Issue Brief

FEDERAL ISSUE BRIEF

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

July 21, 2025

Proposed 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 proposed rule to update the Medicare Physician Fee Schedule (MPFS) for CY 2026.

A copy of the rule has been published by the ***Federal Register*** office, however, the 1,803-page display copy is still currently available at: https://public-inspection.federalregister.gov/2025-13271.pdf.

A comment period ending 60 days after filing (July 14) is provided.

Comments

MPFS regulations are long and complex documents. Given CMS' propensity for rule's without a reasonable table of contents it is not surprising that once again, such is totally missing. An inexcusable item considering this rule's length. Sorry to sound like CMS by repeating much unneeded and unnecessary information.

Trying to follow the material's outline is extremely difficult since CMS does not number section headings with previous headings.

There are numerous errors in the organizational paragraphs. For example, CMS cites Outpatient Therapy Services and KX Modifier Thresholds (as Section II.H.) We could not locate such section.

Addenda Available Only Through the Internet on the CMS Website:

The PFS Addenda along with other supporting documents and tables referenced in the rule are available on the CMS website at: https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1832-p

While there is no table of contents, CMS says the proposal is addressing the following items.

- Determination of PE RVUs (section II.B.) (Page 10)
- Potentially Misvalued Services Under the PFS (section II.C.) (Page 70)
- Payment for Medicare Telehealth Services Under Section 1834(m) of the Act (section II.D.) (Page 105)
- Valuation of Specific Codes (section II.E.) (Page 135)
- Evaluation and Management (E/M) Visits (section II.F.) (Page 296)

- Enhanced Care Management (section II.G.) (Page 299)
- Outpatient Therapy Services and KX Modifier Thresholds (section II.H.) (NONE)
- Advancing Access to Behavioral Health Services (section II.I.) (Page 311)
- Provisions on Medicare Parts A and B Payment for Dental Services Inextricably Linked to Specific Covered Services (section II.J.) (Page 336)
- Payment for Skin Substitutes (section II.K.) (Page 339)
- Strategies for Improving Global Surgery Payment Accuracy (section II.L.) (Page 372)
- Determination of Malpractice Relative Value Units (RVUs) (section II.M.) (Page 380)
- Geographic Practice Cost Indices (GPCIs) (section II.N.) (Page 393)
- Drugs and Biological Products Paid Under Medicare Part B (section III.A.) (Page 415)
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (section III.B.) (Page 447)
- Ambulatory Specialty Model (ASM) (section III.C.) (Page 473)
- Medicare Diabetes Prevention Program (MDPP) (section III.D.) (Page 685)
- Medicare Prescription Drug Inflation Rebate Program (section III.I.) (Page 707)
- Medicare Shared Savings Program (section III.F.) (Page 745)
- Changes to the Regulations Associated with the Ambulance Fee Schedule (section III.G.) (Page 893)
- Updates to the Quality Payment Program and Medicare Promoting Interoperability Program (section IV.) (Page 893)
- Collection of Information Requirements (section V.) (Page 1,113)
- Responses to Comments (section VI.) (Page 1,166)
- Regulatory Impact Analysis (section VII.) (Page 1,167)

The material that follows is based on the rule as well as CMS' fact sheets accompanying the proposal.

PROPOSED CY 2026 PFS RATE SETTING AND CONVERSION FACTORS

Accounting Statement: Classification of Estimated Expenditures (Page 1,282)

Category	Transfers
CY 2026 Annualized Monetized Transfers	Estimated increase in expenditures of $0.4 billion for PFS CF update.
From Whom To Whom?	Federal Government to physicians, other practitioners and providers and suppliers who receive payment under Medicare.

Accounting Statement: Classification of Estimated Costs, Transfer, and Savings (Page 1,670)

Category	Transfers
CY 2026 Annualized Monetized Transfers of beneficiary cost coinsurance.	-$0.4 Billion
From Whom To Whom?	Beneficiaries to Federal Government.

The material that follows, with the exception of the payment updates and conversion factors, basically follows the organization of the rule. Note, not all items are addressed.

PROPOSED PAYMENT PROVISIONS OF THE CY 2026 PFS RULE

Payment Updates and Conversion Factors (CF) (Page 1,187)

As required by section 1848(d)(1)(A) of the Act, beginning in CY 2026, there will be two separate conversion factors (CFs): one for items and services furnished by a qualifying Alternative Payment Model (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.

CMS estimates the proposed CY 2026 PFS qualifying APM CF to be **33.5875** which reflects a 0.55 percent positive budget neutrality adjustment required under section 1848(c)(2)(B)(ii)(II) of the Act and a 0.75 percent update adjustment factor specified under section 1848(d)(20) of the Act.

CMS estimates the proposed CY 2026 PFS nonqualifying APM CF to be **33.4209** which reflects a 0.55 percent positive budget neutrality adjustment required under section 1848(c)(2)(B)(ii)(II) of the Act and the 0.25 percent update adjustment factor specified under section 1848(d)(20) of the Act.

CMS estimates the proposed CY 2026 anesthesia qualifying APM CF to be **20.6754** and the proposed CY 2026 anesthesia nonqualifying APM CF to be **20.5728**, reflecting the same overall PFS adjustments with the addition of anesthesia-specific PE and MP adjustments.

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	0.55 percent (1.0055)	
CY 2026 2.50 Percent Increase	2.50 percent (1.0250)	
CY 2026 Conversion Factor		**33.5875**

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 (1.0045)	
CY 2026 2.50 Percent Increase	2.50 percent (1.0250)	
CY 2026 Conversion Factor		**33.4209**

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	0.55 percent (1.0045)	
CY 2026 2.50 Percent Increase	2.50 percent (1.0250)	
CY 2026 Anesthesia Fee Schedule Practice Expense and Malpractice Adjustment	-2.00 percent (0.9800)	
CY 2026 Conversion Factor		**20.6754**

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	0.55 percent (1.0045)	
CY 2026 2.50 Percent Increase	2.50 percent (1.0250)	
CY 2026 Anesthesia Fee Schedule Practice Expense and Malpractice Adjustment	-2.00 percent (0.9800)	
CY 2026 Conversion Factor		**20.5728**

Impact

The table below shows the payment impact by specialty. (Page 1,191) Note, this year's version is split between facility and non-facility locations.

Proposed 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	$212	0%	7%	0%	7%
	Non-Facility	$204	0%	8%	0%	8%
	Facility	$8	0%	-11%	0%	-11%
ANESTHESIOLOGY	TOTAL	$1,595	0%	-1%	0%	-1%
	Non-Facility	$310	0%	7%	0%	7%
	Facility	$1,285	0%	-3%	0%	-3%
AUDIOLOGIST	TOTAL	$75	0%	0%	0%	-1%
	Non-Facility	$72	0%	0%	0%	0%
	Facility	$3	0%	-13%	0%	-14%
CARDIAC SURGERY	TOTAL	$150	-1%	-3%	0%	-3%
	Non-Facility	$27	0%	6%	0%	6%
	Facility	$124	-1%	-5%	0%	-5%
CARDIOLOGY	TOTAL	$5,995	0%	1%	0%	1%
	Non-Facility	$3,747	0%	5%	0%	5%
	Facility	$2,248	-1%	-6%	0%	-7%
CHIROPRACTIC	TOTAL	$626	-1%	-1%	0%	-2%
	Non-Facility	$624	-1%	-1%	0%	-2%
	Facility	$2	-1%	-15%	0%	-17%

