Primary Care Management (APCM)

In the CY 2025 PFS final rule, CMS finalized separate coding and payment for Advanced Primary Care Management (APCM) services (HCPCS codes G0556, G0557, and G0558).

The rule's TABLE A-G1: contains the APCM codes and descriptions. (Page 419)

For CY 2026, CMS proposed to create optional add-on codes for APCM services that would facilitate providing complementary behavioral health integration (BHI) services by removing the time-based requirements of the existing BHI and Psychiatric Collaborative Care Model (CoCM) codes.

These optional add-on codes for APCM services would be considered a "designated care management service" under § 410.26(b)(5) and, as such, could be provided by auxiliary personnel under the general supervision of the billing practitioner. CMS is not creating an add-on code for CPT code 99494

(Page 425)

2. Behavioral Health Integration Add-On Codes for APCM (HCPCS codes GPCM1, GPCM2, GPCM3) (Page 425)

CMS proposed the establishment of three new G-codes to be billed as add-on services when the APCM base code (HCPCS codes G0556, G0557, and G0558) is reported by the same practitioner in the same month. 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, and HCPCS code GPCM3, an add-on code for general behavioral health integration services based on CPT code 99484.

The time-based requirements for CPT codes 99492, 99493, and 99484 remain in the instance these CPT codes are billed on a standalone basis, outside of the provision of APCM services

3. Valuation of Behavioral Health Integration Add-on Codes for APCM Services (Page 428)

In consideration that the services described by the proposed add-on codes are meant to be directly comparable to the existing CoCM and BHI codes, CMS proposed a direct crosswalk to the current work RVU values of CPT code 99492 for HCPCS code GPCM1 (work RVU 1.88), CPT code 99493 for HCPCS code GPCM2 (work RVU 2.05), and CPT code 99484 for HCPCS code GPCM3 (work RVU 0.93).

CMS also proposed a direct crosswalk to the current direct PE inputs for CPT codes 99492 (non-facility RVU 2.48, facility RVU 0.80), 99493 (non-facility RVU 1.93, facility RVU 0.86), and 99484 (non-facility RVU 0.66, facility RVU 0.30), to HCPCS codes GPCM1, GPCM2, and GPCM3, respectively.

CMS is finalizing the establishment of three new G codes to be billed as add-on services when the APCM base code (HCPCS codes G0556, G0557, and G0558) is reported by the same practitioner in the same

month: HCPCS code G0568, an add-on code based on CPT code 99492 for an initial month of CoCM services delivered to patients also receiving APCM services, HCPCS code G0569, an add-on code based on CPT code 99493 for CoCM services delivered to patients also receiving APCM services, and HCPCS code G0570, an add-on code for general behavioral health integration services based on CPT code 99484, and are finalizing the valuation of these codes as proposed. (Page 429)

OUTPATIENT THERAPY SERVICES AND KX MODIFIER THRESHOLDS (section II.H.) (Page 432)

For CY 2026, CMS proposed to increase the CY 2025 KX modifier threshold amount by the most recent forecast of the 2017-based MEI. For CY 2026, the proposed MEI increase is estimated to be 2.7 percent and is based on the expected historical percentage increase of the 2017-based MEI. Multiplying the CY 2025 KX modifier threshold amount of \$2,410 by the proposed CY 2026 percentage increase in the MEI of 2.7 percent ($\$2,410 \times 1.027$) and rounding to the nearest \$10.00 results in a proposed CY 2026 KX modifier threshold amount of \$2,480 for physical therapy and speech-language pathology services combined and \$2,480 for occupational therapy services.

CMS is finalizing the CY 2026 KX modifier threshold amounts as proposed; that is \$2,480 for physical therapy and speech-language pathology services combined and \$2,480 for occupational therapy services.

POLICIES TO IMPROVE CARE FOR CHRONIC ILLNESS AND BEHAVIORAL HEALTH NEEDS (SECTION II.I.) (Page 436)

Updates to Payment for Digital Mental Health Treatment (DMHT) and Comment Solicitation on Payment Policy for Software as a Service (SaaS)

Effective January 1, 2025, CMS finalized three HCPCS G-codes for DMHT devices, to be billed by physicians and practitioners who are authorized to furnish services for the diagnosis and treatment of mental illness: HCPCS code G0552, HCPCS code G0553 and HCPCS code G0554.

CMS is clarifying that the patient must have a mental health condition diagnosis, but the billing practitioner does not need to be the practitioner who made the diagnosis.

CMS proposed to expand its payment policies for HCPCS codes G0552, G0553, and G0554 to also make payment for DMHT devices cleared under section 510(k) of the FD&C Act or granted De Novo authorization by FDA and in each instance classified at § 882.5803 Digital therapy device for Attention Deficit Hyperactivity Disorder (ADHD).

CMS also proposed that all the conditions of payment for HCPCS codes G0552, G0553, and G0554 finalized in the CY 2025 PFS final rule would apply to DMHT devices classified at § 882.5803.

CMS is finalizing payment for DMHT devices cleared under section 510(k) of the FD&C Act or granted De Novo authorization by FDA and in each instance classified at 21 CFR section 882.5803, Digital therapy device for Attention Deficit Hyperactivity Disorder (ADHD), as proposed.

Social Determinants of Health Risk Assessment (HCPCS code G0136)

CMS believes that the resource costs described by HCPCS code G0136 are already accounted for in existing codes, including but not limited to E/M visits. Therefore, CMS proposed to delete this code for CY 2026.

CMS is retaining HCPCS code G0136 and revising the code descriptor to read "Administration of a standardized, evidence-based assessment of physical activity and nutrition, 5-15 minutes, not more often than every 6 months."

Community Health Integration Services (HCPCS codes G0019)

CMS will replace the term "social determinants of health (SDOH)" with the term "upstream driver(s)".

PROVISIONS ON MEDICARE PARTS A AND B PAYMENT FOR DENTAL SERVICES INEXTRICABLY LINKED TO OTHER COVERED SERVICES (SECTION II.J.) (Page 471)

For CY 2026, CMS is not making any proposals in response to the submissions that it received for dental services and will take the information and recommendations submitted into consideration for the future.

PAYMENT FOR SKIN SUBSTITUTES (SECTION II.K.) (Page 474)

CMS says that industry changes are causing a significant increase in spending under Medicare Part B for skin substitute products in the non-facility setting.

CMS has historically considered skin substitutes to be biologicals for payment purposes under Medicare Part B. Under this methodology, a vast majority of drugs and biologicals separately paid under Medicare Part B are paid at the Average Sales Price (ASP) plus 6.0 percent.

For CY 2026, CMS is finalizing to pay for skin substitute products 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 OPSS in the hospital outpatient department setting.

CMS is also finalizing to align skin substitute categorization consistent with their FDA regulatory status, such as 361 Human Cells, Tissues, and Cellular and Tissue-Based Products (HCT/P) and the device types: Pre-Market Approvals (PMAs) and 510(k)s. CMS believes that grouping and paying for skin substitute products based on relevant product characteristics, consistent with their FDA regulatory status, recognizes the clinical and resource differences in product types and would incentivize competition to create more innovative products, while also resulting in significant savings to the Medicare Trust Fund.

