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CY 2026 Medicare Physician Fee Schedule Proposed Rule Summary Including the Medicare Shared Savings Program and the Quality Payment Program

On July 14, the Centers for Medicare & Medicaid Services (CMS) released the Medicare Physician Fee Schedule (MPFS) proposed rule and fact sheet for CY 2026 (CMS-1832-P). This rule updates payment policies and payment rates for Part B services furnished under the MPFS, as well as makes changes to the Quality Payment Program (QPP). The rule in its entirety and the addenda, including Addendum B, which lists the proposed RVUs for each CPT® code can be found here. Comments are due September 12.

In this proposed rule, CMS discusses several significant policy changes that align with the administration's efforts to curb fraud, waste, and abuse, and advance the agency's Make American Health Again initiative. Some of the changes include new payment policy to adjust work RVUs downward to account for efficiency gains over time, creation of policy to cut practice expenses amounts for services performed in the facility setting, expansion of behavioral health initiatives, and making permanent changes to some telehealth provisions. Additionally, the agency seeks feedback on strategies to enhance support for prevention and management of chronic disease.

Note that the page numbers listed in this document refer to the display copy of the proposed rule. Additionally, new CPT codes do not have final code numbers assigned. The complete code numbers will be provided when the final rule is released in early November.

Regulatory Impact Analysis

Conversion Factor for 2026
2026 marks the first year that there are two separate conversion factors: one for practitioners working in a qualifying advanced APM and the other for those not participating in a qualifying APM. The conversion factor for the former will increase to $33.59, an increase of 3.83%, and the latter to $33.42, an increase of 3.62%. These increases reflect the 2.5% increase to the 2026 conversion factor included in the reconciliation package recently adopted by Congress.

Specialty Level Impact of the Proposed Policy Changes – p. 1,191
The are two proposals in this rule, a new indirect practice expense calculation which creates a site of service payment differential and an efficiency adjustment, creating downward pressure on physician payment, even though Congress passed a 2.5% positive update to the conversion factor in 2026. Additionally, CMS has chosen **to not use** the new American Medical Association (AMA) Physician Practice Information Survey (PPIS) data for 2026 rate setting. The proposals have led to substantial variations in the impact percentages for both

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facility and non-facility (office) sites of service, with the office setting seeing positive changes to payment for certain physician services.

Table 92 of the rule (**Appendix A of this summary**) estimates the specialty level impacts of the policies included in the proposed rule and includes impacts of rate-setting changes and changes to RVUs within the budget neutral system. The impact of the proposed rule's policies on group practices and individual physicians varies based on practice type and the mix of patients and services provided to those patients.

Development of Strategies for Updates to Practice Expense Data Collection and Methodology – p. 47
Highlight: CMS does not use the updated AMA PPIS data for rate setting citing concerns with survey validity.

After years of delaying an update to the practice expense per hour (PE/HR) specialty data and promising to do so only after it received new data from the AMA's Physician Practice Information Survey (PPIS), CMS will not incorporate the new survey data into rate setting calculations. Instead, the agency will maintain the current PE/HR data and cost shares for 2026 rate setting. The agency notes several reasons for not incorporating the new PPIS data including low response rates and lack of representativeness, small sample size, lack of comparability to previous survey data, and missing or incomplete data submissions.

As background, the PE/HR is the estimated cost per hour of operating a medical practice and varies from specialty to specialty. The PE/HR includes direct practice expenses like clinical staff wages, medical supplies, equipment and indirect expenses like rent, utilities, and administrative costs. The AMA RUC uses the PPIS to inform their recommendations to CMS regarding the practice expense component of the total relative value unit (RVU). Given that CMS did not use the updated AMA PPIS data to update the PE/HR rates for each physician specialty, the PE/HR remains at 2017 levels for 2026.

Updates to Practice Expense (PE) Methodology – Site of Service Payment Differential – p. 61
Highlight: Practice expense RVUs for services performed in the facility setting will be cut by half under CMS's new policy.

CMS proposes to change the methodology for the allocation of indirect practice expenses (PE) within the physician payment formula. As described in the rule CMS proposes "*for each service valued in the facility setting under the PFS, we propose to reduce the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to nonfacility PE RVUs beginning in CY 2026*." According to the agency, this proposed change will reflect the current state of clinical practice with fewer physicians working in private practice settings,

and therefore, "*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*."

Historically, the share of physicians who owned or were part owners of their own practice was as high as 72% in the years prior to the development of the RBRVS, but in 2024 the percentage is only 34.5%. When the MPFS was first implemented, the methodology for allocating indirect PE was partly based on the assumption that many physicians maintained an office-based practice, even if they also provided care in a facility setting. As a result, the methodology assigned the same amount of indirect costs per work RVU regardless of the care setting.

As CMS states in the rule, an increasing number of physicians do not own their practice and are employed by hospitals, and therefore the indirect costs should not be the same in both the facility and non-facility setting. The agency does recognize that there are some indirect costs for physicians who are solely based in the facility setting like coding, billing, and scheduling activities. However, the agency does not believe that these indirect PE costs are the same for facility and non-facility-based physicians, and therefore, believes that cutting the indirect PE amounts in the facility setting in half will more accurately account for the costs incurred.