(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
CLINICAL PSYCHOLOGIST	TOTAL	$727	3%	2%	-1%	3%
	Non-Facility	$589	3%	3%	-1%	5%
	Facility	$138	3%	-5%	-1%	-3%
CLINICAL SOCIAL WORKER	TOTAL	$1,011	4%	2%	-1%	4%
	Non-Facility	$871	4%	3%	-1%	6%
	Facility	$140	4%	-5%	-1%	-2%
COLON AND RECTAL SURGERY	TOTAL	$146	-1%	-2%	0%	-2%
	Non-Facility	$53	0%	7%	0%	7%
	Facility	$93	-1%	-7%	0%	-7%
CRITICAL CARE	TOTAL	$336	0%	-5%	0%	-4%
	Non-Facility	$54	0%	7%	0%	7%
	Facility	$281	0%	-7%	1%	-7%
DERMATOLOGY	TOTAL	$3,898	0%	-1%	0%	-2%
	Non-Facility	$3,757	0%	-1%	0%	-1%
	Facility	$142	-1%	-13%	0%	-14%
DIAGNOSTIC TESTING FACILITY	TOTAL	$913	0%	0%	0%	0%
	Non-Facility	$911	0%	0%	0%	0%
	Facility	$2	-1%	0%	1%	-1%
EMERGENCY MEDICINE	TOTAL	$2,408	0%	-3%	1%	-1%
	Non-Facility	$217	0%	7%	0%	7%
	Facility	$2,191	0%	-4%	1%	-2%
ENDOCRINOLOGY	TOTAL	$526	0%	2%	0%	3%
	Non-Facility	$425	0%	6%	0%	6%
	Facility	$101	0%	-11%	0%	-10%

(A) Specialty	(B) Total: Non-Facility/Facility	(C) Allowed Charges (mil)	(D) Impact of Work RVU Changes	(E) Impact of PE RVU Changes	(F) Impact of MP RVU Changes	(G) Combined Impact
FAMILY PRACTICE	TOTAL	$5,426	0%	3%	0%	3%
	Non-Facility	$4,367	0%	6%	0%	6%
	Facility	$1,059	0%	-9%	0%	-9%
GASTROENTEROLOGY	TOTAL	$1,391	0%	-3%	0%	-4%
	Non-Facility	$504	0%	6%	0%	6%
	Facility	$887	-1%	-9%	0%	-10%
GENERAL PRACTICE	TOTAL	$372	0%	3%	0%	3%
	Non-Facility	$298	0%	5%	0%	6%
	Facility	$73	0%	-8%	0%	-7%
GENERAL SURGERY	TOTAL	$1,524	0%	-3%	0%	-3%
	Non-Facility	$447	0%	6%	0%	6%
	Facility	$1,078	-1%	-7%	0%	-7%
GERIATRICS	TOTAL	$199	1%	1%	0%	1%
	Non-Facility	$127	1%	7%	0%	8%
	Facility	$72	0%	-10%	0%	-9%
HAND SURGERY	TOTAL	$260	0%	0%	0%	-1%
	Non-Facility	$141	0%	5%	0%	5%
	Facility	$119	-1%	-7%	0%	-7%
HEMATOLOGY/ONCOLOGY	TOTAL	$1,537	0%	0%	0%	0%
	Non-Facility	$984	0%	6%	0%	6%
	Facility	$552	0%	-11%	0%	-11%
INDEPENDENT LABORATORY	TOTAL	$545	0%	-1%	0%	-1%
	Non-Facility	$531	0%	-1%	0%	-1%
	Facility	$14	-1%	-1%	0%	-3%
INFECTIOUS DISEASE	TOTAL	$537	0%	-7%	0%	-6%
	Non-Facility	$85	0%	7%	0%	7%
	Facility	$452	0%	-10%	0%	-9%

(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
INTERNAL MEDICINE	TOTAL	$9,378	0%	-2%	0%	-1%
	Non-Facility	$4,649	0%	6%	0%	6%
	Facility	$4,729	0%	-9%	0%	-8%
INTERVENTIONAL PAIN MGMT	TOTAL	$825	0%	3%	0%	3%
	Non-Facility	$645	0%	7%	0%	6%
	Facility	$180	-1%	-8%	0%	-9%
INTERVENTIONAL RADIOLOGY	TOTAL	$437	-1%	2%	0%	2%
	Non-Facility	$259	0%	7%	0%	7%
	Facility	$178	-2%	-6%	1%	-7%
MULTISPECIALTY CLINIC/OTHER PHYS	TOTAL	$155	0%	-2%	0%	-2%
	Non-Facility	$77	0%	5%	0%	5%
	Facility	$78	0%	-9%	0%	-9%
NEPHROLOGY	TOTAL	$1,623	0%	0%	0%	1%
	Non-Facility	$971	1%	6%	0%	7%
	Facility	$653	0%	-9%	0%	-9%
NEUROLOGY	TOTAL	$1,312	0%	1%	0%	1%
	Non-Facility	$833	0%	6%	0%	6%
	Facility	$480	0%	-9%	0%	-9%
NEUROSURGERY	TOTAL	$682	-1%	-4%	0%	-5%
	Non-Facility	$115	0%	6%	0%	6%
	Facility	$567	-1%	-6%	0%	-7%
NUCLEAR MEDICINE	TOTAL	$47	-1%	0%	0%	-1%
	Non-Facility	$21	0%	2%	0%	1%
	Facility	$27	-1%	-2%	0%	-3%
NURSE ANES / ANES ASST	TOTAL	$1,060	0%	-2%	0%	-1%

(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
	Non-Facility	$20	0%	9%	0%	10%
	Facility	$1,040	0%	-2%	0%	-1%
NURSE PRACTITIONER	TOTAL	$7,704	0%	0%	0%	1%
	Non-Facility	$5,074	0%	5%	0%	5%
	Facility	$2,630	0%	-9%	0%	-9%
OBSTETRICS/GYNECOLOGY	TOTAL	$540	0%	-1%	0%	-1%
	Non-Facility	$369	0%	4%	0%	4%
	Facility	$171	-1%	-10%	1%	-10%
OPHTHALMOLOGY	TOTAL	$4,444	0%	-1%	0%	-2%
	Non-Facility	$3,143	0%	3%	0%	3%
	Facility	$1,301	-1%	-12%	0%	-13%
OPTOMETRY	TOTAL	$1,356	0%	2%	0%	2%
	Non-Facility	$1,293	0%	3%	0%	3%
	Facility	$62	0%	-13%	0%	-13%
ORAL/MAXILLOFACIAL SURGERY	TOTAL	$44	0%	1%	0%	0%
	Non-Facility	$33	0%	4%	0%	4%
	Facility	$11	-1%	-10%	0%	-11%
ORTHOPEDIC SURGERY	TOTAL	$3,271	0%	-2%	0%	-3%
	Non-Facility	$1,446	0%	5%	0%	5%
	Facility	$1,825	-1%	-8%	0%	-9%
OTHER	TOTAL	$54	0%	0%	0%	0%
	Non-Facility	$43	0%	3%	0%	3%
	Facility	$11	0%	-9%	0%	-9%
OTOLARNGOLOGY	TOTAL Non-Facility	$892	0%	3%	0%	3%
	Facility	$232	-1%	-11%	0%	-12%
PATHOLOGY	TOTAL	$1,169	-1%	-1%	0%	-2%

(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
	Non-Facility	$620	-1%	-1%	0%	-2%
	Facility	$549	-1%	-2%	0%	-3%
PEDIATRICS	TOTAL	$53	0%	2%	0%	2%
	Non-Facility	$35	0%	6%	0%	7%
	Facility	$19	0%	-8%	0%	-7%
PHYSICAL MEDICINE	TOTAL	$1,136	0%	-2%	0%	-2%
	Non-Facility	$540	0%	6%	0%	6%
	Facility	$596	0%	-9%	0%	-9%
PHYSICAL/OCCUPATIONAL THERAPY	TOTAL	$6,183	0%	-1%	0%	-1%
	Non-Facility	$6,183	0%	-1%	0%	-1%
	Facility	$0	-1%	-6%	0%	-7%
PHYSICIAN ASSISTANT	TOTAL	$3,926	0%	0%	0%	1%
	Non-Facility	$2,716	0%	4%	0%	4%
	Facility	$1,211	0%	-8%	0%	-8%
PLASTIC SURGERY	TOTAL	$286	-1%	-3%	0%	-4%
	Non-Facility	$127	0%	4%	0%	4%
	Facility	$159	-1%	-9%	0%	-10%
PODIATRY	TOTAL	$1,858	0%	2%	0%	2%
	Non-Facility	$1,648	0%	3%	0%	3%
	Facility	$209	0%	-8%	0%	-9%
PORTABLE **X-**RAY SUPPLIER	TOTAL	$79	0%	-1%	0%	-1%
	Non-Facility	$76	0%	-1%	0%	-1%
	Facility	$3	-1%	-1%	0%	-2%
PSYCHIATRY	TOTAL	$825	1%	0%	0%	0%
	Non-Facility	$499	1%	6%	0%	6%