CMS is finalizing the use of a single payment rate reflecting the highest average for these three categories of skin substitute products to ensure CMS does not underestimate the resources involved with furnishing these services. The final payment rate is approximately \$127.28.

In future years, CMS intends to propose payment rates that differentiate among the three FDA regulatory categories. CMS is finalizing these policy changes in both the hospital outpatient department and physician office settings to remain consistent across different settings of care. The finalized payment policy for skin substitutes in the hospital outpatient setting is provided in the CY 2026 OPPI/ Ambulatory Surgical Center (ASC) final rule.

STRATEGIES FOR IMPROVING GLOBAL SURGERY PAYMENT ACCURACY (SECTION II.L.)

(Page 540)

For CY 2026, as part of an iterative process towards improving the accuracy of global surgical service valuation and payment, CMS solicited public comment to ascertain what next steps it could take to improve the accuracy of payment for global surgical packages.

CMS says it will consider comments received for potential future rulemaking.

DETERMINATION OF MALPRACTICE RELATIVE VALUE UNITS (RVUS) (SECTION II.M.)

(Page 547)

CMS says it considers the following factors when it determines MP RVUs for individual PFS services: (1) specialty-level risk values derived from data on specialty-specific MP premiums incurred by practitioners; (2) service-level risk values derived from Medicare claims data of the weighted average risk values of the specialties that furnish each service; and (3) an intensity/complexity of service adjustment to the service-level risk value based on either the higher of the work RVU or clinical labor portion of the direct PE RVU. (Page 547)

For the CY 2026 update, CMS did not propose any major methodological refinements to the development of MP premium data. However, CMS has continued to refine the universe of specialties subject to imputation and sources of imputation for each specialty. (Page 550)

Table A-M2 shows the risk index values by specialty type and service risk group. (Page 553)

GEOGRAPHIC PRACTICE COST INDICES (GPCIS) (SECTION II.N.) (Page 560)

Section 1848(e)(1)(A) of the Act requires CMS to develop separate Geographic Practice Cost Indices (GPCIs) to measure relative cost differences among localities compared to the national average for each of the three fee schedule components (that is, work, practice expense (PE), and malpractice (MP)).

Since more than 1 year has passed since the previous GPCI update was implemented in CY 2023 and 2024, CMS will phase in 1/2 of the GPCI adjustment in CY 2026 and the remaining 1/2 of the adjustment for CY 2027. (Page 560)

Work GPCIs (Page 563)

The work GPCIs are designed to reflect the relative cost of physician labor by Medicare PFS locality. As required by statute, the work GPCI reflects one quarter of the relative wage differences for each locality compared to the national average.

CMS used wage data for nine professional specialty occupation categories, adjusted to reflect one-quarter of the relative cost differences for each locality compared to the national average, as a proxy for physicians' wages.

For the CY 2026 GPCI update, CMS used updated BLS Occupational Employment and Wage Statistics (OEWS) data (2020 through 2023) as a replacement for the 2017 through 2020 data to compute the work GPCIs

Practice Expense (PE) GPCIs (Page 564)

The PE GPCIs are designed to measure the relative cost difference in the mix of goods and services comprising PEs (not including MP expenses) among the PFS localities as compared to the national average of these costs.

The PE GPCIs are comprised of four component indices (employee wages; purchased services; office rent; and equipment, supplies and other miscellaneous expenses).

In calculating the CY 2026 GPCI update, CMS used updated BLS OEWS data (2020 through 2023) as a replacement for the 2017 through 2020 data for purposes of calculating the employee wage component and purchased service index component of the PE GPCI. In calculating the CY 2026 GPCI update for the office rent index component of the PE GPCI, CMS used the 2018 through 2022 American Community Survey (ACS) 5-year estimates as a replacement for the 2015 through 2019 ACS data.

Malpractice Expense (MP) GPCIs (Page 565)

The CY 2026 MP GPCI update reflects premium data presumed in effect no later than December 31, 2023.

GPCI Cost Share Weights (Page 566)

The CY 2026 GPCI cost share weights are displayed in the rule’s TABLE AN-1: (below).

GPCI Cost Share Weights for CY 2026

Expense Category	Current and CY 2026 GPCI Cost Share Weights (2006-based MEI)	2017-based MEI Cost Share Weights*
Work	50.866%	47.522%
Practice Expense	44.839%	51.129%
- Employee Compensation	16.553%	25.450%
- Office Rent	10.223%	5.683%
- Purchased Services	8.095%	13.419%
- Equipment, Supplies, Other	9.968%	6.576%
Malpractice Insurance	4.295%	1.349%
TOTAL	100.000%	100.000%

PE GPCI Floor for Frontier States (Page 569)

There are no changes in the states identified as Frontier States for the CY 2026 PFS. The qualifying states are: Montana; Wyoming; North Dakota; South Dakota; and Nevada. In accordance with statute, CMS will apply a 1.0 PE GPCI floor for these states in CY 2026.

“The 1.0 work GPCI floor is established by statute and expired on September 30, 2025 (NOTE: If necessary, this date may be changed after the next round of clearance). CMS does not have the authority to extend the 1.0 work floor beyond the September 30, 2025 expiration and will process claims in accordance with statutory and regulatory requirements.” (Page 578)

The final GPCIs and summarized GAFs are displayed in Addenda D and E to this final rule. (Page 588)

III. OTHER PROVISIONS OF THE RULE

DRUGS AND BIOLOGICAL PRODUCTS PAID UNDER MEDICARE PART B (SECTION III.A.)

(Page 589)

Requiring Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs to Provide Refunds with Respect to Discarded Amounts (§§ 414.902 and 414.940)

Questions? Contact Andrew Wheeler, MHA’s Vice President of Federal Finance, at 573-893-3700 | ext. 136 or awheeler@MoHospitals.org

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By statute, manufacturers are required to pay Medicare a refund for specified discarded amounts of certain single-dose container or single-use package drugs under Part B.

CMS reviewed two applications for increased applicable percentage for specific products for CY 2026. CMS is not approving increased applicable percentages for either drug. (Leukine® (sargramostim) and Jelmyto® (mitomycin for pyelocalyceal solution)). (Page 597)

Average Sales Price: Price concessions and bona fide service fees (\$414.804 and 414.802)
(Page 598)

Drugs payable under Medicare Part B fall into three general categories: those furnished incident to a physician's service (hereinafter referred to as "incident to") (section 1861(s)(2) of the Act), those furnished via a covered item of durable medical equipment (DME) (section 1861(s)(6) of the Act), and other drugs for which coverage is specified by statute (for example, certain vaccines described in sections 1861(s)(10)(A) and (B) of the Act).

CMS proposed a definition to state "Bundled Arrangement means an arrangement regardless of physical packaging under which the rebate, discount, or other price concession is conditioned upon the purchase of the same drug or biological or other drugs or biologicals or another product or some other performance requirement (for example, the achievement of market share, inclusion or tier placement on a formulary, purchasing patterns, prior purchases), or where the resulting discounts or other price concessions are greater than those which would have been available had the bundled drugs or biologicals been purchased separately or outside the bundled arrangement."

