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CY 2026 Medicare Physician Fee Schedule Proposed Rule

The Centers for Medicare and Medicaid Services (CMS) recently released the Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) Proposed Rule, which includes an increase in the conversion factor – largely due to the statutorily required 2.5% increase contained in the recently enacted tax and spending legislation. This article recaps key provisions contained in the rule and current activity in the push for legislative changes.

KEY TAKEAWAYS

- *Increase of 3.8% for Qualifying APM Conversion Factor, or 3.3% for Non-Qualifying APM Conversion Factor (before sequestration).*
- *Efficiency adjustment of 2.5% to decrease Work RVUs for non-time-based services.*
- *Greater PE RVUs for services provided in a non-facility setting than in a facility setting.*
- *These changes result in significant swings in Total RVUs for some specialties, with considerable differences between office-based and hospital-based services.*

Conversion Factor

Medicare reimbursement for professional services is generally determined by multiplying the applicable relative value unit (RVU) amounts for billed services by the conversion factor in place on the date the service was rendered, adjusted for the specific locality. Current law requires any changes in the Medicare Physician Fee Schedule to be budget-neutral, except for any provisions explicitly excluded from the budget neutrality requirements.

In accordance with current law requiring two separate conversion factors beginning in 2026, the proposed rule for the first time provides separate calculations: one for qualifying alternative minimum payment model

(APM) participants (QPs) and another for those not meeting the APM requirements. To be a QP, a practitioner must participate in an Advanced APM and meet required payment or patient count thresholds. Advanced APMs must use certified electronic health record (EHR) technology, provide payment based on certain quality measures, and bear appropriate financial risk.

The recently enacted "One Big Beautiful Bill Act" (OBBBA) included a 2.5% increase to the conversion factor for 2026. While earlier versions would have provided annual increases based on the medical inflation rate, the final version of the law included only a one-year fix.

The resultant conversion factors for 2026 in the proposed rule were calculated as follows:

	Qualifying APM Conversion Factor	Non-Qualifying APM Conversion Factor
CY 2025 Conversion Factor	$ 32.35	$ 32.35
CY 2026 Qualifying APM Update Factor	0.75%	0.25%
CY 2026 RVU Budget Neutrality Adjustment	0.55%	0.55%
CY 2026 2.5% Increase	2.50%	2.50%
CY 2026 Conversion Factor	**$ 33.59**	**$ 33.42**

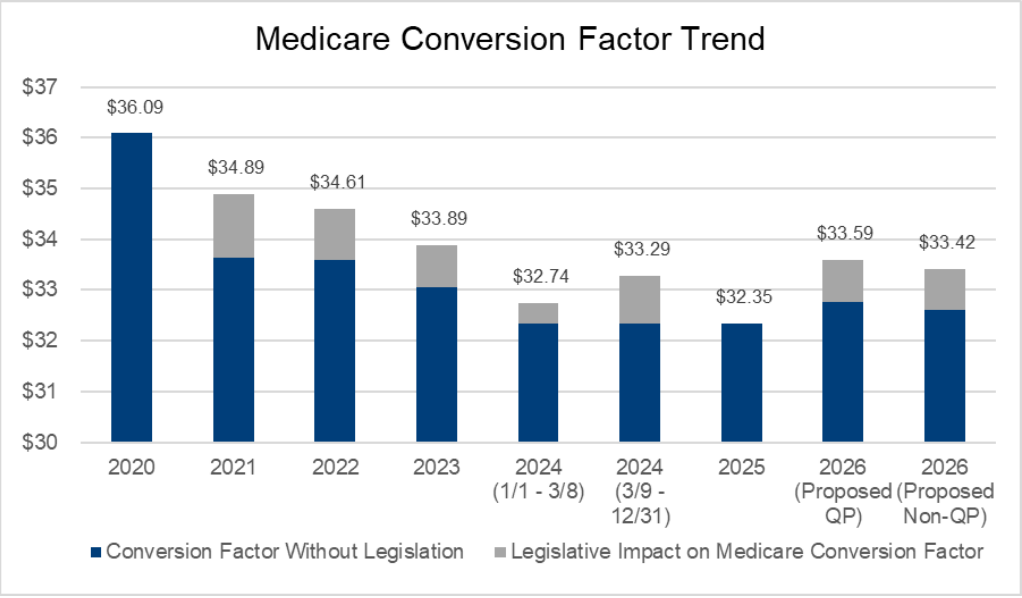
Derived from Tables 88 and 89 of the proposed rule.