Given this proposed change has quite a significant impact on payment amounts for services provided in the facility setting, the agency seeks comments on several issues including:

- Is reducing the facility PE amounts by half an appropriate reduction or is there a more appropriate percentage reduction that better reflects the practice expenses for services provided in the facility setting?
- What are the specific types and magnitude of indirect PE costs incurred by physicians who practice partially or exclusively in facility settings? Recall that indirect PE includes items like billing, scheduling, and other overhead costs. Additionally, the agency seeks information on any factors that influence whether, and to what extent, a practice incurs these costs.
- Are there other data sources to assist the agency in creating indirect PE allocations that more accurately reflect site of service differential?

Proposed Efficiency Adjustment – p. 142
Highlight: A proposed efficiency adjustment to be applied to nearly all services on the physician fee schedule will cut payment rates, and CMS takes aim at the AMA RUC.

For the first time, CMS proposes an efficiency adjustment aimed at improving the accuracy of work RVUs and intraservice physician time estimates for non-time-based services. Specifically, CMS proposes to apply an efficiency adjustment of –2.5% to the work RVUs and intraservice time for nearly all services on the MPFS including procedures, radiology services, and diagnostic tests. The adjustment **would not apply** to time-based services,

including evaluation and management (E/M) visits, behavioral health services, maternity global codes, and care management services. The table below, taken directly from the rule provides an example of how the -2.5% adjustment affects intraservice time and the work RVU of a service.

Table 1. Example of Proposed Efficiency Adjustment

CPT Code	Short Descriptor	Current Intraservice Time (min)	Current Work RVU	Intraservice Time after Adjustment (min)	Work RVU After Adjustment
11200	Removal skin tags	7.00	0.82	6.83	0.80
63047	Lam facetectomy & foraminotomy	90	15.37	87.75	14.99

The rationale for the proposed adjustment comes from the agency's concerns about the reliability of the traditional data sources used to determine physician time and work relative values for services paid on the MPFS. Those traditional data sources are surveys administered by the RUC with the assistance of medical specialty societies, who send the surveys to their members. CMS notes that RUC surveys often suffer from low response rates (median survey response for payment year 2015 was 52 per survey conducted) and potential bias (overestimating time to perform a procedure). CMS also notes that RUC surveys undervalue efficiency gains that naturally occur over time through provider experience in performing the procedure which may lead to a decrease in time that it takes to perform the service. Workflow and advances in technology may also account for efficiency gains not accounted for or captured in a RUC survey.

CMS states that the efficiency adjustment is needed because of the many years that elapse from a code's original value to the time when the RUC may revalue the code. CMS estimates that there are 25.49 years between the establishment of a code's original RVU and subsequent reevaluation by the RUC. Additionally, when a code is reviewed by the RUC, two to three years may pass from the time the survey data is collected to its implementation within the fee schedule rate setting process. The agency believes this two-to-three-time gap creates an overvaluation of a service at the outset because there may already be unaccounted for efficiency gains.

To determine the percentage of the efficiency adjustment, the –2.5% was derived from the five-year cumulative productivity adjustment embedded in the Medicare Economic Index (MEI), which CMS believes reflects a reasonable approximation of the efficiency gains throughout services on the MPFS. The MEI is "a measure of inflation faced by physicians with respect to their practice costs and general wage levels, and includes inputs used in furnishing physicians' services such as physician's own time, non-physician employees'

compensation, rents, medical equipment, and more." CMS intends to continue to use the MEI to revise the efficiency adjustment as needed and will update the adjustment amount every three years. That means the efficiency adjustment may not be -2.5% in three years' time, it could be higher or lower. By applying this adjustment, CMS aims to better align payment with actual resource use and mitigate potential distortions in the RVU valuation process.

CMS seeks comment on the proposal and again reminds stakeholders that alternative methods to valuing services on the MPFS that use empirical data, and not data derived from surveys will carry greater weight. The agency also indicates interest in establishing a broader framework that incorporates objective time data, such as information from operative notes with time stamps, into the valuation of services, with the goal of reducing reliance on subjective survey data.

Geographic Practice Cost Indices (GPCIs) – p. 393
Highlight: CMS proposes updates to the GPCIs using more current data on wages, rent, equipment, and insurance to better reflect local cost differences, while phasing in the changes over two years and continuing to use existing MEI cost share weights for practice expense calculations in 2026.

CMS is required to develop separate GPCIs to measure relative cost differences among localities compared to the national average for each of the three fee schedule components (work, practice expense (PE), and malpractice). By law, GPCIs must be reviewed at least every three years. In this proposed rule, CMS proposes revisions to the GPCI amounts and proposes changes to the calculations and data inputs.

Specifically, CMS proposes to use updated data related to employee wages, office rent, medical equipment/supplies, and insurance to better reflect cost differences among localities. CMS also proposes phasing in half of the updated GPCI values in CY 2026, with the remainder implemented in CY 2027.

