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CY 2026 Medicare Physician Fee Schedule Final Rule

The Centers for Medicare and Medicaid Services (CMS) recently released the Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) Final Rule, which includes an increase from the 2025 conversion factor – largely due to the statutorily required 2.5% increase contained in the tax and spending legislation passed by Congress earlier this year. The rule finalizes most of the proposals released this summer. Below is a short recap of the key provisions, and what changed from the proposed rule. Additional background regarding various provisions can be found in our article on the CY 2026 Medicare PFS Proposed Rule.

KEY PROVISIONS

- *Increase of 3.8% (Qualifying APM Conversion Factor) or 3.3% (Non-Qualifying APM Conversion Factor) from 2025 rate (before sequestration).*
- *Efficiency adjustment of 2.5% to decrease Work RVUs for non-time-based services.*
- *Significant reduction in PE RVUs for services provided 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

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 “One Big Beautiful Bill Act” included a 2.5% increase to the conversion factor for 2026. The conversion factors for 2026 were calculated as follows, which are slightly lower than the proposed rates due to a minor change in the budget neutrality adjustment:

	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	0.49%	0.49%
CY 2026 2.5% Increase	2.50%	2.50%
CY 2026 Conversion Factor	**$ 33.57**	**$ 33.40**

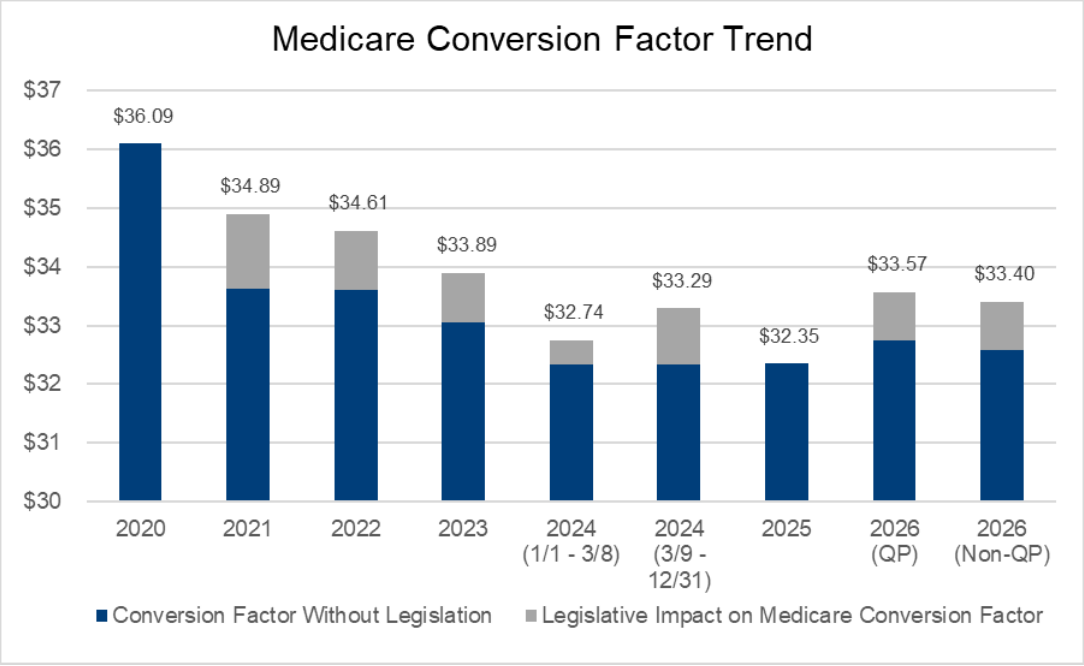
Derived from Tables DB-3 and DB-4 of the final rule.

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	0.49%	0.49%
CY 2026 2.5% Increase	2.50%	2.50%
CY 2026 Anesthesia Fee Schedule PE and Malpractice Adjustment	-2.30%	-2.30%
CY 2026 Conversion Factor	**$ 20.60**	**$ 20.50**

Derived from Tables DB-5 and DB-6 of the final rule.