Similarly, the two anesthesia conversion factors for 2026 are proposed as follows:

	Anesthesia Qualifying APM Conversion Factor	Anesthesia Non-Qualifying APM Conversion Factor
CY 2026 National Average Anesthesia Conversion Factor	$ 20.32	$ 20.32
CY 2026 Qualifying APM Update Factor	0.75%	0.25%
CY 2026 RVU Budget Neutrality Adjustment	0.55%	0.55%
CY 2026 2.5% Increase	2.50%	2.50%
CY 2026 Anesthesia Fee Schedule PE and Malpractice Adjustment	-2.00%	-2.00%
CY 2026 Conversion Factor	**$ 20.68**	**$ 20.57**

Derived from Tables 90 and 91 of the proposed rule.

Significant volatility in the conversion factor began in 2021 in response to substantial increases in Work RVUs (wRVUs) for many office visits and similar services that were determined to be undervalued historically. Ever since, physicians have battled statutory restrictions limiting reimbursement increases, which have often (but not always) been mitigated at the last minute by legislative action, as illustrated below:



Still, even with legislative intervention the conversion factor has consistently remained below the 2020 level, with even the higher QP proposed rate for 2026 almost 7% lower than the 2020 conversion factor. Meanwhile, inflation has increased the cost of operating a medical practice. According to the American Medical Association (AMA), Medicare physician reimbursement has declined 33% from 2001 to 2025 on an inflation-adjusted basis.

Sequestration Impact

It should be noted that the rates reflected above do not incorporate the impact of sequestration. Sequestration is a required across-the-board spending cut resulting from three budget enforcement rules:

- The Statutory Pay-As-You-Go Act of 2010 (PAYGO);
- The Budget Control Act of 2011 (BCA); and
- The Fiscal Responsibility Act of 2023 (FRA).

Only the sequestration stemming from the BCA is currently in effect, and it will impact Medicare payments through fiscal year 2032. Under this law, cuts to Medicare benefit payments cannot exceed 2%. The sequestration adjustment only applies to the portion of the payment made by Medicare and excludes the patient share.

PAYGO requires spending cuts across the federal government if legislation enacted in a given year results in an increase in projected budget deficits. The recently enacted OBBBA would trigger PAYGO in 2026 without additional Congressional action. PAYGO cuts to Medicare benefit payments would be capped at 4%. However, neither PAYGO nor any subsequent legislation includes details on how the two sequesters would be implemented together.

The FRA sequester applies to discretionary funding and can be triggered if applicable budget enforcement rules are broken. Since the Medicare program is funded by both mandatory and discretionary spending, any FRA sequester could impact Medicare. However, this sequester would impact only discretionary components of the Medicare program, such as administration and fraud investigation activities. Payments to providers for services rendered to Medicare beneficiaries would not be impacted.

Other Key Provisions

The 2026 MPFS Proposed Rule contains additional provisions that impact billing and reimbursement for a variety of services. While this is not a comprehensive summary, key components are recapped below.

RVU Changes

Work Component

CMS has historically utilized survey data provided by the AMA Relative Value Scale Update Committee to estimate practitioner time, work intensity, and practice expense (PE) that are reflected in RVUs for various services. However, CMS believes there is an inherent conflict of interest, and only a small portion of the codes are reevaluated each year. According to the proposed rule, RVUs have not been adjusted to “take into account changes in medical practice” and “studies have demonstrated that CMS continues to overvalue non-time-based services” CMS notes in the rule that the Medicare Payment Advisory Commission (MedPAC) has recommended in the past several options to address this issue, including “an across-the-board reduction to all fee schedule services other than ambulatory E&M [evaluation and management] services.”

To combat what it describes as services that are “very likely overinflated,” CMS introduces an “efficiency adjustment.” As stated in the proposed rule, “Our proposal is based on our assumption that both the intraservice portion of physician time and the work intensity (including mental effort, technical effort, physical effort, and risk of patient complications) would decrease as the practitioner develops expertise in performing

the specific service. As expertise develops, learning leads to enhanced familiarity with the various aspects of a service, variations in the anatomy of each patient, and confidence in the practitioner's own ability to handle unexpected challenges that arise." The efficiency adjustment, calculated based on the medical economic index (MEI) productivity adjustment, is proposed to be 2.5% for 2026. This adjustment would decrease Work RVUs for non-time-based services. CMS proposes to apply the efficiency adjustment to the intraservice portion of physician time and wRVUs every three years.