For the CY 2026 GPCIs, CMS is proposing to continue to use the current 2006-based MEI cost share weights for determining the proposed PE GPCI values. Specifically, the agency will use cost share weights to weight the four components of the PE GPCI: employee compensation, office rent, purchased services, and medical equipment, supplies, and other miscellaneous expenses. The agency seeks feedback on future integration of more updated data.

CMS welcomes feedback related to specific information and data that would aid transparency in future GPCI updates. For more information and a detailed explanation of the GPCIs, see page 393 of the proposed rule. See Addenda D of the proposed rule for the CY 2026 proposed GPCIs.

Potentially Misvalued Services Under the Physician Fee Schedule – p. 70
Each year the agency reviews potentially misvalued services. The criteria to identify a misvalued service are applied at the code level, and refinements are proposed by CMS for each code deemed misvalued. The review of values for the CPT code set is required by law, and since 2009, CMS has reviewed more than 1,700 codes.

Fine Needle Aspiration (FNA) (CPT codes 10021, 10004, 10005, 10006) – p. 98
The fine needle aspiration services represented by CPT codes 10021, 10004, 10005, and 10006 have been nominated as misvalued again. The nominating party requested that the work RVUs be restored to the 2019 levels, which were supported by the AMA RUC. The nominator stated that the site of service is shifting to the facility setting due to low reimbursement in the non-facility. Additionally, the nominator stated that due to those low reimbursement levels, many endocrinologists and surgeons are not interested in learning how to perform fine needle aspirations, which will result in access to care issues for Medicare beneficiaries.

CMS does not agree that these codes are misvalued and refers readers to four previous rules for discussion of its rationale. However, the agency will monitor for shifts in sites of service for these services and would seek a resurvey if warranted. CMS is once again requesting comments on this issue.

Payment for Medicare Telehealth Services under Section 1834(m) of the Act – p. 105
Highlight: CMS proposes to modify the process to add telehealth services and makes permanent direct supervision of incident-to services.

Proposal to Modify the Medicare Telehealth Services List and Review Process – p. 106
CMS proposes to simplify the telehealth review process by removing steps 4 and 5 of the review process and focusing on whether a service can be furnished using an interactive telecommunications system. Step 4 had previously looked at whether the service elements of the requested service map to the service elements of services on the list that has a permanent status described, while step 5 had previously looked at whether there is evidence of clinical benefit analogous to the clinical benefit of the in-person service when the patient receives the service by telehealth. The agency believes that the complex professional judgment of the physician or practitioner is sufficient to ensure that a service can be safely furnished via telehealth and that the service will be clinically beneficial to the patient. CMS proposes that services on the Medicare Telehealth Services List will be included on a permanent basis; there will no longer be a provisional basis for including services. The process and decision-making parameters that the agency uses to make determinations as to whether a code(s) may be placed on the telehealth service list is found on page 110 of the proposed rule.

Requests to Add Services to the Medicare Telehealth Services List for CY 2026
The agency received several requests to add services to the Medicare Telehealth Services List, which can be found in Table 8, page 113 in the proposed rule.

Group Behavioral Counseling for Obesity – p. 115
CMS received a request to add CPT code G0473 (*Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes)* to the Medicare Telehealth Services List. The agency believes that it meets the three steps for review and proposes to add the service to the Medicare Telehealth Services List.

Telemedicine E/M Services – p. 119
CMS received a request to add the telemedicine E/M services (CPT 98000-98015) to the Medicare Telehealth Services List. Since these services are not separately payable under the Medicare PFS and are assigned service indicator I (not valid for Medicare purposes), the agency proposes to not add the services.

Frequency Limitations on Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations – p. 121
CMS proposes to permanently remove frequency limitations on furnishing services via telehealth for the codes listed on page 123 of the proposed rule relating to subsequent inpatient visits, subsequent nursing facility visits, and critical care consultation services. The agency reiterates that physicians and practitioners can use their complex professional judgment to determine whether they can safely furnish a service by telehealth.

Direct Supervision via Use of Two-way Audio/Video Communications Technology – p. 125
CMS proposes to permanently allow certain services to be furnished under direct supervision that allows the immediate availability of the supervising practitioner using audio/video real-time communications technology (excluding audio-only). This would apply to all services provided incident-to a physician services, except for services with a global surgery indicator of 010 or 090. The agency proposes to apply this definition to the applicable cardiac, pulmonary, and intensive cardiac rehabilitation services.

Proposed Changes to Teaching Physicians' Billing for Services Involving Residents with Virtual Presence – p. 130
CMS proposes to transition back to the pre-Public Health Emergency (PHE) policy and to not extend the current policy that allows teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings. The agency is concerned that allowing a virtual presence will not allow the teaching physician to have personal oversight and involvement over the management of the portion of the case that is billing billed. The agency maintains the rural exception, which was in place before the PHE, and allows teaching physicians in rural areas to utilize audio/video real-time communications technology to fulfill the presence requirement. This proposal does not

impact teaching physician's ability to provide virtual supervision of residents for educational purposes.