(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	$326	1%	-9%	0%	-9%
PULMONARY DISEASE	TOTAL	$1,227	0%	-2%	0%	-1%
	Non-Facility	$536	0%	7%	0%	7%
	Facility	$691	0%	-8%	0%	-8%
RADIATION ONCOLOGY AND RADIATION THERAPY CENTERS	TOTAL	$1,502	-1%	-1%	0%	-1%
	Non-Facility	$1,006	0%	-1%	0%	-1%
	Facility	$496	-1%	-1%	0%	-2%
RADIOLOGY	TOTAL	$4,492	-1%	-1%	0%	-2%
	Non-Facility	$1,964	0%	1%	0%	1%
	Facility	$2,528	-2%	-2%	1%	-3%
RHEUMATOLOGY	TOTAL	$523	0%	4%	0%	4%
	Non-Facility	$469	0%	6%	0%	6%
	Facility	$54	0%	-12%	0%	-12%
THORACIC SURGERY	TOTAL	$288	-1%	-3%	0%	-3%
	Non-Facility	$55	0%	8%	0%	8%
	Facility	$233	-1%	-5%	0%	-5%
UROLOGY	TOTAL	$1,600	0%	1%	0%	0%
	Non-Facility	$1,123	0%	5%	0%	5%
	Facility	$477	-1%	-9%	0%	-10%
VASCULAR SURGERY	TOTAL	$929	0%	5%	0%	5%
	Non-Facility	$656	0%	9%	0%	9%
	Facility	$273	0%	-6%	1%	-6%
TOTAL	**TOTAL**	**$90,545**	**0%**	**0%**	**0%**	**0%**
	Non-Facility	$57,482	0%	4%	0%	4%
	Facility	$33,064	0%	-7%	0%	-7%

II. PROVISIONS OF THE PROPOSED RULE

DETERMINATION OF PE RVUS *(Section II.B.)* (Page 10)

Practice expense (PE) is the portion of the resources used in furnishing a service that reflects the general categories of physician and practitioner expenses, such as office rent and personnel wages, but excluding malpractice (MP) expenses. As required by section 1848(c)(2)(C)(ii) of the Act, CMS uses a resource-based system for determining PE RVUs for each physicians' service. CMS develops PE RVUs by considering the direct and indirect practice resources involved in furnishing each service.

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

Facility and Non-facility Costs (Page 15)

For procedures that can be furnished in a physician's office, as well as in a facility setting, where Medicare makes a separate payment to the facility for its costs in furnishing a service, CMS establishes 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 is proposing a modification in the allocation of indirect PE.

CMS is proposing to update the price of 35 supplies and seven 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 proposed updated prices are listed in the valuation of specific codes section of the preamble under Table 6, CY 2026 Invoices Received for Existing Direct PE Inputs. (Page 35)

Due to several limitations with the data, CMS says it is not proposing to implement the PE/HR data or cost shares from the AMA's PPI and Clinician Practice Information (CPI) Survey data for 2026 rate setting. Specifically, CMS' concerns focus on small sample sizes and sampling variation, low response rates and representativeness, potential measurement error, and incomplete data submission. CMS modeled estimated payment impacts of the data's implementation, which it included in the proposed rule for public comment and potential consideration in future rulemaking.

While CMS is not proposing to incorporate the PPI and CPI Survey data into the PFS rate setting, CMS is proposing significant updates to its PE methodology. Specifically, CMS is proposing to recognize greater indirect costs for practitioners in office-based settings compared to facility settings. The original allocation methodologies assumed physicians maintained separate practice locations even if they furnished some care in hospitals. Since the methodologies were established decades ago, there has been a steady decline in the number of physicians working in private practice, with a corresponding rise in physician employment by hospitals and health systems. Therefore, CMS believes that the allocation of indirect costs for PE RVUs in the facility setting at the same rate as the non-facility setting may no longer reflect contemporary clinical practice.

CMS also is proposing to utilize data from auditable, routinely updated hospital data (i.e., from the Medicare Outpatient Prospective Payment System (OPPS)) to set relative rates and inform its costs assumptions for some technical services paid under PFS. For CY 2026, CMS is proposing to use this data in setting rates for radiation treatment services, and for some remote monitoring services.

POTENTIALLY MISVALUED SERVICES UNDER THE PFS (SECTION II.C.) (Page 70)

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 says it received 11 requests concerning potentially misvalued codes (PMVC). The nominations are as follows: CMS is not proposing to nominate these codes as potentially misvalued.

1) Maxillofacial Prosthetic Services (CPT codes 21076, 21077, 21079, 21080, 21081, 21082, 21083, 21084, 21085, 21086, 21087) (Page 76)
2) Supervision of preparation and provision of antigens for allergen immunotherapy (CPT codes 95145, 95146, 95147, 95148, 95149). (Page 79)
3) Electronic analysis of implanted neurostimulator pulse generator/transmitter (CPT codes 95970, 95976, 95977). (Page 82)
4) Excimer laser treatment for psoriasis (CPT codes 96920, 96921, 96922) (Page 84)
5) Optical coherence tomography (OCT) of retina (CPT code 0605T) (Page 90)
6) Mechanical separation of plasma from blood (CPT code 36514). (Page 92)
7) Remote interrogation device evaluation (CPT code 93296) (Page 95)
8) Fine Needle Aspiration (FNA) (CPT codes 10021, 10004, 10005, 10006) (Page 98)
9) Nasal sinus irrigation (CPT codes 31000 and 31002) (Page 100)
10) Portable X-ray Services (HCPCS codes R0070, R0075) (Page 101)
11) Cryoablation Therapy to Treat Postoperative Pain (Page 103)

PAYMENT FOR MEDICARE TELEHEALTH SERVICES UNDER SECTION 1834(M) OF THE ACT (SECTION II.D.) (Page 105)

CMS is proposing, beginning for the CY 2026 Medicare Telehealth Services List, to revise the 5-step review process for reviewing requests to the Medicare Telehealth Services List. (Page 107)

CMS is proposing to 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 our review criteria and retain Steps 1 through 3.

Under this proposal, 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. (Page 107)

Requests to Add Services to the Medicare Telehealth Services List for CY 2026 (Page 113)

The proposal's table 8 identifies requests 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
	98003	Synch audio-video new hi 60

Category	HCPCS	Short Descriptor
	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 the following from the above table. (Page 121)

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 proposing to permanently remove frequency limitations via telehealth for the following codes relating to Subsequent Inpatient Visits, Subsequent Nursing Facility Visits, and Critical Care Consultation Services: (Page 123)

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 125)

CMS is proposing to revise 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. (Page 129)

Proposed Changes to Teaching Physicians' Billing for Services Involving Residents with Virtual Presence (Page 130)

CMS says it now believes that permitting Medicare payment to continue for this Public Health Emergency (PHE) flexibility is no longer necessary. This proposal to not extend the current policy to allow teaching physicians to have a virtual presence for services furnished virtually aligns with CMS statutory obligations under section 1842(b)(7)(A)(i)(I) of the Act, which requires teaching physicians to provide appropriate oversight and personal involvement in resident-furnished services for which Medicare payment is sought.

Further, CMS says it will maintain flexibility for services provided outside MSAs. In these rural settings, teaching physicians may continue utilizing audio/video real-time communications technology to fulfill the presence requirement, provided they maintain active, real-time observation and participation in the service. This geographical distinction aligns with CMS' longstanding commitment to enhancing Medicare beneficiary access to covered services in rural areas. (Page 133)

Telehealth Originating Site Facility Fee Payment Amount Update (Page 134)

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

VALUATION OF SPECIFIC CODES (SECTION II.E.) (Page 135)

The proposed work RVUs, work time and other payment information for all CY 2026 payable codes are available on the CMS website at: https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1832-p

Proposed Efficiency Adjustment (Page 142)

CMS is proposing to apply an efficiency adjustment to the work RVU and corresponding intraservice portion of physician time of 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.