Practice Expense (PE) Component

Additionally, CMS generally relies on AMA Physician Practice Information survey data to inform assumptions relating to practice expenses. This survey data was updated in 2024 for the first time since 2008. However, CMS has concerns about the reliability of the data, including small sample size and response rates. Instead, the rule proposes to utilize "data from auditable, routinely updated hospital data" to inform cost assumptions for certain technical services. Additionally, CMS acknowledges the significant increase in physician employment by hospitals and health systems and corresponding decrease in the number of private-practice physicians. To appropriately address this dynamic, the proposed rule deviates from the historical methodology and instead allocates greater practice expense (PE) RVUs for services provided in a non-facility setting than in a facility setting. Specifically, CMS proposes to "reduce the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to nonfacility PE RVUs beginning in CY 2026." This is intended to more accurately account for the resource costs for furnishing care in different settings.

Malpractice (MP) Component

CMS utilized updated premium data from state insurance rate filings to calculate 2026 MP RVUs. The proposed rule notes that the rates were calculated using a methodology similar to that used in a 2023 update, which considers specialty-specific premium data collected from all fifty states. In accordance with current law, the updated rates are rescaled to achieve budget neutrality.

Telehealth Services

The rule proposes to streamline the process of adding approved telehealth services. Instead of distinguishing services as either "provisional" or "permanent," all services on the Medicare Telehealth Services List would be considered permanent.

Medicare telehealth frequency limitations were suspended during the COVID-19 public health emergency (PHE) for a variety of services. Although the limitations resumed upon expiration of the PHE in 2023, they were again suspended through the end of 2025 for the following services:

- Subsequent Inpatient Visit CPT Codes (99231, 99232, and 99233);
- Subsequent Nursing Facility Visit CPT Codes (99307, 99308, 99309, and 99310); and
- Critical Care Consultation Services (HCPCS Codes G0508 and G0509).

The proposed rule seeks to permanently eliminate frequency limitations for these services to allow practitioners to exercise their professional judgment in determining the appropriate service modality based on specific circumstances.

CMS is proposing to permanently adopt a definition of direct supervision that allows physicians to utilize real-time audio and video interactive telecommunication (but not audio-only) to meet the presence and "immediately available" requirement for direct supervision, except services with a global surgery indicator of 010 or 090. These services will still require in-person supervision to ensure the supervising practitioner is able to intervene quickly if complications arise in higher-risk circumstances.

CMS has chosen not to extend the current policy that has allowed teaching physicians to have a virtual presence during the provision of telehealth services. Instead, teaching physicians must maintain physical presence during critical portions of all services provided by residents beginning in 2026. However, in rural settings (those provided outside of Metropolitan Statistical Areas), teaching physicians may continue

utilizing real-time audio/video technology to fulfill the presence requirement, as long as they maintain active, real-time observation and participation in the service.

Evaluation/Management Add-On Codes

A separate add-on code – HCPCS code G2211 – was added in 2024 to provide additional reimbursement to compensate for the increased time and resources related to the intensity and complexity inherent in office or outpatient E/M visits that are part of ongoing care related to a patient's single, serious, or complex condition. The proposed rule seeks to allow G2211 to be applied to home and residence E/M visits (CPT codes 99341 – 99345 and 99347-99350) as well.

Advanced Primary Care Management

In 2025, CMS established three new HCPCS G-codes for a set of advanced primary care management (APCM) services in an effort to provide a mechanism for continued and intentional improvements to primary care. The practitioner who bills for APCM services is responsible for the patient's primary care and serves as the continuing focal point for all needed health care services. The proposed rule would create optional add-on codes for APCM services that would remove the time-based requirements of the existing behavioral health integration (BHI) and Psychiatric Collaborative Care Model (CoCM) codes. In doing so, CMS aims to reduce documentation requirements to encourage primary care providers to offer BHI and CoCM services. The add-on codes could be provided by auxiliary personnel under the general supervision of the billing practitioner. The proposed rule would establish three new G-codes to be billed as add-on services when the APMC base code is reported by the same practitioner in the same month.