Significant volatility in the conversion factor began in 2021 in response to substantial increases in Work RVUs (wRVUs) for many office visits and other 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 by legislative action. Even with legislative intervention the conversion factor has consistently remained below the 2020 level, with even the higher QP rate for 2026 around 7% lower than the 2020 conversion factor. Sequestration reductions further exacerbate the problem. Meanwhile, inflation has increased the cost of operating a medical practice.



Other Key Provisions

RVU Changes

Work Component – Despite concerns raised by commenters, CMS finalized the 2.5% efficiency adjustment for 2026 as proposed. This adjustment will decrease Work RVUs for non-time-based services with corresponding updates to the intraservice portion of physician time inputs for non-time-based services. CMS did, however, add some new exceptions. Certain time-based codes, services on the CMS telehealth list, and new codes established for 2026 will not be subject to the efficiency adjustment in 2026.

Practice Expense (PE) Component – CMS finalized its controversial proposal to significantly reduce the PE RVUs for services provided in a facility setting. Specifically, the portion of the facility PE RVUs allocated to facility PE RVUs will be half the amount allocated to nonfacility PE RVUs beginning in 2026. This will drastically reduce reimbursement for hospital-based services. Additionally, utilized "data from auditable, routinely updated hospital data" to set 2026 rates for radiation treatment services and certain remote monitoring services.

Malpractice (MP) Component – As proposed, CMS utilized updated premium data from state insurance rate filings to calculate 2026 MP RVUs, rescaled to achieve budget neutrality.

Telehealth Services – The rule removes the distinction of services as either "provisional" or "permanent" and instead considering all services on the Medicare Telehealth Services List permanent. Additionally, frequency limitations for subsequent inpatient visits (CPT Codes 99231-99233), subsequent nursing facility visits (CPT Codes 99307-99310), and critical care consultation services (HCPCS Codes G0508-G0509) are permanently eliminated. CMS also permanently adopted 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.

While CMS did not propose to extend the current policy that has allowed teaching physicians to have a virtual presence during the provision of telehealth services, the final rule changes this position. In response to comments regarding how pervasive this practice has become, CMS will permanently allow teaching physicians to have a virtual presence in teaching settings for services furnished virtually.

Evaluation/Management Add-On Codes – As proposed, the final rule allows G2211 to be applied to home and residence evaluation and management (E/M) visits (CPT codes 99341-99345 and 99347-99350) as well as office or outpatient E/M visits.

Advanced Primary Care Management – Consistent with the proposal, the final rule creates 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, removing remove the time-based requirements of the existing behavioral health integration (BHI) and Psychiatric Collaborative Care Model (CoCM) codes. The add-on codes may be provided by auxiliary personnel under the general supervision of the billing practitioner.

Behavioral Health Services – The final rule, as proposed, allows payment for approved DMHT devices used to treat Attention Deficit Hyperactivity Disorder (ADHD). The rule clarifies that while the patient must have a mental health condition diagnosis, the billing practitioner does not have to be the one who made the diagnosis. Additionally, the 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.

The proposed rule sought to remove HCPCS Code G0136 (administration of a standardized, evidence-

based social determinants of health risk assessment tool), under the premise that the resource costs are already accounted for in existing codes. However, in response to comments received, CMS opted instead to retain G0136 and change the descriptor to "administration of a standardized, evidence-based assessment of physical activity and nutrition, 5-15 minutes, not more often than every 6 months." This will allow practitioners to assess risks related to the root cause of many chronic conditions. It is not intended to be a routine screening but in provided in response to suspected patient needs in these areas. The code will also remain on the telehealth services list.

Payment for Skin Substitutes – As proposed, CMS will 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 rule creates site-neutral payment for skin substitutes under the PFS and the OPPS. Accordingly, payment rates for skin substitutes in each of three FDA categories will use the rates established under the OPPS to derive the PE and MP RVUs to be applied to existing HCPCS codes to achieve similar reimbursement under the PFS. For 2026, a single rate will apply to all three categories.

Ambulatory Specialty Model – Despite a variety of concerns raised in comments, including calls to make the model voluntary, CMS finalized a new Ambulatory Specialty Model (ASM), which will begin in 2027 and run for five performance years. This model will be mandatory, as proposed, and will focus on care provided by specialists involved in treating heart failure and lower back pain.