CMS is finalizing its proposed bundled arrangement definition, excluding the terms "purchasing patterns" and "prior purchases." The finalized definition is effective for sales occurring on or after January 1, 2026, which is reflected in the Medicare Part B Drug Payment Limit File beginning July 2026. (Page 606)

CMS says it believes this aligns with its stated intent to support program alignment with the Medicaid Drug Rebate Program (MDRP) and reduces administrative complexity.

Second, to address the suggestion that the agency determine whether additional guidance would be appropriate for the areas described in the December 2022 OIG report for how to account for unbundling a bundled arrangement, CMS notes that Medicaid's definition of "bundled sale" at § 447.502 directs that discounts in a bundled sale, including those discounts resulting from a contingent arrangement, are allocated proportionally to the total dollar value of the units of all drugs or products sold under the bundled arrangement.

However, after consideration of public comments, CMS is not finalizing its proposed definition of BFSF nor the standards and methodology that manufacturers should use to determine FMV. (Page 610)

Autologous Cell-based Immunotherapy and Gene Therapy Payment (Page 640)

CMS is finalizing, as proposed, continuation of the existing bundled payment policy for CAR T-cell therapies and extending that policy to autologous cell-based immunotherapy and gene therapy, such that preparatory procedures for patient-specific cell or tissue procurement required for manufacturing are included in the payment for the product itself.

However, CMS is not finalizing the proposal to prevent these payments from qualifying as BFSFs or to require their inclusion in ASP beginning January 1, 2026. Instead, CMS concludes that such payments may be treated as BFSFs when the four-part test at § 414.802 is satisfied and therefore excluded from ASP, consistent with section 1847A(c)(3) of the Act and § 414.804(a)(2)(ii). This final rule maintains cross-setting alignment under the OPPS and PFS—where Medicare does not pay separately for each step used to manufacture a drug or biological but does pay separately for the administration service—and ensures that ASP reporting remains consistent with statutory and regulatory requirements.

RURAL HEALTH CLINICS (RHCS) AND FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs) (SECTION III.B) (Page 641)

Integrating Behavioral Health into Advanced Primary Care Management (APCM) (Page 644)

CMS is adopting the add-on codes for APCM that would facilitate billing for behavioral health integration (BHI) and Psychiatric Collaborative Care Model (CoCM) services when RHCs and FQHCs provide advanced primary care, as proposed. For CY 2026, RHCs and FQHCs furnishing APCM services may report HCPCS code G0568, G0569, or G0570 when they integrate behavioral health services with these services. (Page 651)

CMS is finalizing, effective January 1, 2026, its proposal to require RHCs and FQHCs to report the individual codes that make up the CoCM HCPCS code, G0512. That is, HCPCS code G0512 will no longer be payable when billed by RHCs and FQHCs; instead, RHCs and FQHCs will be required to bill the individual CPT and HCPCS codes that make up HCPCS G0512. Payment for these services will be based on the national non-facility PFS payment rate when the individual code is on an RHC or FQHC claim, either alone or with other payable services and the payment rates are updated annually based on the PFS amounts for these codes. CMS is also finalizing the revisions to § 405.2464(c) to reflect the change for payment of CoCM services for RHCs and FQHCs. (Page 654)

The current list of base codes and add-on codes that make up G0512 are listed in Table B-BA1, (Page 646), titled “*Psychiatric Collaborative Care Model HCPCS Codes And Descriptors.*”

For this final rule, CMS says to clarify and to be consistent with how it paid for the services that made up HCPCS code G0511, beginning January 1, 2026, RHCs and FQHCs can bill CPT code 99494. (Page 655)

Code Descriptors For Communication Technology-Based Services And Remote Evaluation Services.”

Payment for Communication Technology-Based Services (CTBS) and Remote Evaluation Services – HCPCS Code G0071 (Page 656)

For respective CTBS code descriptors, please refer to Table B-BA2. (Page 658)

CMS is finalizing requiring RHCs and FQHCs to report the individual codes that make up HCPCS code G0071. That is, beginning January 1, 2026, RHCs and FQHCs furnishing these services must report HCPCS codes G2010, G2250, and CPT code 98016 to receive separate payment. Payment for these services will be based on the national non-facility PFS payment rate when the individual code is on an RHC or FQHC claim, either alone or with other payable services and the payment rates are updated annually based on the PFS amounts for these codes. (Page 661)

Aligning with the PFS for Care Coordination Services (Page 661)

CMS notes that previously that RHCs and FQHCs cannot bill under the PFS for RHC or FQHC services and individual practitioners working at RHCs and FQHCs cannot bill under the PFS for RHC or FQHC services while working at the RHC or FQHC.

CMS is adopting that services that are established and paid under the PFS and designated as care management services as care coordination services for purposes of separate payment for RHCs and FQHCs (Page 666)

Services Using Telecommunications Technology (Page 667)

CY 2026 Regarding Direct Supervision in RHCs/FQHCs (Page 670)

CMS is finalizing revisions at § 405.2401(b) to include a definition of “Direct Supervision” to mean that the physician (or other supervising practitioner) must be present in the RHC or FQHC and immediately available to furnish assistance and direction throughout the performance of the service. It does not mean that the physician (or other supervising practitioner) must be present in the room when the service is performed. The presence of the physician (or other practitioner) includes virtual presence through audio/video real-time communications technology (excluding audio-only).

Payment for Medical Visits Furnished Via Telecommunications Technology (Page 672)

CMS is finalizing policies for non-behavioral health visits furnished via telecommunication technology that allow RHCs and FQHCs to bill for RHC and FQHC 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 (ASM) (SECTION III.C) (Page 680)

Under the authority of the Center for Medicare and Medicaid Innovation (Innovation Center) in section 1115A(b) of the Act, CMS is proposing the implementation and testing of an Ambulatory Specialty Model (ASM), a new mandatory alternative payment model with 5 performance years that would begin January 1, 2027 and end December 31, 2031. ASM would 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 (EHR) technology (CEHRT) results in enhanced quality of care and reduced costs through more effective upstream chronic condition management.

ASM would be established as a mandatory model focused on the care provided by select specialists to Medicare beneficiaries with the chronic conditions of heart failure and low back pain.

To ensure savings in the financial impacts for the model, ASM would also retain a percentage of the payments rather than distributing all funds as clinicians' payment adjustments. ASM participants would receive neutral, negative, or positive payment adjustments on future Medicare Part B payments for covered professional services based on their performance during an ASM performance year. (Page 685)

CMS is finalizing its proposed definitions for "ASM test period" and "ASM payment year" as proposed at § 512.705. CMS is also finalizing January 1, 2027 as the ASM start date as proposed. (Page 704)

Mandatory Participation (Page 704)

CMS will require that certain clinicians who treat heart failure and low back pain to participate in the ASM.