CMS is proposing to use a sum of the past five years of the Medicare Economic Index (MEI) productivity adjustment percentage to calculate this efficiency adjustment. The MEI productivity adjustment is calculated by the CMS Office of the Actuary (OACT) each year, and CMS is proposing a look-back period of five years, which would result in a proposed efficiency adjustment of -2.5% for CY 2026.

Proposed Efficiency Adjustment for CY 2026

CY	MEI Productivity Adjustment (%)
2022	0.2
2023	0.5
2024	0.4
2025	0.6
2026*	0.8*
Efficiency Adjustment	**2.5%**

* Proposed, will be updated for CY 2026 final rule

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.

1	Tympanostomy (CPT code 0583T) (Page 162)
2	Temporary Female Intraurethral Valve-Pump (CPT codes 0596T and 0597T) (Page 163)
3	Limb Lengthening-Shortening – Femur (CPT codes 27465, 27466, 27468, and 27XX0) (Page 164)
4	Limb Lengthening-Shortening – Tibia (CPT codes 27715 and 27XX1) (Page 164)
5	Arthrodesis Great Toe (CPT codes 28750 and 28755) (Page 165)
6	Closure Left Atrial Appendage with Endocardial Implant (CPT code 33340) (Page 166)
7	Thoracic Branch Endograft Services (CPT codes 33880, 33881, 33883, 33886, 33XX2, and 35XX1) (Page 166)
8	Lower Extremity Revascularization (CPT codes 37XX1, 37X02, 37X03, 37X04, 37X05, 37X06, 37X07, 37X08, 37X09, 37X10, 37X11, 37X12, 37X13, 37X14, 37X15, 37X16, 37X17,37X18, 37X19, 37X20, 37X21, 37X22, 37X23, 37X24, 37X25, 37X26, 37X27, 37X28, 37X29, 37X30, 37X31, 37X32, 37X33, 37X34, 37X35, 37X36, 37X37, 37X38, 37X39, 37X40, 37X41, 37X42, 37X43, 37X44, 37X45, and 37X46) (Page 172)
9	Irreversible Electroporation of Tumors (CPT codes 4001X and 5XX11) (Page 180)
10	Endoscopic Sleeve Gastroplasty (CPT code 4XX04) (Page 181)
11	Transurethral Robotic-assisted Resection of Prostate (CPT codes 52500, 52601, 52630, 52648, 52649, and 52XX1) (Page 182)

12	Cystourethroscopy (CPT code 52XX2) (Page 185)
13	Prostate Biopsy Services (CPT codes 55705, 55706, 5XX00, 5XX01, 5XX02, 5XX03, 5XX04, 5XX07, 5XX08, 5XX09, 5XX10, and 76872) (Page 186)
14	Laparoscopic Prostatectomy (CPT codes 55840, 55842, 55845, 55866, 55867, 558X1, and 558X2) (Page 188)
15	Endovascular Therapy with Imaging (CPT codes 61624, 61626, 75894, and 75898) (Page 190)
16	Guided High Intensity Focused Ultrasound (CPT code 61715) (Page 193)
17	Percutaneous Interlaminar Lumbar Decompression (CPT codes 62XX0 and 62XX1) (Page 197)
18	Percutaneous Decompression of Median Nerve (CPT code 647XX) (Page 197)
19	Baroreflex Activation Therapy (CPT codes 64XX5, 64XX6, 64XX7, 64XX8, 64XX9, 64X10, 93XX4, and 93XX5) (Page 197)
20	Percutaneous Electrical Nerve Field Stimulation (CPT code 64X11) (Page 201)
21	Laminotomy – Repair of Disc Defect (CPT code 6XX13)) (Page 201)
22	Cerebral Perfusion & CT Angiography-Head & Neck (CPT codes 70496, 70498, 70XX1, 70XX2, and 70XX3). (Page 202)
23	Coronary Atherosclerotic Plaque Assessment (CPT code 75XX6) (Page 202)
24	Use of the Relationship Between OPPS 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 204)
25	Combination COVID-19 Vaccine Administration (CPT codes 90480 and 9X16X) (Page 220)
26	Immunization Counseling (CPT codes 90XX1, 90XX2, and 90XX3) (Page 221)
27	Colon Motility Services (CPT codes 91XX1 and 91XX2) (Page 223)
28	Dark Adaptation Diagnostic and Screening Services (CPT codes 92284 and 922X1) (Page 224)
29	Coronary Therapeutic Services and Procedures (CPT codes 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92973, 92X01, 92X02, 93571, and 93572) (Page 226)
30	RSV Monoclonal Antibody Administration (CPT codes 96380 and 96381) (Page 228)
31	Remote Monitoring (CPT codes 98975, 98976, 98977, 98978, 98980, 98981, 98XX4,98XX5, 98XX6, 98XX7, 99091, 99453, 99454, 99457, 99458, 99473, 99474, 99XX4, and 99XX5) (Page 229)
32	Scalp Cooling Services (CPT codes 9XX01, 9XX02, and 9XX03) (Page 232)

EVALUATION AND MANAGEMENT (E/M) Visits (SECTION II.F.) (Page 296)

CMS is proposing 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 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))". (Page 298)

ENHANCED CARE MANAGEMENT (SECTION II.G.) (Page 299)

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 25 (Pages 299-302) contain the APCM codes and descriptions.

For CY 2026, CMS is proposing 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 proposed 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. (Page 305)

2. Behavioral Health Integration Add-On Codes for APCM (HCPCS codes GPCM1, GPCM2, GPCM3) (Page 305)

CMS is proposing 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.

3. Valuation of Behavioral Health Integration Add-on Codes for APCM Services (Page 307)

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 proposes 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 is also proposing 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.

[While CMS has identified a Section II.H, there is none in the text. The next section is II.I (below).]

POLICIES TO IMPROVE CARE FOR CHRONIC ILLNESS AND BEHAVIORAL HEALTH NEEDS (SECTION II.I.) (Page 311)

[Comment CMS also describes this item as ADVANCING ACCESS TO BEHAVIORAL HEALTH SERVICES (SECTION II.I)]

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 is proposing 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). (Page 314)

CMS also proposes 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.

Social Determinants of Health Risk Assessment (HCPCS code G0136) (Page 332)

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 is proposing to delete this code for CY 2026. Accordingly, it will also be removed from the Medicare Telehealth Services list.

Community Health Integration Services (HCPCS codes G0019) (Page 332)

CMS is proposing to 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 336)

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 339)

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 proposing 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 OPPS in the hospital outpatient department setting.

Payment for Skin Substitutes Under the Outpatient Prospective Payment System (OPPS) (Page 344)

Comment

The following is from CMS' summary of this section in the rule. (Page 370)

Summary

CMS proposes, starting January 1, 2026, to separately pay for skin substitute products as incident-to supplies in both the non-facility and hospital outpatient settings. CMS proposes to create three groups to pay for skin substitutes based on their FDA regulatory categories: PMA, 510(k), and 361 HCT/P, and would include each skin substitute in the applicable category based on its FDA approval, clearance, or self-determination, unless a skin substitute is licensed under section 351 of the PHS Act.

CMS proposes calculate initial payment rates for skin substitute products in each of the three FDA regulatory categories using the volume-weighted average ASP for skin substitute products in each group as submitted by manufacturers, when available, and the mean unit cost data (MUC) when ASP is not available.

For CY 2026, the proposed PE and MP RVUs would result in an initial payment rate of approximately $125.38/cm2 (prior to the application of the geographic adjustments) for PMA approvals, 510(k)s, and self-determined 361 HCT/Ps. CMS proposes to accomplish this by maintaining the current HCPCS codes for skin substitutes and then applying this rate to each code. CMS proposes to update the rates for the skin substitute categories annually through rulemaking using the most recently available calendar quarter of ASP data, when available, to set the rates, though CMS is seeking comments on whether a single quarter is most advisable.