Behavioral Health Services

In 2025, CMS established payment for digital mental health treatment (DMHT) devices that have been cleared by the Food and Drug Administration (FDA) if the billing practitioner is incurring the cost of furnishing the device to the patient. The device must be part of an ongoing treatment plan, and the billing practitioner must diagnose the patient and prescribe or order the DMHT device. CMS now proposes to expand the payment policy to allow payment for approved DMHT devices used to treat Attention Deficit Hyperactivity Disorder (ADHD).

Additionally, the proposed rule clarifies that marriage and family therapists (MFTs) and mental health counselors (MHCs) can bill for personally performed Community Health Integration (CHI) and Principal Illness Navigation (PIN) services for the diagnosis or treatment of mental illness. It is the responsibility of the billing practitioner to ensure that all applicable licensure, certification, and training requirements are met by auxiliary personnel providing CHI and PIN services.

CMS also proposes a change in terminology from "social determinants of health" to "upstream driver(s)," which it believes encompasses a wider range of root causes of the issues addressed through CHI services. The proposed rule deletes HCPCS Code G0136 (administration of a standardized, evidence-based social determinants of health risk assessment tool), believing that the resource costs are already accounted for in existing codes, including E/M visits.

Payment for Skin Substitutes

Historically, skin substitutes have been paid as biologicals instead of supplies, using a payment methodology based on average sales price plus 6%. However, Part B spending for skin substitutes increased dramatically from $250 million to over $10 billion in just five years (2019 to 2024), while the number of patients receiving such products merely doubled over the same time period. To address this, CMS proposes to treat certain groups of skin substitute products as incident-to supplies beginning in 2026 when they are used during a covered procedure in a non-facility setting or paid under the Outpatient Prospective Payment System (OPPS). Incident-to supplies are subject to cost-based reimbursement rather than sales price. The proposed rule seeks to create site-neutral payment for skin substitutes under the PFS

and the OPPS. Accordingly, payment rates for skin substitutes in each of three FDA categories would be established for 2026 under the OPPS, then used to derive the PE and MP RVUs to be applied to existing HCPCS codes to achieve similar reimbursement under the PFS. (According to the proposed rule, the associated work component is already captured in the application codes, CPT codes 15271-15278.) The skin substitute payment rates would be subject to annual updates.

Ambulatory Specialty Model

CMS proposes a new Ambulatory Specialty Model (ASM), which would begin in 2027 and run for five years. This model would be mandatory and would focus on care provided by specialists involved in treating heart failure and lower back pain. The model would be used to test whether these chronic conditions are managed more effectively when payment to specialists is adjusted based on performance. Targeted measures would focus on quality and cost of care, care coordination, and meaningful use of certified electronic health record technology. Clinicians participating in the ASM would be evaluated individually rather than at an organization level. They would receive neutral, negative, or positive payment adjustments on future payments for covered professional services based on their performance during an ASM performance year. The first performance year, 2027, would be used to impact payments in 2029.

Medicare Diabetes Prevention Program

The Medicare Diabetes Prevention Program (MDPP) was established in 2017 to prevent or delay the onset of type 2 diabetes in eligible Medicare beneficiaries. Certain changes to the program were implemented during Covid, and the 2024 and 2025 PFS rules included changes to simplify the payment structure and extend the ability for MDPP suppliers to deliver some or all sessions via distance learning. However, participation in the program has remained quite low. To improve participation of both providers and beneficiaries, CMS proposes several changes, including extending Covid-era flexibilities to allow online sessions through 2029 and introducing an asynchronous delivery modality.

Medicare Shared Savings Program

The proposed rule includes numerous revisions to the Medicare Shared Savings Program (MSSP). Notably, CMS seeks to limit the length of time ACOs can participate in a one-sided risk model to five performance years instead of seven. This would be effective for agreement periods beginning on or after January 1, 2027. Also, CMS is modifying the requirement that ACOs have at least 5,000 assigned Medicare fee-for-service beneficiaries. According to the proposed rule, ACOs applying to enter a new agreement period beginning on or after January 1, 2027, must have at least 5,000 assigned beneficiaries by the third benchmark year. ACO participants below that threshold at any point during the first two years would only be eligible for the BASIC track, and shared savings and shared losses would be capped anytime the number of assigned beneficiaries drops below 5,000.