Telehealth Originating Site Facility Fee Payment Amount Update – p. 134
For CY 2026, the proposed payment amount for HCPCS code Q3014 (*Telehealth originating site facility fee*) is $31.85.

Valuation of Specific Codes – p. 162
Each year, CMS receives work and practice expense RVU recommendations from the AMA RUC for new and revised CPT codes. The agency reviews these recommendations for inclusion in the fee schedule.

Remote Monitoring (CPT codes 98975, 98976, 98977, 98978, 98980, 98981, 98XX4, 98XX5, 98XX6, 98XX7, 99091, 99453, 99454, 99457, 99458, 99473, 99474, 99XX4, and 99XX5) – p. 229
At the September 2024 CPT Editorial Panel meeting, several revisions were made to the remote monitoring services code set to increase flexibility in reporting these services and to better align with current clinical practice. These changes impact both remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) services, and includes the creation of new codes, while clarifying descriptors and coding requirements for others.

New codes were created that recognize shorter durations of data collection. Previously, reimbursement for device supply codes required 16 or more days of data be collected in a 30-day period. The new codes, however, CPT codes 99XX4 and 98XX4 through 98XX6 were created to capture 2 to 15 days of data within a 30-day period.

Additionally, new RPM treatment management codes were created to reflect shorter durations of clinician time. Specifically, new CPT codes 99XX5 (RPM) and 98XX7 (RTM) capture the first 10 minutes of clinical staff, physician, or other qualified health care professional time spent in treatment management during a calendar month. The new codes 99XX5 and 98XX7 also require one real-time, live interactive communication with the patient or caregiver per calendar month to be billed. The shorter time limit in these codes better reflects real-world clinical practice as many visits associated with RPM and RTM are less than 20 minutes. Appendix B lists the new and revised CPT codes RPM and RTM services.

Evaluation and Management (E/M) Visit Complexity Add-on – p. 296
Highlight: CMS to allow the use of G2211 with home and residence E/M services.

The agency proposes to broaden the applicability of HCPCS code G2211(*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) to include home and residence-based E/M visits.

CPT codes captured in this E/M code family include 99341, 99342, 993444, 99345, 99347, 99348, 99349, and 99350. The agency heard from stakeholders that home and residence visits are "high-touch" and involve the development of longitudinal relationships, which is a critical component required for billing G2211. Many home bound patients need to be seen on a monthly or weekly or even weekly basis due the nature or seriousness of the illness. This frequent interaction leads to the development of a trusted, longitudinal relationship between the provider and the patient.

Policies to Improve Care for Chronic Illness and Behavioral Health Needs – p. 311

Comments for Payment Policy for Software as a Service – p. 319
CMS notes that there has been a rapid development in the use of software-based technologies to support clinical decision-making in the outpatient and physician office setting, some of which may be devices that require FDA clearance, approval, or authorization, which is referred to in the proposed rule as software as a service (SaaS). These technologies often incorporate software algorithms and AI, which are not accounted for in the current PE methodology. One example is the Fractional Flow Reserve Computed Tomography (Heartflow), which the agency allowed for limited separate PFS payment of in CY 2022.

CMS requests comment on how to consider paying for SaaS under the MPFS.

- How should CMS value the physician work associated with utilizing and interpreting the clinical outputs associated with SaaS and AI?
- Is there an alternative data source outside of the limited Medicare claims data currently available and hospital invoices provided by manufacturers that can accurately reflect the costs of the SaaS?
- How are these technologies used in the treatment of chronic disease?
- How may CMS best evaluate the quality and efficacy of SaaS and AI technologies?

Request for Information on Prevention and Management of Chronic Disease – p. 322
In response to the Executive Order on "Establishing the President's Make America Healthy Again Commission," the agency is focused on the prevention and management of chronic diseases as a top priority. The agency requests feedback on how to enhance support for the prevention and management of chronic disease, including these specific questions:

- How could the agency better support prevention and management, including self-management, of chronic disease?
- Are there certain services that address the root causes of disease, chronic disease management, or prevention, where the time and resources to perform the services

are not adequately captured by the current physician fee schedule code set? If so, please provide specific examples.