In the event ASP is not available for a particular product, CMS proposes to use the hospital outpatient MUC data. If MUC is not available, CMS proposes to use the product's WAC or 89.6 percent of AWP if WAC is also unavailable. CMS proposes to include all skin substitute products used across both settings as well as the combined product utilization patterns, as soon as data is available that reflects the results of this policy, to determine a weighted average per-unit cost by group to set the payment rates for each of the three categories.

CMS is also seeking comments on how to best integrate this data into updated PE RVUs for years subsequent to CY 2026. Specifically, CMS is seeking comment on whether it should apply PE scaling factors to the data (that is, volume-weighted ASP or MUC) in order to optimize relativity with other PFS services and supplies once these products are incorporated into PFS data used for rate setting. CMS proposes to evaluate all complete HCPCS Level II applications for skin substitutes in our biannual cycles. Finally, CMS proposes to codify the definition of "biological" as "a product licensed under section 351 of the Public Health Service Act" at §§ 414.802 and 414.902.

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

(Page 372)

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

CMS is specifically seeking comment related to the procedure shares and what the procedure shares should be based on when the transfer of care modifier(s) are applied for the 90-day global packages. CMS is also seeking comment and stakeholder input as to current practice standards and division of work between surgeons and providers of post-operative care.

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

(Page 379)

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 380)

For the CY 2026 update, CMS is not proposing 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 384)

CMS is proposing to map TC-only services to the specialty allergy/immunology, which now has a risk index value of 0.427. Mapping the TC only services to the specialty allergy/immunology would be consistent with the CY 2020 and 2023 updates of the MP RVUs and maintain stability in the rate-setting process.

CMS requests comments regarding the risk index value for TC-only services. The rule's Table 30 shows the risk index values by specialty type and service risk group. (Page 387)

GEOGRAPHIC PRACTICE COST INDICES (GPCIS) (SECTION II.N.) (Page 393)

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)).

CMS is proposing new GPCIs beginning for CY 2026. See Addenda D and E for the CY 2026 proposed GPCIs and summarized GAFs. These Addenda are available on the CMS website under the supporting documents section of the CY 2026 PFS proposed rule at:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html

Since more than 1 year has passed since the previous GPCI update was implemented in CY 2023 and 2024, CMS is proposing to phase in 1/2 of the proposed GPCI adjustment in CY 2026 and the remaining 1/2 of the adjustment for CY 2027. (Page 394)

Work GPCIs (Page 396)

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 proposed work GPCIs

Practice Expense (PE) GPCIs (Page 398)

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 399)

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

GPCI Cost Share Weights (Page 399)

The proposed CY 2026 GPCI cost share weights are displayed in the rule's Table 31 (below).

Proposed GPCI Cost Share Weights for CY2026

Expense Category	Current and CY 2026 Proposed 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 403)

There are no changes in the states identified as Frontier States for the CY 2026 PFS proposed rule. 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.

III. OTHER PROVISIONS OF THE PROPOSED RULE

DRUGS AND BIOLOGICAL PRODUCTS PAID UNDER MEDICARE PART B (SECTION III.A.) (Page 415)

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)

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. In this proposed rule, CMS reviewed two applications for increased applicable percentage for specific products for CY 2026, but CMS is not proposing increased applicable percentages for either drug. (Leukine® (sargramostim) and Jelmyto® (mitomycin for pyelocalyceal solution))

Average Sales Price: Price concessions and bona fide service fees (§414.804 and 414.802)

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 is proposing policies to provide additional guidance on two aspects of the calculation of manufacturer's ASP. First, CMS is proposing regulatory text to specify when certain fees are considered price concessions and on how manufacturers should allocate pricing for drugs sold under a bundled arrangement. Second, CMS is proposing to revise the definition of bona fide service fees (BFSFs) by (1) specifying the methodology that should be used to determine fair market value (FMV) and the time period after which manufacturers should reassess the FMV; and (2) further explaining what CMS considers to be sufficient evidence of whether or not a fee is passed on in whole or in part to an affiliate, client, or customer of an entity.

CMS is also proposing that in the absence of specific guidance, manufacturers be required to submit any reasonable assumptions they utilize for manufacturer's ASP calculations (which is currently voluntary), including documentation of the methodology used to determine fair market value and periodic reviews of fair market value. (Page 426)

CMS is proposing 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." (Page 430)

Autologous Cell-based Immunotherapy and Gene Therapy Payment (Page 441)

CMS proposes that preparatory procedures for tissue procurement required for manufacturing an autologous cell-based immunotherapy or gene therapy be included in the payment of the product itself. This proposal continues the current payment policies for CAR T-cell therapies, and extends the same payment policy to other autologous cell-based therapies. (Page 445)

RURAL HEALTH CLINICS (RHCS) AND FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS) (SECTION III.B) (Page 447)

Integrating Behavioral Health into Advanced Primary Care Management (APCM) (Page 451)

CMS is proposing to adopt add-on codes for APCM that would facilitate billing for BHI and CoCM services when RHCs and FQHCs are providing advanced primary care CMS is proposing to require RHCs and FQHCs to report the individual codes that make up the CoCM HCPCS code, G0512 beginning January 1, 2026.

Similar to what was finalized in the CY 2025 PFS final rule for the general care management HCPCS code G0511, HCPCS code G0512 would 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. The current list of base codes and add-on codes that make up G0512 are listed in the rule's Table 34, titled "Psychiatric Collaborative Care Model HCPCS Codes and Descriptors." (Page 454)

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 proposing to revise § 405.2464(c) to reflect its proposal on payment of CoCM services for RHCs and FQHCs.

Payment for Communication Technology-Based Services (CTBS) and Remote Evaluation Services – HCPCS Code G0071 (Page 455)

CMS is proposing to require RHCs and FQHCs to report the individual codes that make up HCPCS code G0071 beginning January 1, 2026. 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 proposing to revise § 405.2464(e) to reflect its proposal for payment of CTBS and remote evaluation services for RHCs and FQHCs.

Aligning with the PFS for Care Coordination Services (Page 458)

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.

Therefore, CMS has proposed payment policies for RHCs and FQHCs that complement the new services for care coordination established under the PFS to align use of the RHC and FQHC resources for those services with a separate payment.

Services Using Telecommunications Technology (Page 463)

Proposal for CY 2026 Regarding Direct Supervision in RHCs/FQHCs (Page 466)

CMS is proposing, on a temporary basis, to facilitate payment for non-behavioral health visits (hereafter referred to in this discussion as "medical visit services") furnished via telecommunications technology using an approach that closely aligns with the methodology CMS used during and after the PHE, RHCs and FQHCs would continue to bill for RHC and FQHC medical visit services furnished using telecommunications technology, including services furnished using audio-only communications technology, by reporting HCPCS code G2025 on the claim.

AMBULATORY SPECIALTY MODEL (ASM) (SECTION III.C) (Page 473)

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 479)

Proposed Mandatory Participation (Page 484)

CMS proposes that certain clinicians who treat heart failure and low back pain would be required to participate in ASM.

CMS also proposes at § 512.710(d)(2), for the ASM low back pain cohort, to select clinicians with a specialty type of anesthesiology, interventional pain management, neurosurgery, orthopedic surgery, pain management, and physical medicine and rehabilitation, provided they meet all applicable ASM participant eligibility criteria for an ASM performance year.

Mandatory Geographic Areas (Page 504)

The proposed geographic unit of selection for participation is CBSAs except in cases where OMB has divided large metropolitan statistical areas (MSAs) into metropolitan divisions. For these MSAs, CMS proposes to use these metropolitan divisions in place of the CBSA.

To determine which CBSAs and metropolitan divisions would be included in the model, CMS proposes to use a stratified random sampling method to select approximately 25 percent of CBSAs and metropolitan divisions into ASM.

CMS proposes at § 512.710(g)(1)(i), for the 2027 ASM performance year/2029 ASM payment year only, to identify preliminarily eligible ASM participants using the ASM participant eligibility criteria and applicable data from calendar year 2024.

CMS expects to release this information by the end of July 2026, preceding the start of the 2027 ASM performance year/2029 ASM payment year.

CMS proposes that CMS would make public the ASM participants for a given ASM performance year annually in a form and manner determined by CMS.