CMS proposes the removal of health equity adjustments from ACO quality scores beginning in performance year 2025, and related terminology revisions. Additionally, the proposed rule would revise the definition of a beneficiary eligible for Medicare Clinical Quality Measures. Beginning in performance year 2025, the definition would require at least one primary care service during the applicable performance year from an ACO professional who is either a primary care physician, has an approved specialty designation, or who is a physician assistant, nurse practitioner, or clinical nurse specialist.

The proposed rule includes several quality measures that would be implemented in performance year 2025, as reflected in the 2025 PFS final rule. Other quality measures would be phased in in subsequent years.

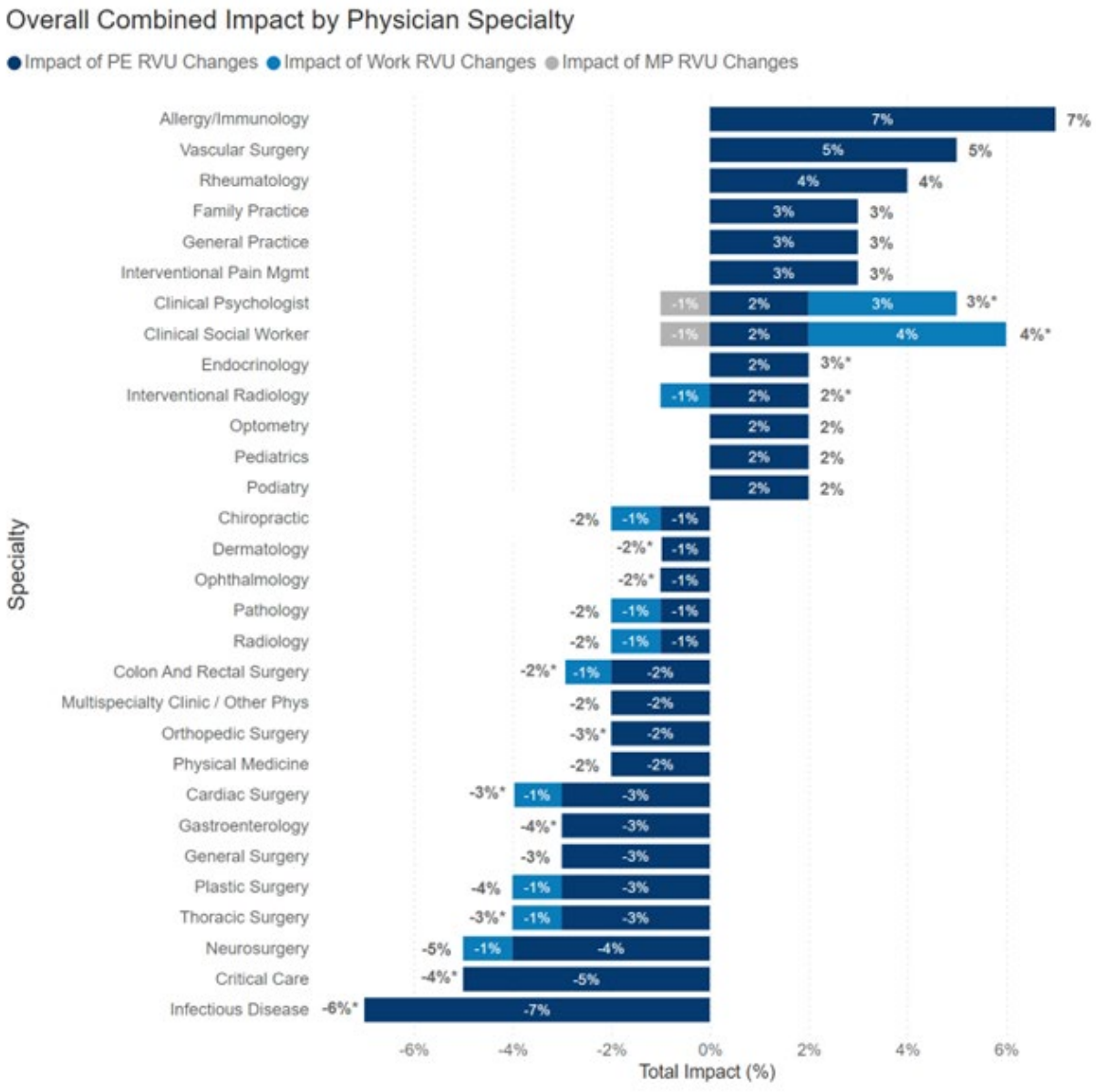
Specialty Impact

CMS performed an analysis to estimate the ranges of impact for practitioners within each specialty, based on 2024 utilization data. Some specialties will experience RVU changes resulting from the misvalued code initiative. Many office-based specialties are expected to see significant increases in RVUs related to the