CMS is finalizing without modification its proposal at § 512.710(a) that clinicians who meet the ASM participant eligibility criteria for any year of the model will remain ASM participants for the duration of the model. CMS is also finalizing its proposal to exempt ASM participants from reporting under MIPS for only those years that they meet ASM participant eligibility criteria as proposed. (Page 712)

ASM Heart Failure Cohort (Page 717)

CMS is finalizing without modification its proposal at § 512.705 to define the "ASM heart failure cohort" as all ASM heart failure participants. CMS is also finalizing without modification its proposal at § 512.710(d)(1) to include only clinicians with a cardiology specialty code on the plurality of their Medicare Part B claims in the ASM heart failure cohort.

ASM Low Back Pain Cohort (Page 721)

CMS is finalizing the "ASM low back pain participant" and "ASM low back pain cohort" definitions as proposed at § 512.705. CMS is also finalizing without modification its proposal at § 512.710(d)(2) to include in the ASM low back pain cohort only clinicians with a specialty code of anesthesiology,

interventional pain management, neurosurgery, orthopedic surgery, pain management, or physical medicine and rehabilitation on the plurality of their Medicare Part B claims.

ASM Participant Eligibility Criteria

CMS is finalizing without modification its proposal at § 512.710(b)(2) to identify ASM participants at the TIN/NPI level. (Page 733)

Mandatory Geographic Areas (Page 752)

To determine which CBSAs and metropolitan divisions would be included in the model, CMS will use a stratified random sampling method to select approximately 40 percent of CBSAs and metropolitan divisions into ASM.

CMS is finalizing its proposed policy to use CBSAs and metropolitan divisions as the geographic unit for selection and to use the ZIP Codes of the service locations of each clinician to assign each clinician to a single CBSA or metropolitan division including ZIP Codes designated as rural by HRSA's FORHP using the most recent FORHP Eligible ZIP Code file available. CMS is finalizing its proposed policy to require all eligible clinicians within a CBSA or metropolitan division that the Innovation Center selects through the stratified random sampling methodology as part of the intervention group described in section III.C.2.c.(4).(d) in this final rule to participate in ASM. Finally, CMS is finalizing its proposed policy to use the CBSA and metropolitan division designations in OMB Bulletin 23-01 issued on July 21, 2023 as the CBSA designations for purposes of selecting participants for this model. (Page 758)

Table of Contents for the ASM model

For the proposed rule, we constructed a table of contents for the ASM section. We are now doing such below. There is simply too much material to summarize each item. Furthermore, not all will be impacted by this model.

- 1. Overview of Ambulatory Specialty Model (Page 680)**
 - a. Introduction (Page 680)
 - b. Background (Page 686)
- 2. Provisions of Ambulatory Specialty Model (Page 698)**
 - a. Definitions (Page 698)
 - b. Length of Model Test (Page 699)
 - c. ASM Participants (Page 704)
 - (1) Mandatory Participation (Page 704)

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- (2) ASM Participants (Page 712)
 - (a) ASM Heart Failure Cohort (Page 718)
 - (b) ASM Low Back Pain Cohort (Page 721)
 - (3) ASM Participant Eligibility Criteria (Page 728)
 - (a) ASM Participant and Specialty Type Identification (Page 731)
 - (i) ASM Participant Identification (Page 731)
 - (ii) Participant Exclusion due to Change in TIN During an ASM Performance Year (Page 734)
 - (iii) ASM Specialty Identification (Page 737)
 - (b) Episode-based Cost Measure (EBCM) Episode Volume (Page 742)
 - (4) Mandatory Geographic Areas (Page 752)
 - (a) Identification of Geographic Areas (Page 752)
 - (b) Exclusion of Certain CBSAs and Metropolitan Divisions (Page 758)
 - (c) Geographic Selection Methodology (Page 760)
 - (d) Stratified Random Selection of Mandatory Geographic Areas (Page 762)
 - (e) Assignment of Geographic Areas to Clinicians (Page 764)
 - (5) Selection and Notification Process for ASM Participants (Page 768)

Note, there are no sections a, b, c

- (d) Proposed ASM Performance Assessment Approach, Data Submission Requirements, and ASM Performance Category Requirements and Scoring (Page 774)

It appears CMS is restarting page numbering below.

(1) Performance Assessment and Data Submission Requirements (Page 777)

(a) ASM Performance Categories (Page 777)

(b) Data Submission Requirements (Page 783)

- (i) Quality ASM performance category data submission requirements (Page 792)
- (ii) Improvement activities ASM performance category data submission requirements (Page 794)
- (iii) Promoting Interoperability ASM performance category data submission requirements (Page 795)
- (iv) ASM performance categories without data submission requirements (Page 795)

- (v) Data submission types (Page 796)
- (vi) Data submission deadline (Page 797)
- (vii) Treatment of multiple data submissions (Page 797)

(2) Quality ASM Performance Category (Page 798)

(a) Background (Page 799)

- (i) Performance Year for the Quality ASM Performance Category (Page 801)

There are no sections (ii) or (iii)

(b) Quality Measure Set for the ASM Heart Failure Cohort (Page 801)

- (iv) Controlling High Blood Pressure (MIPS Q236) (Page 811)
- (v) Functional Status Assessments for Heart Failure (MIPS Q377) (Page 815)

(c) Quality Measure Set for the ASM Low Back Pain Cohort (Page 827)

- (i) Magnetic Resonance Imaging (MRI) Lumbar Spine for Low Back Pain, Respecified to Be Relevant to ASM Participants Treating Low Back Pain (Page 827)
- (ii) Use of High-Risk Medications in Older Adults (MIPS Q238) (Page 830)
- (iii) Preventive Care and Screening: Screening for Depression and Follow-Up Plan (MIPS Q134) (Page 833)
- (iv) Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (MIPS Q128) (Page 836)
- (v) Functional Status Change for Patients with Low Back Impairments (MIPS Q220) (Page 839)

(d) Other Measures Under Consideration (Page 851)

- (i) Patient Activation Measure (PAM) (MIPS Q503) (Page 851)
- (ii) Advance Care Plan (MIPS Q047) (Page 854)
- (iii) Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (MIPS Q484) (Page 856)
- (iv) Cardiac Rehabilitation Patient Referral from an Outpatient Setting (MIPS Q243) (Page 857)
- (v) Falls: Plan of Care (Page 860)

(e) Removal and Addition of Quality Measures (Page 862)

(f) Maintenance of Technical Specifications for Quality Measures (Page 865)