Comment

This is one of the longer sections of this proposed rule -- some 215 pages. CMS is proposing many items with respect to the model operations. It would appear that CMS still does not have a grasp on what it is trying to accomplish since it has, by our count, asked for comments 55 times to its ASM proposals.

It is extremely difficult to follow CMS' table organization for this item. Paragraph section numbers just run on, and in several cases there are either no sequence in numbering or lettering. Below is our interpretation of CMS' outline for this section of the proposal.

1. **Overview of Proposed Ambulatory Specialty Model** (Page 473)

a. Introduction (Page 473

b. Background (Page 480)

2. **Provisions of Proposed Ambulatory Specialty Model** (Page 482)

a. Definitions (Page 482)

b. Proposed Length of Model Test (Page 482)

c. Proposed ASM Participants (Page 484)

(1) Proposed Mandatory Participation (Page 484)

(2) Proposed ASM Participants (Page 486)

(a) ASM Heart Failure Cohort (Page 488)

(b) ASM Low Back Pain Cohort (Page 489)

(3) ASM Participant Eligibility Criteria (Page 491)

(a) ASM Participant and Specialty Type Identification (Page 493)

(b) Episode-based Cost Measure (EBCM) Episode Volume (Page 500)

(4) Mandatory Geographic Areas (Page 504)

(a) Identification of Geographic Areas (Page 504)

(b) Exclusion of Certain CBSAs and Metropolitan Divisions (Page 507)

(c) Geographic Selection Methodology (Page 508)

(d) Stratified Random Selection of Mandatory Geographic Areas (Page 511)

(e) Assignment of Geographic Areas to Clinicians (Page 512)

(5) Proposed Selection and Notification Process for ASM Participants (Page 515)

[NO a, b, c]

d. Proposed ASM Performance Assessment Approach, Data Submission Requirements, and ASM Performance Category Requirements and Scoring

(Page 518)

(1) Proposed Performance Assessment and Data Submission Requirements (Page 521)

(a) ASM Performance Categories (Page 521)

(b) Data Submission Requirements (Page 524)

(2) Proposed Quality ASM Performance Category (Page 529)

(a) Background (Page 529)

(b) Quality Measure Set for the ASM Heart Failure Cohort (Page 531)

(c) Quality Measure Set for the ASM Low Back Pain Cohort (Page 538)

(d) Other Measures Under Consideration (Page 544)

(e) Removal and Addition of Quality Measures (Page 550)

(f) Maintenance of Technical Specifications for Quality Measures (Page 550)

(g) Data Submission Criteria for the Quality ASM Performance Category (Page 551)

(h) Data Completeness Requirement and Case Minimums for the Quality ASM Performance Category (Page 551)

(i) Quality Measure Achievement Points and Quality ASM Performance Category Scoring (Page 553)

(3) Proposed Cost ASM Performance Category (Page 559)

(a) Background (Page 599)

(b) Performance Year for Cost ASM Performance Category (Page 560)

(c) Cost Measure for the ASM Heart Failure Cohort (Page 560)

(d) Cost Measure for ASM Low Back Pain Cohort (Page 562)

(e) Removal and Addition of Cost Measures (Page 563)

(f) Minimum Case Requirements (Page 564

(g) Cost Measure Achievement Points and Cost ASM Performance Category Scoring (Page 564)

(4) Proposed Improvement Activities ASM Performance Category (Page 568)

(a) Background (Page 569)

(b) Performance Year for Improvement Activities (Page 570)

(c) Improvement Activities (Page 570)

(d) Improvement Activities Data Submission, Achievement Points, ASM Performance Category Scoring (Page 579)

(5) Proposed Promoting Interoperability ASM Performance Category (Page 580)

(1) ASM Performance Category Weights and Scoring Adjustments (Page 596)

(2) Requirements to Receive a Final Score (Page 599)

(3) Complex Patient Scoring Adjustment (Page 603)

(4) Small Practice Scoring Adjustment (Page 609)

(5) Final Score Calculation (Page 612)

(6) ASM Performance Report (Page 614)

[AT THIS POINT, I CAN NOT FIGURE OUT CMS' INDEXING]

f. Proposed ASM Payment Approach (Page 615)

(1) Payment Approach (Page 615)

(2) Payment Methodology Overview (Page 616)

(3) Comparison of ASM Participant Performance (Page 621)

(4) Calculation of ASM Payment Adjustment Factors and ASM Payment Multipliers (Page 623)

(a) Overview of ASM Payment Adjustment Factor and Payment Multiplier Calculation Process (Page 624)

(b) ASM Incentive Pool (Page 628)

(c) Exchange Function (Page 634)

(d) Notification of ASM Payment Adjustment Factors and ASM Payment Adjustment Multipliers to ASM Participants (Page 642)

g. Proposed Timely Error Notice Process (Page 646)

h. Proposed Waivers of Medicare Program Requirements (Page 648)

(1) Background (Page 648)

(2) MIPS Waiver (Page 649)

(3) Telehealth (Page 650)

(a) Background (Page 650)

(b) Telehealth Waivers (Page 653)

i. Proposed Extreme and Uncontrollable Circumstances (EUC) Policy (Page 655)

j. Proposed Data Sharing (Page 658)

(1) Data Provided to ASM Participants (Page 659)

(a) Legal Authority to Share Beneficiary-Identifiable Data and Applicability to Proposed ASM Data Sharing Processes

(b) Medicare Beneficiary Opportunity to Request Restrictions on Data Sharing (Page 665)

(2) ASM Data Sharing Agreement (Page 667)

(a) General Requirement for Beneficiary-Identifiable Data

(b) Content of the ASM Data Sharing Agreement (Page 668)

k. Proposed ASM Beneficiary Incentives, Collaborative Care Arrangements, and Applicability of CMS-Sponsored Model Safe Harbor at § 1001.952(ii) (Page 670)

(1) ASM Beneficiary Incentives

(2) Collaborative Care Arrangements (Page 674)

(3) Application of the CMS-Sponsored Model Arrangements and Patient Incentives Safe to ASM Beneficiary Incentives and Collaborative Care Arrangements (Page 676)

l. Proposed Evaluation Approach (Page 678)

(1) Background

(2) Design and Evaluation Methods (Page 678)

(3) Data Collection Methods (Page 680)

(4) Key Evaluation Research Questions (Page 681)

(5) Evaluation Period and Anticipated Reports (Page 682)

m. Proposed Overlap with Other Models Tested Under Section 1115A and CMS Programs (Page 683)

n. Application of Standard Provisions for Mandatory Innovation Center Models (Page 685)

[there is no Section D.]

MEDICARE DIABETES PREVENTION PROGRAM (MDPP) (SECTION III.E.) (Page 686)

MDPP was established in 2017 as an "additional preventive service,"253 covered by Medicare and not subject to beneficiary cost-sharing, in addition to being available once per lifetime to eligible beneficiaries. As of March 2025, there were 331 approved MDPP suppliers.

CMS is proposing 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 DPRP Standards.

Specifically, CMS is proposing changes to 42 CFR 410.79(b) to add definitions for the following terms: Live Coach interaction, Online delivery period, and Online session while modifying the definition of "Online." CMS also proposes changes to the expanded model by amending § 410.79 (c)(1)(ii) and (e)(3)(iii)(C) to address operational questions and barriers related to weight collection requirements.

CMS also proposes to extend flexibilities allowed during the PHE for COVID-19 through December 31, 2029 by modifying the definition of extended flexibilities period in § 410.79(b).

Finally, CMS is proposing to test the inclusion of an asynchronous delivery modality by modifying § 410.79 by revising paragraph (b) adding paragraph (f) and amending § 424.205(c)(10), (f)(2)(i), and (f)(5), which will allow MDPP suppliers to deliver the Set of MDPP services Online through December 31, 2029, clarify that MDPP suppliers are not required to maintain in-person delivery capability through December 31, 2029, and introduce a new G-code and payment for Online sessions. These changes are expected to expand beneficiary access to MDPP, reduce barriers to participation, improve MDPP session attendance and retention, and promote safety.

MEDICARE PRESCRIPTION DRUG INFLATION REBATE PROGRAM (SECTION III.E.) (Page 707)

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.