proposed adjustment to the indirect PE allocation. Likewise, hospital-based services will see decreases resulting from the indirect PE allocation. In fact, the rule notes that "several specialties appear on the specialty impacts table with both the largest projected increase in payment as well as the largest projected decrease in payment, split across the site of service differential."

Certain specialties are also impacted by the new efficiency adjustment. Specialties that bill more frequently for timed codes are likely to see an increase in RVUs since those services are not subject to the efficiency adjustment. Other specialties, however, would likely see a decrease. Because the efficiency adjustment is applied to a broad range of services, the budget neutrality calculation yields an overall increase to the conversion factor that will partially offset the impact of the decreased RVUs.

Overall, the specialties with the greatest expected increases and decreases in RVUs are as follows:



Data obtained from Table 92 of the proposed rule. Total impact may not equal the sum of the component impacts due to rounding.

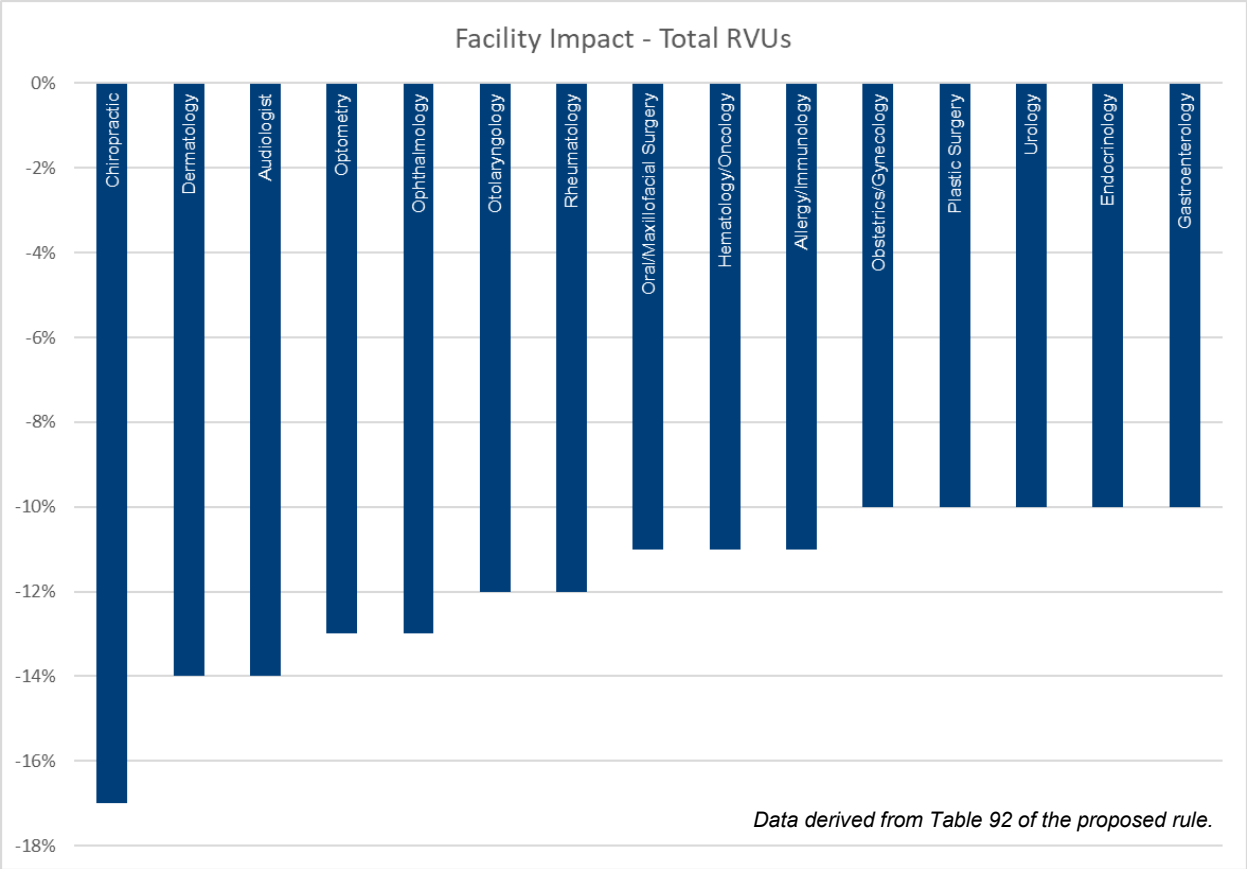
From a non-facility perspective, only the following specialties are expected to experience a decline in Total