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- (g)** Data Submission Criteria for the Quality ASM Performance Category (Page 866)
 - (h)** Data Completeness Requirement and Case Minimums for the Quality ASM Performance Category (Page 868)
 - (i) Data Completeness Requirement (Page 868)
 - (ii) Minimum Case Requirements (Page 873)
 - (i)** Quality Measure Achievement Points and Quality ASM Performance Category Scoring (Page 875)
 - (i) Quality Measure Achievement Points (Page 875)
 - (ii) Benchmarking (Page 876)
 - (iii) Topped-out Quality Measures (Page 881)
 - (iv) Calculation of the Quality ASM Performance Score (Page 883)
 - (3) Cost ASM Performance Category (Page 887)**
 - (a)** Background (Page 887)
 - (b)** Performance Year for Cost ASM Performance Category (Page 888)
 - (c)** Cost Measure for the ASM Heart Failure Cohort (Page 888)
 - (d)** Cost Measure for ASM Low Back Pain Cohort (Page 896)
 - (e)** Removal and Addition of Cost Measures (Page 902)
 - (f)** Minimum Case Requirements (Page 902)
 - (g)** Cost Measure Achievement Points and Cost ASM Performance Category Scoring (Page 903)
 - (i) Cost Measure Achievement Points (Page 904)
 - (ii) Benchmarking (Page 904)
 - (iii) Calculation of the Cost ASM Performance Category Score (Page 907)
 - (4) Improvement Activities ASM Performance Category (Page 911)**
 - (a)** Background (Page 911)
 - (b)** Performance Year for Improvement Activities (Page 912)
 - (c)** Improvement Activities (Page 914)
 - (d)** Improvement Activities Data Submission, Achievement Points, ASM Performance Category Scoring (Page 914)
 - (i) Improvement Activity 1 (IA-1): Connecting to Primary Care and Ensuring Completion of Health-Related Social Needs Screening (Page 914)
 - (ii) Improvement Activity 1 (IA-1) Specifications (Page 916)

(iii) Improvement Activity 2 (IA-2): Establishing Communication and Collaboration Expectations with Primary Care using Collaborative Care Arrangements (CCAs) (Page 924)

(iv) Improvement Activity 2 (IA-2) Specifications (Page 927)

(5) Promoting Interoperability ASM Performance Category (Page 933)

(a) Background (Page 934)

(b) ASM Performance Year for the Promoting Interoperability ASM Performance Category (Page 934)

(c) Reporting for the Promoting Interoperability Performance Category (Page 935)

(i) Required CEHRT Use (Page 936)

(ii) Promoting Interoperability Objectives and Measures (Page 943)

(iii) Adding, Removing, and Modifying Measures (Page 946)

(iv) Supporting Use of CEHRT (Page 949)

(d) Alternatives Considered for the Promoting Interoperability Reporting Requirements (Page 950)

(e) Promoting Interoperability ASM Performance Category Scoring (Page 953)

The rule has two section (e)s.

(e) Final Score Methodology (Page 958)

(1) ASM Performance Category Weights and Scoring Adjustments (Page 959)

(2) Requirements to Receive a Final Score (Page 969)

(a) Determining a Final Score When an ASM Participant Meets or Does Not Meet Minimum Data Submission Requirements (Page 969)

(b) Not Determining a Final Score When an ASM Participant Cannot Be Scored on the Quality or Cost ASM Performance Category (Page 971)

(3) Complex Patient Scoring Adjustment (Page 974)

(4) Small Practice Scoring Adjustment (Page 984)

(5) Final Score Calculation (Page 991)

(6) ASM Performance Report (Page 994)

(f) Payment Approach (Page 997)

(1) Payment Approach (Page 997)

(2) Payment Methodology Overview (Page 998)

(3) Comparison of ASM Participant Performance (Page 1,011)

(4) Calculation of ASM Payment Adjustment Factors and ASM Payment Multipliers (Page 1,015)

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- (a) Overview of ASM Payment Adjustment Factor and Payment Multiplier Calculation Process (Page 1,016)
 - (b) ASM Incentive Pool (Page 1,020)
 - (i) ASM Risk Level (Page 1,022)
 - (ii) ASM Redistribution Percentage (Page 1,028)
 - (c) Exchange Function (Page 1,033)
 - (d) Notification of ASM Payment Adjustment Factors and ASM Payment Adjustment Multipliers to ASM Participants (Page 1,033)
 - (g) Timely Error Notice Process (Page 1,049)**
 - (h) Waivers of Medicare Program Requirements (Page 1,052))**
 - (1) Background (Page 1,052))
 - (2) MIPS Waiver (Page 1,053)
 - (3) Telehealth (Page 1,055)
 - (a) Background (Page 1,055)
 - (b) Telehealth Waivers (Page 1,058)
 - (i) Extreme and Uncontrollable Circumstances (EUC) Policy (Page 1,060)**
 - (j) Data Sharing (Page 1,068))**
 - (1) Data Provided to ASM Participants (Page 1,067)
 - (a) Legal Authority to Share Beneficiary-Identifiable Data and Applicability to ASM Data Sharing Processes (Page 1,067)
 - (b) Medicare Beneficiary Opportunity to Request Restrictions on Data Sharing (Page 1,072)
 - (c) Aggregated Data Sharing (Page 1,074)
 - (2) ASM Data Sharing Agreement (Page 1,076)
 - (a) General Requirement for Beneficiary-Identifiable Data (Page 1,076)
 - (b) Content of the ASM Data Sharing Agreement (Page 1,077)
 - (c) Aggregated Data Sharing (Page 1,074)
 - (k) ASM Beneficiary Incentives, Collaborative Care Arrangements, and Applicability of CMS-Sponsored Model Safe Harbor at § 1001.952(ii) (Page 1,080)**
 - (1) ASM Beneficiary Incentives Page 1,080)
 - (2) Collaborative Care Arrangements (Page 1,084)
 - (3) Application of the CMS-Sponsored Model Arrangements and Patient Incentives Safe

to ASM Beneficiary Incentives and Collaborative Care Arrangements (Page 1,090)

(l) Evaluation Approach (Page 1,092)

(1) Background (Page 1,092)

(2) Design and Evaluation Methods (Page 1,092)

(3) Data Collection Methods (Page 1,093)

(4) Key Evaluation Research Questions (Page 1,094)

(5) Evaluation Period and Anticipated Reports (Page 1,095)

(m) Overlap with Other Models Tested Under Section 1115A and CMS Programs (Page 1,098)

(n) Application of Standard Provisions for Mandatory Innovation Center Models (Page 1,108)

Comments

At 430 pages in length, this is the longest and perhaps the most difficult section in the rule to comprehend. CMS' numbering system is extremely strenuous to navigate. Not sure why CMS has restarted its major section numbering. There are errors with the numbering system itself. Sections appear missing and some have duplicate numbers. If CMS has problems in numbering, what else could be incorrect as well.

There is no doubt that the numerous comments suggest much concern from many about this model. Here we go again with averages and scoring to pay providers. What is definitely apparent is CMS' desire to reduce outlays. One must question if the stated approach will achieve such.

To say the least, this appears to be one of the most complicated systems CMS has developed.

MEDICARE DIABETES PREVENTION PROGRAM (MDPP) (SECTION III.E.) (Page 1110)

MDPP was established in 2017 as an "additional preventive service," covered by Medicare and not subject to beneficiary cost-sharing, in addition to being available once per lifetime to eligible beneficiaries.

CMS proposed several changes which are aimed towards increasing the uptake of this prevention-focused program while empowering beneficiaries and promoting further alignment between MDPP and the CDC Diabetes Prevention Recognition Program (DPRP) Standards.