- Are there current services being performed to address social isolation and loneliness of persons with Medicare, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set?
    - If so, what evidence has supported these services, and what do these services entail?
    - What services have been delivered by Medicare providers or community-based organizations, including area agencies on aging and other local aging and disability organizations?
    - What has been the impact?
- Are there current services being performed that improve physical activity, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set? How should CMS consider provider assessment of physical activity, exercise prescription, supervised exercise programs, and referral, given the accelerating use of wearable devices and advances in remote monitoring technology?
- Should CMS consider creating separate coding and payment for intensive lifestyle interventions, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set, and how should these interventions be prioritized? If so, what evidence has supported these services, and what do the services entail? How would additional coding and payment be substantively different from coding and payment for Intensive Behavioral Therapy (IBT)? There are HCPCS G codes to report IBT for obesity (G0447 and G0473) and for cardiovascular disease (G0446).
- Should CMS consider creating separate coding and payment for medically-tailored meals, as an incident-to service performed under general supervision of a billing practitioner? If so, what would be the appropriate description of such a service, and under what patient circumstances (that is, after discharge from a hospital)?
    - Do community-based organizations providing medically tailored meals currently employ a physician, nurse practitioner, physician assistant, or other practitioner who could both bill Medicare and supervise a medically-tailored meal service?
    - Should CMS consider allowing billing providers to refer to community-based organizations to deliver and ensure quality of medically-tailored meals while under general supervision (please see § 410.26(a)(3) for further information about general supervision) of the referring billing provider?
    - If CMS were to create separate coding and payment for medically tailored meals, how should CMS ensure integrity of the service being delivered?
- Please provide information on whether we should consider creating separate coding and payment for FDA-cleared digital therapeutics that treat or manage the symptoms

of chronic diseases an incident-to service performed under the general supervision of a billing practitioner.

- Are there technical solutions that would enhance the uptake of the annual wellness visit (AWV), or the improving accessibility, impact, and usefulness of the AWV? How can CMS better support practitioners and beneficiaries in relation to the AWV? Should CMS consider moving some of the required components of the AWV to optional add-on codes of the AWV instead, with the intent of decreasing burden, improving uptake, and allowing practitioners to select additional AWV elements that may be more relevant to particular patients?
- Are there certain existing or new Physician Fee Schedule codes and payment, or Innovation Center Models, which could better support practitioner provision of successful interventions through partnerships between health care entities, areas of aging, community care hubs, and other local aging and disability organizations? If so, please provide specific examples.

CMS is considering creating additional coding and payment for motivational interviewing, which is defined as a collaborative, goal-oriented style of communication with particular attention to the language of change. The agency seeks feedback on this proposal, the appropriate definition of motivational interviewing, and what types of clinical staff could perform motivational interviewing incident-to a physician.

Technical Refinements to Revise Terminology for Services Related to Upstream Drivers of Health – p. 332
Highlight: CMS proposed to remove the term "social determinants of health" from the code descriptor, while deleting a code used to report the work associated with health risk assessments.

CMS proposes to delete HCPCS code G0136 (*Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5-15 minutes, not more often than every 6 months*) created by the agency in 2024 to capture work and provide payment for services associated with the administration of a standardized, evidenced based social determinants of health risk assessment tool. The agency believes that the work associated with G0136 may already be accounted for in other types of services like evaluation and management visits.

Regarding terminology used in the description of services captured under HCPCS code G0019 – community health integration (CHI) services – CMS proposes to replace the term "social determinants of health" with the term "upstream drivers of health". The agency notes that it received comments during the 2024 rule making cycle requesting that CMS align terms across programs and received suggestions for alternative descriptions of social determinants of health such as social drivers of health, drivers of health or health-related social needs. Therefore, with this rule, CMS proposes the use of the term "upstream drivers" as this

"encompasses a wider range of root causes of the problems that practitioners are addressing through CHI services. This type of whole-person care can better address the upstream drivers that affect patient behaviors (such as smoking, poor nutrition, low physical activity, substance misuse, etc.) or potential dietary, behavioral, medical, and environmental drivers to lessen the impacts of the problem(s) addressed in the CHI initiating visit."

Provisions on Medicare Parts A and B Payment for Dental Services Inextricably Linked to Specific Covered Services – p. 336
Highlight: No dental services will be added to the agency's list of dental services inextricably linked to other covered services.

Submissions Received Through Public Submissions Process
The agency received seven submissions to be considered as dental services that are inextricably linked to, and substantially related and integral to the clinical success of other clinical services. Many of the submissions recommended clinical scenarios involving diabetes mellitus, particularly around the impact of dental infections on diabetes-associated retinopathy and nephropathy. Another submitter included additional information related to autoimmune disease and oral health.

For CY 2026, the agency is not making any proposals in response to the received submissions and will take the information and recommendations into consideration for future rulemaking.

Ambulatory Specialty Model – p. 473
Highlight: New mandatory payment model focuses on treatment in the ambulatory setting and encourages clinicians to develop longitudinal relationships with patients with low back pain and heart failure.

CMS proposes the implementation and testing of the Ambulatory Specialty Model (ASM), a new mandatory alternative payment model that would begin January 1, 2027, and end December 31, 2031. The ASM will focus on the care provided by select specialists to Medicare beneficiaries with the chronic conditions of heart failure and low back pain. Clinicians would be required to report a select set of measures and activities that are clinically relevant to their specialty type and the chronic condition of interest. These measures and activities would assess quality, cost, interoperability, and care coordination practices.

To promote preventive care, the model will incentivize specialists who are ASM participants to ensure that their patients have a regular source of primary care and are screened to help identify risks and early signs of chronic conditions. The proposed measures would provide a pathway for clinicians to have conversations about non-medical, lifestyle-based interventions with their patients. The model would incentivize clinicians to coordinate care for their patients more seamlessly.