RVUs, ranging from 1% to 2%:

- Independent laboratory
- Physical/occupational therapy
- Portable x-ray supplier
- Radiation oncology and radiation therapy centers
- Dermatology
- Chiropractic
- Pathology

Most specialties (80% of those listed in the CMS analysis) are expected to experience an increase in Total RVUs of 3% or more for services provided in a non-facility setting. The biggest winners are nurse anesthetist (10%), vascular surgery (9%), and allergy/immunology, geriatrics, and thoracic surgery (all at 8%). The median increase is 6%.

On the other hand, all specialties are expected to see a decline in Total RVUs for services provided in a facility setting. The decreases range from 1% to 17%, with a median of 9%. The biggest losers are as follows:



In the proposed rule, CMS also provides the impact on selected high-volume procedures. This indicates that commonly used office visit codes (99203, 99213, and 99214) would all receive an increase in Total RVUs for services provided in a non-facility setting and a decline in Total RVUs for facility-based services. Commonly used hospital visit codes would all experience a reduction in Total RVUs.

CPT Code	Short Descriptor	Facility	Non-Facility
99203	Office o/p new low 30-44 min	-9%	9%
99213	Office o/p est low 20-29 min	-10%	7%
99214	Office o/p est mod 30-39 min	-10%	9%
99222	1st hosp ip/obs moderate 55	-6%	NA
99223	1st hosp ip/obs high 75	-6%	NA
99231	Sbsq hosp ip/obs sf/low 25	-5%	NA
99232	Sbsq hosp ip/obs moderate 35	-7%	NA
99233	Sbsq hosp ip/obs high 50	-5%	NA
99236	Hosp ip/obs same date hi 85	-4%	NA
99239	Hosp ip/obs dschrg mgmt >30	-3%	NA

It should be noted that while there are some significant swings anticipated to Total RVUs for certain specialties or between services provided in facility and non-facility settings, most are related to the PE component and not wRVUs. This could result in considerable swings in reimbursement, without corresponding changes in compensation for providers on a compensation plan driven by wRVU productivity. Accordingly, it will be imperative for practices to determine whether compensation plans may need to be modified so that there is reasonable correlation between revenue generated and compensation earned.