CMS is finalizing its proposal to add definitions for "live Coach interaction", "Online session", and "Online delivery period," while modifying the definition of "Online". (Page 1,117)

CMS is finalizing the changes to the provision at § 410.79(c)(1)(ii) to allow for 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 with an updated timeframe of 5 calendar days,

which CMS says provides sufficient flexibility while maintaining clear separation between sessions. (Page 1,120)

CMS is finalizing the proposal at §410.79(f)(2)(i)(C) that MDPP suppliers may not mix delivery modalities by billing for a combination of Online, In-Person, and Distance learning sessions during the Online delivery period. (Page 1,132)

CMS is not revising the MDPP payment methodology to separately account for cellular-enabled weight scales or similar technology costs. (Page 1,140)

MEDICARE PRESCRIPTION DRUG INFLATION REBATE PROGRAM (SECTION III.E.) (Page 1,146)

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 and/or covered under Part D faster than the rate of inflation.

CMS is finalizing new policies for the Medicare Part B Drug Inflation Rebate Program and Medicare Part D Drug Inflation Rebate Program (collectively referred to as the “Medicare Prescription Drug Inflation Rebate Program”) that include, but are not limited to, establishing a claims-based methodology to remove 340B units from Part D rebate calculations starting on January 1, 2026. Additionally, CMS is establishing a Medicare Part D Claims Data 340B Repository (hereinafter, “340B repository”) for voluntary submissions by covered entities for Part D claims with dates of service on or after January 1, 2026, to allow CMS to begin usability testing for the 340B repository.

MEDICARE SHARED SAVINGS PROGRAM (SECTION III.F.) (Page 1,214)

Comment

This section is the third longest section of this rule at 213 pages. The material that follows is, to a large extent, from a fact sheet accompanying the rule.

Purpose (Page 1,214)

As of January 1, 2025, the Shared Savings Program has 477 Accountable Care Organizations (ACOs) with over 650,000 health care providers providing care to over 11.2 million people with Traditional Medicare.

CMS is finalizing the following changes to Shared Savings Program policies to:

- Modify requirements for determining an ACO’s eligibility for Shared Savings Program participation options, for agreement periods beginning on or after January 1, 2027, to limit participation in a one-sided model to an ACO’s first agreement period under the BASIC track’s glide path (if eligible), and require ACOs inexperienced with performance-based risk Medicare

ACO initiatives (defined at § 425.20) to progress more rapidly to higher levels of risk and potential reward under Level E of the BASIC track or the ENHANCED track (subject to the exception prohibiting ACOs with fewer than 5,000 assigned beneficiaries in benchmark year (BY) 1, BY2, or both, from participating in the ENHANCED track under the provisions discussed in section III.F.4.b.(2).(b).), compared to existing policies (section III.F.2).

- Modify Shared Savings Program eligibility requirements to require ACOs to make certain changes to their ACO participant list when an ACO participant experiences a change of ownership (CHOW) where the surviving Taxpayer Identification Number (TIN) is newly enrolled in the Provider Enrollment, Chain, and Ownership System (PECOS) with no prior Medicare billing claims history, during the performance year and outside of the annual change request cycle, and similarly allow for changes during the performance year to the ACO's Skilled Nursing Facility (SNF) affiliate list if a SNF affiliate undergoes a CHOW resulting in change to the Medicare enrolled TIN (section III.F.3.).
- Modify the Shared Savings Program eligibility requirements and financial reconciliation requirements in connection with the statutory requirement that ACOs have at least 5,000 assigned Medicare FFS beneficiaries to:
 - ++ Require ACOs applying to enter a new agreement period to have at least 5,000 assigned beneficiaries in BY3, while allowing the ACO to have fewer than 5,000 assigned beneficiaries in BY1, BY2, or both (section III.F.4.b.(2)(a).)
 - ++ Require ACOs that enter a new agreement period with fewer than 5,000 assigned beneficiaries in BY1, BY2, or both to enter the BASIC track (section III.F.4.b.(2).(b).)
 - ++ Cap shared savings and shared losses at a lesser amount for ACOs with fewer than 5,000 assigned beneficiaries in any of the three BYs, to help ensure the amounts reflect the ACO's performance in the program rather than normal variation in expenditures (section III.F.4.c.(1).)
 - ++ Exclude ACOs that fall below 5,000 assigned beneficiaries in any benchmark year from being eligible to leverage existing policies that provide certain low revenue ACOs participating in the BASIC track with increased opportunities to share in savings (section III.F.4.c.(2).)
- Update the definition of primary care services used in beneficiary assignment at § 425.400(c) (section III.F.5.)
- Revise the quality performance standard and other quality reporting requirements, including the following (section III.F.6.):
 - ++ Revise the definition of a beneficiary eligible for Medicare CQMs at § 425.20 for performance year 2025 and subsequent performance years so that the population identified for reporting within the Medicare CQM collection type would have greater overlap with the beneficiaries that are assignable to an ACO (section III.F.6.b. of this final rule).
 - ++ Remove the health equity adjustment applied to an ACO's quality score beginning in performance year 2026 and revise the terminology used to describe the health equity

adjustment and other related terms for performance years 2023 through 2025 (section III.F.6.c.).

++ Update the APP Plus quality measure set for Shared Savings Program ACOs including the removal of Quality ID: 487 Screening for Social Drivers of Health (section III.F.6.d.).

++ Require CMS-approved survey vendors to administer the CAHPS for MIPS Survey via a web-mail-phone protocol beginning with 2027 (section III.F.6.e.).

- Expand the application of the Shared Savings Program quality and finance extreme and uncontrollable circumstances (EUC) policies to an ACO that is affected by an EUC due to a cyberattack, including ransomware/malware, as determined by the Quality Payment Program, for performance year 2025 and subsequent performance years (section III.F.7.).
- Revise the Shared Savings Program regulations for performance year 2025 and subsequent performance years to rename the “health equity benchmark adjustment” to the “population adjustment” (section III.F.8.).
- Modify the Shared Savings Program quality reporting monitoring requirements at § 425.316 to specify for performance years beginning on or after January 1, 2026, requirements to monitor ACOs for failure to meet both the quality performance standard and the alternative quality performance standard, the latter of which (established in the CY 2023 PFS final rule) was inadvertently omitted from the existing framework. Similarly, modify § 425.224(b)(1)(ii)(A) related to reviewing applications for renewing and re-entering ACOs with a demonstrated pattern of failure to meet both the quality performance standard and the alternative quality performance standard (section III.F.9.).

Taken together, the policies being adopted for the Shared Savings Program in this final rule are anticipated to reduce program spending by \$20 million in total through the end of the 10-year period 2026 through 2035, ranging from approximately \$590 million lower spending at the 10th percentile to \$670 million higher spending.