In this proposed rule, CMS is proposing 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, 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 745)

Comment

This section is 148 pages. It's the third longest section of the proposal. The material that follows is, to a large extent, from a fact sheet accompanying the rule.

Proposals

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

CMS is proposing to reduce the length of time an ACO can participate in a one-sided model of the BASIC track to a maximum of 5 performance years, during the ACO's first agreement period in the BASIC track's glide path (if eligible), instead of 7 performance years. This proposal would be applicable for agreement periods beginning on or after January 1, 2027 and is intended to encourage participation in two-sided risk models.

- Modify 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 benchmark year (BY), while allowing the ACO to have under 5,000 assigned beneficiaries in BY1, BY2, or both (section III.F.4.b.(2)(a) of this proposed rule).

  ++ Require ACOs that enter a new agreement period with less than 5,000 assigned beneficiaries in BY1, BY2, or both to enter the BASIC track (section III.F.4.b.(2).(b). of this proposed rule).

  ++ 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). of this proposed rule).

  ++ 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). of this proposed rule).

- Update the definition of primary care services used in beneficiary assignment at § 425.400(c) (section III.F.5. of this proposed rule).

- Revise the quality performance standard and other quality reporting requirements, including the following (section III.F.6. of this proposed rule):

  ++ 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 proposed rule).

  ++ Remove the health equity adjustment applied to an ACO's quality score beginning in

  performance year 2025 and revise the terminology used to describe the health equity adjustment and other related terms for performance years 2023 and 2024 (section III.F.6.c. of this proposed rule).

++ 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 of this proposed rule).

++ 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. of this proposed rule).

- 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 of this proposed rule).

- 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. of this proposed rule).

- 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 of this proposed rule).

Taken together, the Shared Savings Program proposals in this proposed 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 at the 90th percentile (as described in section VII of this proposed rule).

CMS is proposing changes to other programmatic areas, including: proposed modifications to require ACOs to report certain changes to their ACO participant list during the performance year, such as when an ACO participant experiences a Change of Ownership (CHOW), and similarly to require ACOs to report changes during the performance year to the ACO's Skilled Nursing Facility (SNF) affiliate list, such as when a SNF affiliate undergoes a CHOW; proposed updates to the Shared Savings Program beneficiary assignment methodology to revise the definition of primary care services used for purposes of assignment to align with payment policy proposals under the Medicare PFS; proposed changes to the Shared Savings Program regulations specifying the financial benchmarking methodology applicable for agreement periods beginning on January 1, 2025, and in subsequent years, to rename the "health equity benchmark adjustment" the "population adjustment," and proposed changes to revise the Shared Savings Program quality monitoring policies, such that for performance years beginning on or after January 1, 2026, CMS would also monitor whether ACOs have met the alternative quality performance standard, in addition to monitoring whether ACOs have met the quality performance standard.

Proposal to Remove and Revise the Health Equity Adjustment Applied to an ACO's Quality Score

CMS is proposing to remove the health equity adjustment applied to an ACO's quality score beginning in performance year 2025. CMS believes that the application of the Complex Organization Adjustment and the extension of the electronic Clinical Quality Measure (eCQM)/MIPS CQM reporting incentive, as finalized in prior rules, have made it unnecessary to continue applying the health equity adjustment to an ACO's quality score. The Complex Organization Adjustment upwardly adjusts an ACO's MIPS Quality performance category score when an ACO reports quality data via eCQMs. The eCQM/MIPS CQM reporting incentive supports ACOs in meeting the quality performance standard and in sharing in the maximum shared savings allowable by track. These policies underscore CMS' commitment to all payer/all patient quality measure reporting.

Additionally, to accurately reflect the data used to calculate the health equity adjustment in performance years 2023 and 2024, CMS is proposing to revise the terminology used to describe this adjustment and other related terms in the Shared Savings Program regulations.

Proposal to Revise the Definition of a "Beneficiary Eligible for Medicare CQMs"

CMS is proposing to revise the definition of a beneficiary eligible for Medicare CQMs, for performance year 2025 and subsequent performance years, to require at least one primary care service with a date of service during the applicable performance year from an ACO professional who is a primary care physician or who has one of the specialty designations included in § 425.402(c), or who is a physician assistant, nurse practitioner, or clinical nurse specialist.

CMS says its proposal to revise the definition of a beneficiary eligible for Medicare CQMs would reduce ACOs' burden in the patient matching necessary to report Medicare CQMs because the list of beneficiaries eligible for Medicare CQMs would have greater overlap with the list of beneficiaries that are assignable to an ACO.

Proposal to Update the APP Plus Quality Measure Set

For performance year 2025 and subsequent performance years, Shared Savings Program ACOs are required to report the Performance Pathway (APP Plus) quality measure set. CMS is proposing several updates to the APP Plus quality measure set for Shared Savings Program ACOs, including the removal of Quality ID: 487 Screening for Social Drivers of Health.

Table 51 below (from the proposal—Page 857) displays measures included in the app plus quality measure set for shared savings program ACOs beginning with performance year 2028 or the performance eCQM that is one year after the eCQM specification becomes available for quality id: 493, whichever is later.

Quality #	Measure Title	Collection Type	Submitter Type	Meaningful Measures 2.0 Area	Measure Type
321	CAHPS for MIPS	CAHPS for MIPS Survey	Third Party Intermediary	Person-Centered Care	Patient Engagement/Experience
479	Hospital-Wide, 30-day, All- Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Administrative Claims	N/A	Affordability and Efficiency	Outcome^
484	Clinician and Clinician Group Risk- standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	Administrative Claims	N/A	Affordability and Efficiency	Outcome^
001	Diabetes: Glycemic Status Assessment Greater Than 9%	eCQM/Medicare CQM	APM Entity/Third Party Intermediary	Chronic Conditions	Intermediate Outcome^
134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	eCQM/Medicare CQM	APM Entity/Third Party Intermediary	Behavioral Health	Process
236	Controlling High Blood Pressure	eCQM/Medicare CQM	APM Entity/Third Party Intermediary	Chronic Conditions	Intermediate Outcome^
112	Breast Cancer Screening	eCQM/Medicare CQM	APM Entity/Third Party Intermediary	Wellness and Prevention	Process
113	Colorectal Cancer Screening	eCQM/Medicare CQM	APM Entity/Third Party Intermediary	Wellness and Prevention	Process

Quality #	Measure Title	Collection Type	Submitter Type	Meaningful Measures 2.0 Area	Measure Type
305	Initiation and Engagement of Substance Use Disorder Treatment	eCQM/Medicare CQM	APM Entity/Third Party Intermediary	Behavioral Health	Process
493	Adult Immunization Status	/Medicare CQM	APM Entity/Third Party Intermediary	Wellness and Prevention	Process

Proposal to Add a Web-based Survey Mode to the CAHPS for MIPS Survey

Shared Savings Program ACOs are required to administer the CAHPS for MIPS Survey, an annual survey, in order to meet the quality reporting requirement under the Shared Savings Program. Currently, data is collected using a mail-phone survey administration protocol. In order to help increase survey response rates, CMS is proposing that beginning with performance year 2027, it would implement a web-mail-phone protocol and discontinue the mail-phone protocol for the CAHPS for MIPS Survey.

Summary of Proposals

The rule's Tables 52 and 53 summarize the quality reporting requirements and quality performance standard policies for performance year 2025 and subsequent performance years, including its proposals in this proposed rule. (Page 859)

IV. UPDATES TO THE QUALITY PAYMENT PROGRAM (SECTION IV.) Page 897

Comment

This section is 217 pages. It's the longest section of the proposal. The material that follows is, to a large extent, from a 39-page fact sheet accompanying the rule.

QPP Policy Overview:

CMS is proposing a limited number of policies for QPP, keeping its focus on stability in the program. The proposals support the continuing transformation of the Merit-based Incentive Payment System (MIPS) through MIPS Value Pathways (MVPs), and center on alignment across programs as well as responsiveness to feedback and concerns raised by interested parties.