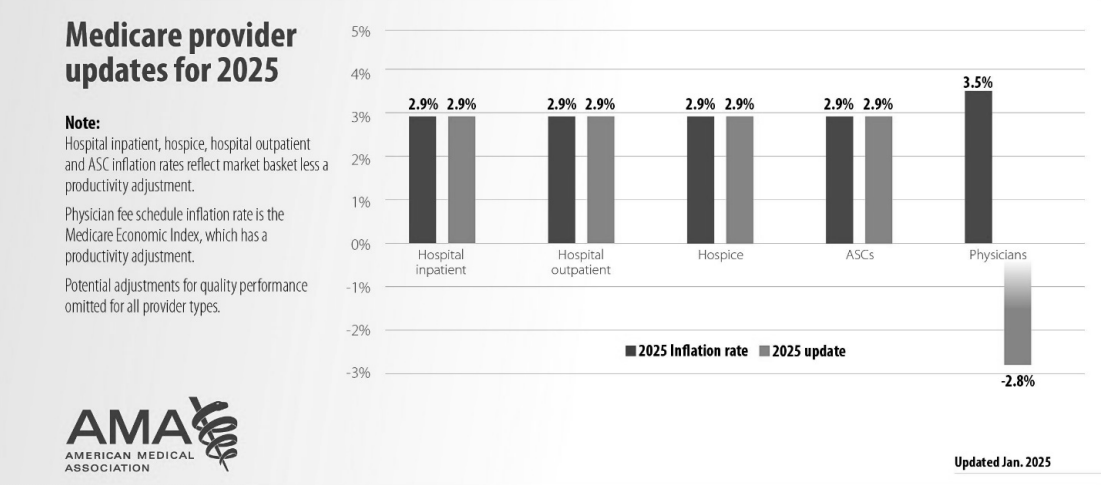
Industry and Legislative Response

In its March 2025 report to Congress, the Medicare Payment Advisory Commission (MedPAC) noted that "given recent inflation, input-cost increases in 2026 … could be difficult for physicians to absorb." In response, MedPAC recommended that the payment rate for physicians and other healthcare practitioners should be increased for 2026 by a percentage equal to the projected increase in the Medical Economic Index (MEI) minus one percentage point. Such an increase was recommended to be a permanent update that would therefore be built into the calculation of rate updates in subsequent years, in contrast to legislative fixes that revert back in subsequent years without continued Congressional intervention. This is not the first time MedPAC has advocated for an inflationary increase. In both the 2023 and 2024 reports to Congress, MedPAC recommended that the payment rate be increased by 50% of the projected increase in the MEI.

The 2025 Medicare Trustees Report similarly noted concern with the current payment levels for physicians, stating that physician payment amounts "do not vary based on underlying economic conditions, and they are not expected to keep pace with the average rate of physician cost increases. These rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. … If the health sector cannot transition to more efficient care delivery and if the provider reimbursement rates paid by commercial insurers continue to be based on the same negotiated process, then the availability, particularly with respect to physician services, and quality of health care received by Medicare beneficiaries will, under current law, fall over time compared to that received by those with private health insurance." Again, this mirrored the observations from the 2023 and 2024 Medicare Trustees Reports, but nothing has been done to address the concerns on a long-term basis.

The Medicare Patient Access and Practice Stabilization Act of 2025 was introduced in January. It would reverse the 2.83% cut to the 2025 Medicare Physician Fee Schedule and add an additional 2% update through the end of 2025. The Senate version would also reverse the 2.83% cut for 2025 and add an 8.51% increase for services rendered from June through December 2025 to take into account inflationary increases in practice operating expenses. While the House version received bipartisan support, no action has been taken.

As discussed previously, the tax and spending legislation enacted into law July 4 provided a one-year 2.5% increase to the 2026 conversion factor. However, without further action this temporary fix will be removed from the calculation in subsequent years, leading to yet another reimbursement decline. The AMA highlights that there is a disparity in how providers have been treated as it relates to reimbursement updates, with physicians being the only ones who did not receive a payment update in 2025:



Industry groups like AMA continue to push for a long-term solution. Ideally this would include a baseline update to recognize the increase in practice costs that has occurred while physician reimbursement has lagged, as well as ongoing annual inflationary updates tied to the MEI similar to what MedPAC has recommended in recent years.

JTaylor's healthcare consulting team includes a group of professionals who specialize in physician practice dynamics, as well as individuals who focus on strategy and operations. If you are interested in finding out how the 2026 MPFS Proposed Rule would impact reimbursement for your practice, with its unique services and payer mix, we can help. Our team can also support you from a strategic perspective as you plan for impact of these proposed rules, including the impact of reduced reimbursement. To find out more or to contact a member of our team, please visit our website. We will continue to monitor developments related to legislative activity impacting the healthcare industry.

Sources:

- Proposed Rule - *Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program.* [CMS-1832-P]. 90 Fed. Reg. 32352 (16 July 2025).
- Fact Sheet: 2026 MPFS Proposed Rule – Center for Medicare and Medicaid Services (CMS). *Fact Sheet: Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) Proposed Rule (CMS-1832-P).* (14 July 2025).
- Fact Sheet: 2026 MPFS Proposed Rule – MSSP Proposals– CMS. *Calendar Year (CY) 2026 Medicare Physician Fee Schedule Proposed Rule (CMS-1832-P) Medicare Shared Savings Program Proposals.* (14 July 2025).
- MedPAC 2025 Report to Congress – Medicare Payment Advisory Commission. *Report to the Congress: Medicare Payment Policy*. (13 March 2025.)
- 2025 Medicare Trustees Report – The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. *2025 Annual Report of The Boards of Trustees of The Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.* (18 June 2025.)
- *Physicians will see Medicare payments rise in 2026* – American Medical Association (AMA). (21 July 2025).
- AMA: Payment Reform – AMA.