Certain policies, including both existing policies and the new policies adopted in this final rule, rely upon the authority granted in section 1899(i)(3) of the Act to use other payment models that the Secretary determines will improve the quality and efficiency of items and services furnished under the Medicare program, and that do not result in program expenditures greater than those that would result under the statutory payment model. The following policies require the use of CMS’ authority under section 1899(i) of the Act: changes to the requirements for ACOs’ progression to performance-based risk under the program’s participation options (described in section III.F.2); potentially applying an alternative loss recoupment limit, in conducting financial reconciliation for each performance year, for an ACO with fewer than 5,000 assigned beneficiaries in any BY, for agreement periods beginning on or after January 1, 2027 (described in section III.F.4.c); excluding ACOs that fall below 5,000 assigned beneficiaries in any BY from being eligible to benefit from the policies providing certain low revenue ACOs participating in

the BASIC track with additional opportunities to share in savings, for agreement periods beginning on or after January 1, 2027 (described in section III.F.4.c); and mitigating shared losses for an ACO determined to be affected by an EUC due to a cyberattack, including ransomware/malware, as determined by the Quality Payment Program, for performance year 2025 and subsequent performance years (described in section III.F.7.c).

Update the APP Plus Quality Measure Set

The Table below displays the list of the quality measures to be included in the APP Plus quality measure set for Shared Savings Program ACOs as finalized in the CY 2025 PFS final rule and reflects the removal of Quality ID: 487 Screening for Social Drivers of Health from the APP Plus quality measure set.

Quality Measures in the APP Plus Quality Measure Set for Shared Savings Program ACOs

Quality #	Measure Type	Collection Type	Performance Year Phase-in
321	CAHPS for MIPS	CAHPS for MIPS Survey	2025
479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Administrative Claims	2025
001	Diabetes: Glycemic Status Assessment Greater Than 9%	eCQM/MIPS CQM/Medicare CQM (2025 and 2026) eCQM/Medicare CQM (2027 and subsequent performance years)	2025
134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	eCQM/MIPS CQM/Medicare CQM (2025 and 2026) eCQM/Medicare CQM (2027 and subsequent performance years)	2025
236	Controlling High Blood Pressure	eCQM/MIPS CQM/Medicare CQM (2025 and 2026) eCQM/Medicare CQM (2027 and subsequent performance years)	2025
112	Breast Cancer Screening	eCQM/MIPS CQM/Medicare CQM (2025 and 2026) eCQM/Medicare CQM (2027 and subsequent performance years)	2025
113	Colorectal Cancer Screening	eCQM/MIPS CQM/Medicare CQM (2026) eCQM/Medicare CQM (2027 and subsequent performance years)	2026
484	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	Administrative Claims	2026
305	Initiation and Engagement of Substance Use Disorder Treatment	eCQM/Medicare CQM	2027
493	Adult Immunization Status	eCQM/Medicare CQM	2028 or the performance year that is one year after eCQM specifications become available for the measure, whichever is later

Changes to the Regulations Associated with the Ambulance Fee Schedule (Section III. G.)
(Page 1,427)

Effective for ground ambulance services furnished on or after July 1, 2008, and before January 1, 2010, the ambulance fee schedule amounts for ground ambulance services shall be increased as follows:

- For covered ground ambulance transports that originate in a rural area or in a rural census tract of a metropolitan statistical area, the fee schedule amounts shall be increased by 3 percent.
- For covered ground ambulance transports that do not originate in a rural area or in a rural census tract of a metropolitan statistical area, the fee schedule amounts shall be increased by 2 percent.

IV. UPDATES TO THE QUALITY PAYMENT PROGRAM (SECTION IV.) (Page 1,431)

Comment

This section is 217 pages, second longest in the rule.

CY 2026 Modifications to the Quality Payment Program Reporting and Data Submission Summary of Major Changes (Page 1,434)

Transformation of the Quality Payment Program

CMS is expanding its portfolio of available MIPS Value Pathways (MVPs) for the CY 2026 performance period/2028 Merit-based Incentive Payment System (MIPS) payment year and remains committed to its goals of ensuring more meaningful participation in the Quality Payment Program through MVPs.

CMS revised the format of each MVP to categorize the quality measures by clinical conditions or episodes of care. The new format offers a streamlined set of quality measures to aid clinicians in selecting the most clinically relevant measures. (Page 1,435)

Transforming MIPS: MVP Strategy

CMS is finalizing updates to two MVP subgroup policies as follows: (1) update the MVP group registration process to add the specialty self-attestation requirement; and (2) maintain the MVP group reporting option for multispecialty groups with a small practice designation.

CMS is finalizing, as proposed, six new MVPs around the following topics. (Page 1,435)

1. Diagnostic Radiology
2. Interventional Radiology
3. Neuropsychology
4. Pathology

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5. Podiatry
 6. Vascular Surgery

CMS refers readers to the rule's Appendix 3: MVP Inventory, for a detailed description of each new MVP.

CMS is modifying all 21 existing MVPs, to update the quality measure and improvement activity inventories. These changes are also in Appendix 3. They are:

1. Adopting Best Practices and Promoting Patient Safety within Emergency Medicine;
 2. Advancing Cancer Care;
 3. Advancing Care for Heart Disease;
 4. Advancing Rheumatology Patient Care;
 5. Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes;
 6. Improving Care for Lower Extremity Joint Repair;
 7. Optimal Care for Kidney Health;
 8. Optimal Care for Neurological Conditions;
 9. Patient Safety and Support of Positive Experiences with Anesthesia;
 10. Value in Primary Care MVP
 11. Supportive Care for Cognitive-Based Neurological Conditions
 12. Focusing on Women's Health;
 13. Prevention and Treatment of Infectious Disorders Including Hepatitis C and Human
 14. Immunodeficiency Virus (HIV);
 15. Quality Care for the Treatment of Ear, Nose, and Throat Disorders;
 16. Quality Care in Mental Health and Substance Use Disorder; and Rehabilitative Support for Musculoskeletal Care.
 17. Complete Ophthalmologic Care;
 18. Dermatological Care;
 19. Gastroenterology Care;
 20. Pulmonology Care; and
 21. Surgical Care
- CMS will allow groups to attest to their specialty composition (whether they're a single specialty or multispecialty group that meets the requirements of a small practice) during the MVP registration process. (i.e., CMS will not make this determination for them.)
 - CMS is modifying that multispecialty small practices will still be able to report an MVP as a group, and they will not be required to form subgroups beginning in the CY 2026 performance period. (i.e., Subgroup reporting would remain optional for multispecialty small practice.)

Performance Threshold

CMS is setting the performance threshold at 75 points through the CY 2028 performance period/2030 MIPS payment year, to provide continuity and stability to program participants.

Comments

There is much history and redundancy being presented which results in the material extending some 217 pages as previously noted.

The rule's appendices (copy as referenced below), provide extensive and detailed changes to the quality issues.