Medicare Shared Savings Program – CMS finalized its proposal to reduce the length of time ACOs can participate in a one-sided risk model from seven performance years to five, effective for agreement periods beginning on or after January 1, 2027. The final rule also implements the proposed changes relating to the 5,000-beneficiary threshold. As proposed, health equity adjustments will be removed from ACO quality scores beginning in performance year 2026. Additionally, beginning in performance year 2025, the definition of a beneficiary eligible for Medicare Clinical Quality Measures is modified to 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.

Specialty Impact

Since the final rule adopts all the significant changes reflected in the proposed rule, the expected impacts on various specialties have not changed. Many office-based specialties are expected to see significant increases in RVUs related changes to the indirect PE allocation, while hospital-based services will see substantial 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 increases in payment as well as the largest projected decreases in payment, split across the site of service differential."

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, will 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. According to CMS, "almost all specialties will experience no more than +1 or -1 percent change in RVUs as a result of this proposed policy, although the effect on individual services may be greater."

Non-Facility Impact – 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%. Only a few specialties (dermatology, pathology, chiropractic, physical and occupational therapy, radiation oncology / radiation therapy, and independent labs) are expected to experience a decline in Total RVUs, ranging from 1% to 2%:

Facility Impact – **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%. Specialties expected to see the most significant declines include chiropractic (-17%), dermatology and audiology (-14%), ophthalmology and optometry (-13%), otolaryngology and rheumatology (-12%), oral/maxillofacial surgery, hematology/oncology, and allergy/immunology (-11%), and obstetrics/gynecology, plastic surgery, urology, endocrinology, and gastroenterology (-10%).

Provider Compensation Considerations – Importantly, 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. Changes may be required for financial stability of physician practices and to ensure compensation arrangements remain commercially reasonable.

Industry Response

In its response to the final rule, the American Medical Association (AMA) noted that certain provisions "may have unintended consequences." First and foremost, there remains significant concern that the one-year conversion factor boost leaves physicians vulnerable to future reimbursement that does not keep pace with rising operating costs. The AMA is also concerned about the significant disparities in reimbursement based on site of service resulting from the change in methodology for PE RVUs. According to its statement, "these cuts fail to reflect true resource costs incurred by physician practices in the facility setting" and thus "risk reducing competition and encouraging consolidation." The AMA also offered a scathing response to implementation of the efficiency adjustment, noting that it "would reduce payment for more than 7,000 physician services – 95% of all services provided by physicians." Still, certain provisions did receive praise from the AMA – specifically, the removal of frequency limits on certain telehealth services and provisions allowing virtual physician supervision.

The Medical Group Management Association (MGMA) noted that the rule "includes many policies that will threaten the financial sustainability of medical groups." Specifically, "medical groups have had to deal with a 2.83% cut to the Medicare conversion factor for all of 2025, and the 2026 conversion factors are barely an increase over 2024 payment levels. This does not remedy previous cuts that medical groups have absorbed…, nor does it address potential future cuts resulting from budget neutrality." The MGMA calls on Congress to pass legislation that would provide a long-term solution to "systemic inadequacies in the payment structure."

JTaylor's healthcare consulting team includes professionals who specialize in physician practice dynamics, as well as strategy and operations. If you are interested in finding out how the 2026 Medicare Physician Fee Schedule Final Rule will impact your practice, we can help. Our team can also support you from a strategic perspective as you plan for impact of the reimbursement changes. 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:

- Final Rule - *Calendar Year 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-F]. (31 October 2025).
- Fact Sheet: 2026 MPFS Final Rule – Center for Medicare and Medicaid Services (CMS). *Fact Sheet: Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) Final Rule (CMS-1832-F).* (31 October 2025).

- Fact Sheet: 2026 MPFS Proposed Rule – MSSP Changes– CMS. *Calendar Year (CY) 2026 Medicare Physician Fee Schedule Final Rule (CMS-1832-F) Medicare Shared Savings Program Changes.* (31 October 2025).
- Ambulatory Specialty Model (ASM) – CMS.
- AMA Press Release – American Medical Association (AMA). *AMA comments on 2026 Medicare Fee Schedule.* (2 November 2025).
- MGMA Press Release – Medical Group Management Association (MGMA). *MGMA Statement on 2026 Medicare Physician Fee Schedule Final Rule.* (31 October 2025).