In addition to policy proposals, CMS is also including several Requests for Information (RFIs) to obtain feedback from interested parties on a variety of topics before we propose related policies. These RFIs are focused on MIPS Value Pathways (MVPs), a timeline for implementing Fast Healthcare Interoperability Resources (FHIR), and the Promoting Interoperability performance category.

Proposal Highlights

- CMS is proposing 6 new MVPs to be available for reporting in the CY 2026 performance period. (Page 927)
  1. Diagnostic Radiology
  2. Interventional Radiology
  3. Neuropsychology
  4. Pathology
  5. Podiatry
  6. Vascular Surgery

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

- CMS is proposing modifications to all 21 existing MVPs, in alignment with proposals to update the quality measure and improvement activity inventories. 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 is proposing that groups would 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 wouldn't make this determination for them.) CMS believes this proposal would support groups in their transition to MVP reporting and would help these groups assess their need to participate as subgroups.

- CMS is proposing that multispecialty small practices would still be able to report an MVP as a group, and they wouldn't be required to form subgroups beginning in the CY 2026 performance period. (i.e., Subgroup reporting would remain optional for multispecialty small practice.)

- CMS is proposing that Qualified Clinical Data Registries (QCDRs), and Qualified Registries would have one year after a new MVP is finalized before they're required to fully support that MVP, to provide more time to implement necessary system updates to capture the measures and activities finalized for inclusion.

Performance Threshold

The performance threshold is the final score needed to avoid a negative MIPS payment adjustment.

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

MIPS Performance Categories

- CMS is proposing changes to the Alternative Payment Models (APM) Performance Pathway (APP) Plus quality measure set to maintain alignment with the MIPS quality measure inventory.
- CMS is proposing to update candidate event and attribution rules for the Total Per Capita Cost (TPCC) measure.
- CMS is proposing a 2-year informational-only feedback period for new cost measures, allowing clinicians to receive feedback on their score(s) and find opportunities to improve performance before a new cost measure affects their MIPS final score.
- CMS is proposing to add 3 new improvement activities, modify 7 improvement activities, and remove 8 improvement activities.
- CMS is proposing the addition of a new subcategory titled "Advancing Health and Wellness" and the removal of the "Achieving Health Equity" subcategory.

Promoting Interoperability:

- CMS is proposing changes to the High Priority Practices Safety Assurance Factors for Electronic Health Record (EHR) Resilience (SAFER) Guide measure and the Security Risk Analysis measure.
- CMS is proposing to adopt a new optional/bonus measure for the Public Health and Clinical Data Exchange objective, specifically the Public Health Reporting Using the Trusted Exchange Framework and Common Agreement _(TEFCA) measure.
- CMS is proposing to adopt a measure suppression policy for the MIPS Promoting Interoperability performance category and the Medicare Promoting Interoperability Program.
- CMS is proposing to suppress the Electronic Case Reporting measure, in which the measure would not be scored for the current CY 2025 performance period/2027 MIPS payment year for the MIPS Promoting Interoperability performance category and the Medicare Promoting Interoperability Program due to the Centers for Disease Control and Prevention (CDC) temporarily pausing the onboarding of new healthcare organizations for production of electronic case reporting data and new local public health agencies for receipt of electronic case reporting.

Advanced APMs

- CMS is proposing to add a determination of all eligible clinicians in Advanced APMs for Qualifying APM Participant (QP) status at the individual level, in addition to determinations at the APM Entity level. As part of the effort to simplify this process, we're proposing to use Covered Professional Services as the set of services used for QP determinations.

Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs)

- CMS is proposing to revise the definition of a "beneficiary eligible for Medicare Clinical Quality Measures for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare CQMs)", 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 ACO's assignable beneficiary population.

Requests for Information (RFIs)

- CMS is issuing an RFI on how to encourage MVP reporting on key quality measures that reflect the essential components of an MVP, which in turn may provide patients with more directly comparative clinician performance data on select quality measures.
- CMS is seeking comments on:

A potential Core Elements MVP reporting requirement, which would identify a subset of quality measures in each MVP to comprise the MVP's Core Elements.

The intended goals and ideal number of Core Elements in an MVP.

The role of measure collection types, the limitations of measure applicability for some clinicians, the policy implementation timeline, and any anticipated impacts on clinicians' transition to MVP reporting.

Well-being and Nutrition Measures

- CMS is issuing an RFI on well-being and nutrition measures in QPP, which can provide a more comprehensive approach to disease prevention and health promotion.
- CMS is seeking comments on:

  Tools and measures that assess overall health, happiness, and satisfaction in life that could include aspects of emotional well-being, social connections, purpose, and fulfillment.

  Procedural Codes for MVP Assignment

Procedural Codes for MVP Assignment

- CMS is issuing an RFI to solicit feedback on the use of procedural billing codes to assign clinicians to an MVP. This approach would facilitate specialty reporting of MVPs most relevant to their scope of care.
- CMS is seeking comments on:

  The assignment of MVPs based on procedural codes and the data sources CMS should consider utilizing to assign clinicians to an MVP.

  The eligibility determination period to establish procedural code utilization and relevant volume threshold.

  Anticipated impacts on clinicians' transition to MVP reporting.

Transition Toward Digital Quality Measurement

- CMS is including an RFI to gather comment on continued advancements to digital quality measurement and the use of the Health Level 7® Fast Healthcare Interoperability Resources® (FHIR®) standard.
- CMS is seeking comments on:

The anticipated approach to FHIR-based electronic clinical quality measure (eCQM) reporting in quality reporting programs.

ACO experience with the transition to FHIR-based reporting of eCQMs and opportunities to mitigate reporting burden.

Query of Prescription Drug Monitoring Program (PDMP) Measure

- CMS is including an RFI to evaluate the current Query of PDMP measure. (PDMPs are electronic databases that monitor the use of controlled substances, including prescription drug usage and prescription drug history. Increased integration of PDMPs into EHRs and EHR systems continues to reduce barriers and burden of PDMP review by incorporating PDMP queries into the provider workflow.)
- CMS is seeking comments on:

  Changing the Query of PDMP measure from an attestation-based measure ("Yes" or "No") to a performance-based measure (numerator and denominator), with an alternative measure designed to more effectively assess the degree to which participants are utilizing PDMPs.

  Expanding the types of drugs to which the Query of PDMP measure could apply.

Performance-Based Measures in the Public Health and Clinical Data Exchange Objective

Performance-Based Measures in the Public Health and Clinical Data Exchange Objective

- CMS is including an RFI to evaluate the measures under the Public Health and Clinical Data Exchange
- CMS is seeking comments on:

  Whether alternatives to the current attestation-based measures can drive further improvements in the quality and consistency of reporting to public health agencies and associated public health outcomes.

Data Quality

- CMS is including an RFI to evaluate how clinicians exchange health information.
- CMS is seeking comments on:

  The current data environment, including the quality of the data being collected and exchanged and related challenges.

COLLECTION OF INFORMATION REQUIREMENTS (SECTION V.) (Page 1,113)

RESPONSES TO COMMENTS (SECTION VI.) (Page 1,166)

REGULATORY IMPACT ANALYSIS (Section VII) (Page 1,167)

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

APPENDICES (Page 1,391)

Appendix 1: MIPS Quality Measures

- Table Group A: New MIPS Quality Measures Proposed for the CY 2026 Performance Period/2028 MIPS Payment Year and Future Years (Page 1,391)

- Table Group B: Modifications to Previously Finalized Specialty Measure Sets Proposed for the CY 2026 Performance Period/2028 MIPS Payment Year and Future Years (Page 1,404)

- Table Group C: Previously Finalized Quality Measures Proposed for Removal for the CY 2026 Performance Period/2028 MIPS Payment Year and Future Years (Page 1,655)
- 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)

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Appendix 4: Measures for MIPS Cost Performance Category (Page 1,800)

Final Thoughts

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 142) 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 proposal's impact tables.

The ambulatory specialty model's proposal 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 unclear if CMS can fulfill its operation by January 2027.

Not only is this rule extremely long, but there are also many errors. While most appear to be pagination numbering. Nonetheless, it is extremely difficult to navigate.

The primary intent of this analysis is to provide the reader with the issues, and more importantly where within 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.