The model would require the participation of individual clinicians, rather than organizations, which the agency believes will encourage competition and create a level playing field for solo and small practices. The goal is to help identify clinicians within large health systems or provider networks that provide low-value care to patients. The model will focus on clinicians who commonly treat patients in the ambulatory setting, develop longitudinal relationships with patients, and co-manage beneficiaries with primary care clinicians. The model proposes to focus on heart failure and low back pain, as these have previously established episode-based cost measures (EBCMs) specified for the MIPS cost performance category. ASM would leverage components of the MIPS Value Pathway framework to engage specialists in improving the quality of care for high-volume, high-cost chronic conditions and better integrate specialists in primary care.

Additional details on the proposed set of measures and activities, as well as performance period information, can be found in the proposed rule.

Medicare Diabetes Prevention Program (MDPP) – p. 686
Highlight: MDPP online delivery flexibilities are being extended until December 31, 2029, and CMS proposes new definitions to necessary related terminology.

In CY 2024 and CY 2025, the MPFS was updated to reflect the use of telehealth in the MDPP. In CY 2026, CMS proposes to add definitions to the terms Live Coach interaction, online delivery period, and online session, as well as decrease operational burdens of the weight collection requirements. CMS also proposes an extension of the flexibilities granted during the COVID-19 public health emergency through December 31, 2029. These flexibilities include allowing MDPP suppliers to deliver services online. Additionally, CMS proposes a new G-code that will be used to describe the online sessions.

CMS proposes a definition of Live Coach Interaction that is bi-directional communication between the beneficiary and MDPP coach during the period that the beneficiary is engaging with MDPP content, and that the interaction cannot be replaced with AI or machine learning interactions. CMS proposes that the definition of online sessions be amended that sessions must be delivered one hundred percent through the internet in an asynchronous format where there is not a live (including non-artificial intelligence) coach teaching the content. Lastly, CMS proposes a new definition for the term Online delivery period to refer to the four-year period between January 1, 2026, to December 31, 2029, to assess the usage of the online delivery modality.

During the COVID-19 pandemic, MDPP care delivery transitioned from in-person care to virtual services with approximately 41% of participants now receiving care either in a hybrid or virtual model. CMS proposes extending the flexibilities of a hybrid or online care model for four more years, which would extend the flexibilities to December 31, 2029. This proposal

specifically aims to increase access to care for MDPP beneficiaries who are in areas with a limited number of in-person suppliers or where travel may be limited.

CMS proposes changes to the policies for obtaining weight measurements for both the baseline weight requirement and the weight loss goals, as well as modifying the MDPP expanded model emergency policy. CMS proposes that weight measurements can be based on documented weight in the beneficiary's medical record within two days of completion of a MDPP session. This proposal intends to help make it easier for beneficiaries to comply with reporting weight requirements for some beneficiaries, such as those who require a special scale. Additionally, CMS proposes that beneficiaries are allowed to use scales outside of the ones in their direct home (including scales at fitness centers, or on vacation) to submit weight measurement data.

With the proposal for an extended online delivery period through the end of calendar year 2029, CMS will require organizations to submit a separate application for each delivery mode used to the CDC, meaning there will be separate organization codes for each delivery model. CMS proposes that MDPP suppliers do not have to maintain in-person delivery capacity to allow beneficiaries to enroll in online-only programs. To qualify for payment, CMS requires that the online only services must be consistent with the standards for program format, coach interaction, and program intensity set by Diabetes Prevention Recognition Program (DPRP), a quality assurance program. Additionally, providers are responsible for using tools to detect accurate weight measurements from beneficiaries, such as scales with Bluetooth hardware. MDPP providers must also ensure that participants enrolled in self-paced programs are engaged with the program. For online delivery of this program, CMS proposes that the minimum number of sessions in the MDPP program must be delivered during the online delivery period, which comes out to be one session a week for the first six months (a total of 16 sessions) and one session each month for the following six months.

Medicare Prescription Drug Inflation Rebate Program – p. 707
Highlight: CMS proposes policies to implement the Medicare Prescription Drug Inflation Rebate Program.

Overview of the Medicare Prescription Drug Inflation Rebate Program
Sections 11101 and 11102 of the Inflation Reduction Act established requirements that drug manufacturers must pay inflation rebates if they raise their prices for certain drugs payable under Part B and/or covered under Part D faster than the rate of inflation.

CMS proposes to describe how the agency would identify the payment amount benchmark quarter if data were unavailable to calculate the payment amount in the benchmark quarter. CMS proposes to describe the method for calculating the payment amount in the benchmark quarter if a published payment limit is not available, as well as the method for calculating the

payment amount if there is no published payment limit and neither positive ASP nor positive Wholesale Acquisition Cost (WAC) data are available in the ASP Data Collection System.

Under Section 428.203(b)(2), for claims with dates of service on or after January 1, 2026, CMS will exclude from the total number of units used to calculate the total rebate amount for a Part D drug those units for which a manufacturer provided a discount under the 340B program. CMS proposes to use a claims-based methodology to implement this section.