COLLECTION OF INFORMATION REQUIREMENTS (SECTION V.) (Page 1,658)

REGULATORY IMPACT ANALYSIS (Section VI) (Page 1,716)

Do not overlook the regulatory impact analysis section. It contains much additional and helpful information

APPENDICES (Page 1,924)

Appendix 1: MIPS Quality Measures

- Table Group A: New MIPS Quality Measures Finalized for the CY 2026 Performance Period/2028 MIPS Payment Year and Future Years (Page 1,924)
- Table Group B: Modifications to Previously Finalized Specialty Measure Sets Finalized for the CY 2026 Performance Period/2028 MIPS Payment Year and Future Years (Page 1,940)
- Table Group C: Previously Finalized Quality Measures Finalized for Removal for the CY 2026 Performance Period/2028 MIPS Payment Year and Future Years (Page 2,194)
- Table Group D: Proposed Substantive Changes to Previously Finalized MIPS Quality Measures for the CY 2026 Performance Period/2028 MIPS Payment Year and Future Years (Page 1,666)
- Table Group DD: Proposed Substantive Changes to Previously Finalized MIPS Quality Measures Available Only for Use in Relevant MVPs for the CY 2026 Performance Period/2028 MIPS Payment Year and Future Years (Page 1,698)

Appendix 2: Improvement Activities (Page 1,701)

- TABLE F-B1: New Improvement Activities for Adoption Beginning with the CY 2026 Performance Period/2028 MIPS Payment Year (Page 1,701)
- TABLE F-B2: Changes to Previously Finalized Improvement Activities for the CY 2026 Performance Period/2028 MIPS Payment Year and for Future Years (Page 1,706)

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- TABLE F-B3: Improvement Activities Being Removed for the CY 2026 Performance Period/2028 MIPS Payment Year and for Future Years (Page 1,712)

Appendix 3: MVP Inventory (Page 2,266)

- Group A: New MVPs for the CY 2026 Performance Period/2028 MIPS Payment \Year and Future Years

Table A.1 Diagnostic Radiology MVP (Page 2,275)

Table A.2: Interventional Radiology MVP Clinical Groupings (Page 2,279)

Table A.3 Neuropsychology MVP (Page 2,285)

Table A.4 Pathology MVP (Page 2,289)

Table A.5 Podiatry MVP (Page 2,293)

Table A.6 Vascular Surgery MVP (Page 2,298)

- Group B: Modifications to Previously Finalized MVPs for the CY 2026 Performance Period/2028 MIPS Payment Year and Future Years (Page 2,301)

B.1: Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP (Page 2,301)

B.2: Advancing Cancer Care MVP (Page 2,304)

B.3: Advancing Care for Heart Disease MVP (Page 2,307)

B.4: Advancing Rheumatology Patient Care MVP (Page 2,310)

B.5 Complete Ophthalmologic Care MVP (Page 2,313)

B.6: Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes MVP (Page 2,318)

B.7: Dermatological Care MVP (Page 2,319)

B.8: Focusing on Women's Health MVP (Page 2,322)

B.9: Gastroenterology Care MVP (Page 2.325)

B.10: Improving Care for Lower Extremity Joint Repair MVP (Page 2,329)

B.11: Optimal Care for Kidney Health MVP (Page 2,330)

B.12: Optimal Care for Patients with Urologic Conditions MVP (Page 2,333)

B.13: Patient Safety and Support of Positive Experiences with Anesthesia MVP (Page 2,337)

B.14: Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV MVP (Page 2,339)

B.15: Pulmonology Care MVP (Page 2,342)

- B.16: Quality Care for Patients with Neurological Conditions MVP (Page 2,344)
- B.17: Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP (Page 2,346)
- B.18: Quality Care in Mental Health and Substance Use Disorders MVP (Page 2,348)
- B.19: Rehabilitative Support for Musculoskeletal Care MVP (Page 2,352)
- B.20: Surgical Care MVP (Page 2,355)
- B.21: Value in Primary Care MVP (Page 2,359)

Appendix 4: Measures for MIPS Cost Performance Category (Page 2,362)

Except as otherwise noted in this final rule, previously finalized cost measures will continue to apply for the CY 2026 performance period/2028 MIPS payment year and future years. Previously finalized measures and specialty sets are set forth in Table 75 in the CY 2025 PFS final rule.

The Group A Table(s) within this final rule set forth CMS' proposals to modify one or more measures specified for the MIPS cost performance category beginning with the CY 2026 performance period/2028 MIPS payment year.

Group A: Modify MIPS Cost Measures Beginning with the CY 2026 Performance Period/ 2028 MIPS Payment Year (Page 2,362)

Final Thoughts

This writer continues to be perplexed as to why these rules keep growing in length every year. Part of the reason is the reporting of truly unnecessary history. One does not need to know when CMS made a change and the additional changes made to the issue until the present time. What the reader needs to know is what is currently in effect and the changes being made for the ensuing year.

Another reason for the volume is simply the amount of redundancy. Why must CMS tell all commenters that the agency "appreciates and thanks" them. CMS says this nearly 900 times, according to the Adobe word count.

CMS says it is updating the physician fee schedule to acknowledge changes in the industry. Unfortunately, many changes being proposed are intended not to improve systems, but to reduce Medicare payments.

The material regarding the *Proposed Efficiency Adjustment* (Page 182) is such an example. CMS is now looking at reducing the work RVU category by 2.5 percent to account for productivity improvements. The federal FFY PPS updates have a productivity adjustment. But it is mandated by law and not as this rule would do by regulation.

While CMS proposes to change payments between free-standing and hospital-based physician work sites, it is doing such in the way it would pay for a similar service differently at each site, with more amounts going to the non-hospital setting. This is quite evident in reviewing the rule's impact tables.

The ambulatory specialty model section does not indicate those that maybe impacted. It only cites the agency's parameters in selecting potential participants. So much remains to be decided and how these model will work. Three items are clear. Areas selected for the model will mandate participants, the model is intended to save money, and it is still unclear if CMS can fulfill its operation by January 2027.

This rule contains errors. Some are simply typos or pagination items, but others are part of CMS' changes. It appears that these rules lack a final proof and approval system. Both the CY 2026 proposed and now this final rule contain web links that do not work. Something so simple to insure.

A primary intent of this analysis is to provide the reader with the issues, and more importantly where with-in the document information it is presented so all do not have to use time reading non-pertinent information. CMS' headings are incomplete so its problematic trying to locate a specific item. What is needed is a complete table-of-contents and complete reference points of sections within the rule. Right now, for example, when the reader sees a head annotated (IV) one does not know which major head the (IV) belongs to without retracing steps to find the major section containing such a reference.

While CMS has provided several fact sheets, and while they are helpful, none follow the order of material in the rule. It would be extremely helpful if fact sheets sync to the order of the material in the rule.

The most difficult sections to navigate and comprehend are the Ambulatory Specialty Model, the Medicare Shared Savings Program, and, of course , the Updates to the Quality Payment Program.

It is totally understandable why CMS has moved from the lowest of usual, customary and prevailing charges to reimburse physicians to a fee schedule. While incentives in the payment system have significantly changed, the mechanics have become overwhelming. For example, I question the concept being applied as quality. Does all this coding truly reward the efficient practitioner?

If a patient has been told by the physician to do A, but the patient does not, why should such physician be disadvantaged because his or her quality score and/ or benchmark is adjusted negatively because of the patient.