CMS proposes to establish a 340B repository to receive voluntary submissions from 340B covered entities of certain data elements from Part D 340B claims.

Drugs Covered as Additional Preventive Services (DCAPS)
Starting on September 30, 2024, CMS established coverage of Preexposure Prophylaxis (PrEP) using antiretroviral therapy to prevent HIV infection as an additional preventive service under the Social Security Act, which is referred to as DCAPS. CMS proposes to identify DCAPS as Part B rebatable drugs and will calculate rebates based on the current methodology.

Medicare Shared Savings Program – p. 745
Highlight: CMS proposes to eliminate the health equity adjustment applied to an ACO's quality score, and other modifications to ACO eligibility, quality reporting, and financial reconciliation requirements for Medicare Shared Saving Program (MSSP) participation.

The MSSP allows eligible healthcare providers, such as physicians, hospitals, and others, to form or join an accountable care organization (ACO). By doing so, they agree to take responsibility for the overall cost and quality of care provided to a specific group of Medicare fee-for-service (FFS) beneficiaries. Providers and suppliers who participate in an ACO still receive traditional Medicare FFS payments under Parts A and B. If an ACO meets certain quality and savings criteria, it may receive shared savings payments. In some cases, it may also be required to share in losses if healthcare spending increases.

The proposals outlined below aim to ensure that participation in the MSSP will promote better chronic disease management and prevention, more efficient use of resources, promote innovation, and drive increased savings for the Medicare Trust Fund. CMS estimates that the MSSP proposals in this proposed rule will reduce program spending by $20 million in total through 2026 through 2035.

CMS proposes to modify requirements for determining an ACO's eligibility for MSSP participation options. Specifically, ACOs may only participate in a one-sided risk model (no downside risk) during their first agreement period under the BASIC track (if eligible) beginning in 2027. ACOs without experience in performance-based risk would be required to move more quickly to higher-risk options (Level E of the BASIC track or the ENHANCED

track). However, ACOs with fewer than 5,000 assigned beneficiaries in benchmark year (BY) 1, 2, or both, would not be allowed to join the ENHANCED track.

CMS proposes to modify MSSP eligibility requirements to require ACOs to amend their ACO participant list during the performance year, which is outside of the usual annual update cycle, when an ACO participant experiences a change of ownership where the surviving Taxpayer Identification Number (TIN) has no prior Medicare billing history.

CMS proposes to modify MSSP eligibility requirements and financial reconciliation requirements related to the statutory requirement that ACOs have at least 5,000 assigned Medicare FFS beneficiaries. Specifically, the agency proposes the following:

- ACOs must have at least 5,000 assigned beneficiaries in BY3 to enter a new agreement period, even if they fall below that threshold in BY1 or BY2.
- ACOs with fewer than 5,000 beneficiaries in BY1, BY2, or both, must enter the BASIC track.
- Shared savings and losses for ACOs with under 5,000 beneficiaries in any benchmark year will be capped to help ensure the amounts reflect the ACO's performance in the program rather than normal variation in expenditures.
- ACOs with fewer than 5,000 beneficiaries in any benchmark year will not qualify for enhanced savings opportunities available to certain low revenue ACOs in the BASIC track.

CMS proposes to update the definition of primary care services used in ACO assignment under the MSSP beginning January 1, 2026, to include additional HCPCS and CPT codes. Specifically, CMS proposes to include all HCPCS and CPT codes listed under §425.400(c)(1)(ix) of the Code of Federal Regulations, which defines the primary care service codes used for assigning Medicare beneficiaries to an ACO, as well as the Enhanced Care Model Management Services (HCPCS codes (GPCM1, GPCM2, and GPCM3) proposed in this rule. This change is a result of ACO feedback and aims to align with current and proposed billing and coding practices under the MPFS.

CMS proposes several revisions to quality performance and reporting requirements for ACOs, including:

- Revising the definition of a beneficiary eligible for Medicare Clinical Quality Measures (CQMs), beginning in performance year 2025, to require that the beneficiary receive at least one primary care service during the year from an ACO professional who is a primary care physician, a physician specialist, physician assistant, nurse practitioner, or clinical nurse specialist.
- Eliminating the health equity adjustment applied to an ACO's quality score, beginning in 2025, and updating related terminology for prior years. For example, CMS proposes to revise the phrase "health equity adjustment bonus points" to "population

and income adjustment bonus points" in calculating an adjustment to an ACO's quality score for performance years 2023 and 2024. CMS believes that this proposal would simplify the agency's quality scoring methodology.

- Modifying the APP Plus measure set by removing the Screening for Social Drivers of Health measure (Quality ID: 487).
- Changing the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Merit-based Incentive Payment System (MIPS) Survey administration to a web-mail-phone protocol starting in 2027. Currently, data is collected using a mail-phone survey administration protocol.

CMS proposes to expand the application of the MSSP 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.

CMS proposes to revise the MSSP regulations for performance year 2025 and subsequent performance years to rename the "health equity benchmark adjustment" to the "population adjustment." CMS states that this proposed revision would more accurately reflect the nature of the adjustment, which accounts for the proportion of the ACO's assigned beneficiaries who are enrolled in the Medicare Part D LIS or dually eligible for Medicare and Medicaid.

CMS proposes to update MSSP quality reporting monitoring requirements beginning in 2026 to include oversight of ACOs that fail to meet both the quality performance standard and the alternative quality performance standard, the latter of which was unintentionally excluded from the current framework. CMS also proposes to revise application review criteria for renewing or re-entering ACOs to reflect this change.

Updates to the Quality Payment Program – p. 897
Highlight: CMS proposes six new MVPs and seeks feedback from stakeholders on several topics to transform the Quality Payment Program.

Authorized by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the Quality Payment Program (QPP) is a value-based payment program, by which the Medicare program rewards clinicians who provide high-value, high quality care to their patients in a cost-efficient manner. There are two ways for clinicians to participate in the QPP: Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

For the MIPS participation track, MIPS eligible clinicians are subject to a MIPS payment adjustment (positive, negative, or no adjustment) based on their performance in four performance categories: cost, quality, improvement activities, and promoting interoperability. For CY 2026 performance period/2028 MIPS payment year, the scoring weights are proposed to be unchanged and remain as follows: 30 percent for the quality performance category; 30 percent for the cost performance category; 15 percent for the improvement

activities performance category; and 25 percent for the promoting interoperability performance category.

For the Advanced APM track, if an eligible clinician participates in an Advanced APM and achieves Qualifying APM Participant (QP) or Partial QP status, they are excluded from the MIPS reporting requirements and payment adjustment. Under current law, eligible clinicians who are QPs for the 2026 performance period and beyond will receive an increased physician fee schedule update of 0.75 percent based on the QP conversion factor in the corresponding payment year. QPs will continue to be excluded from MIPS reporting and payment adjustments for the applicable year. Historically, QPs received a lump sum APM Incentive Payment in the corresponding payment year, calculated as a specified percentage of the QP's paid claims for covered professional services from the base year. Under current law, payment year 2026 is the last year for these payments. Only legislation enacted by Congress can update either the enhanced QP conversion factor updates or the APM Incentive Payment.

Transforming the QPP – p. 909

Background

In the CY 2022 MPFS final rule, CMS implemented the MIPS Value Pathways (MVP) reporting option for MIPS eligible clinicians beginning in the CY 2023 performance period/2025 MIPS payment year. Each MVP includes a subset of measures and activities that are related to a given specialty or medical condition. The policies outlined in this proposed rule aim to support CMS' goal of phasing out traditional MIPS and transitioning to MVP reporting. However, CMS has not announced an official date for the sunset of traditional MIPS.

MVP participants have several reporting options depending on their group composition and participation type:

- Individual – A single MIPS eligible clinician reports MVP data on their own.
    - Ex: A cardiologist who is the only clinician at a clinic in rural Oklahoma reports the "Advancing Care for Heart Disease" MVP.
- Group – A group of clinicians reporting MVP data collectively.
    - Ex: A primary care clinic in suburban Illinois employing various clinicians (e.g., primary care physicians, nurse practitioners, and internists) regularly treating patients with chronic diseases reports the "Value in Primary Care" MVP.
- Subgroup – A subset of the clinicians in a practice report one MVP as a subgroup.
    - Ex: Several internal medicine physicians at a primary care clinic in suburban Illinois employing various clinicians (e.g., primary care physicians, nurse practitioners, and specialist physicians) and regularly supporting treatment for patients with heart disease report the "Value in Primary Care" MVP.

- APM Entity – Clinicians participating in an Alternative Payment Model (APM) report MVPs through their APM Entity.
    - Ex: An APM Entity participating in the Comprehensive Care for Joint Replacement Model reports the “Improving Care for Lower Extremity Joint Repair” MVP.

Proposed Changes to MVP Reporting
CMS proposes to expand the definition of an MVP Participant to include multispecialty groups meeting the requirements of small practices (2 to 15 clinicians). Therefore, for the CY 2026 performance period/2028 MIPS payment year and future years, MVP Participant means an individual MIPS eligible clinician, single-specialty group, multispecialty group that meets the requirements of a small practice, subgroup, or APM Entity that is assessed on an MVP for all MIPS performance categories.

Consistent with this proposal, CMS proposes that:

- Multispecialty group practices with 15 or fewer clinicians would be exempt from the requirement to report as subgroups if they choose to report an MVP.
- Larger group practices (16+ clinicians) with a single focus of care could report as a single group.
- Larger group practices (16+ clinicians) with multiple specialties must report as subgroups or, if applicable, as individuals. They cannot report as a single group under an MVP.

CMS proposes that, beginning with the CY 2026 performance period/2028 MIPS payment year, a group practice registering for MVP reporting would need to attest their specialty composition either as a single specialty group or a multispecialty group that meets the requirements of a small practice during MVP registration. CMS will not make this determination for them. The agency believes this will support groups in their transition to MVP reporting and would help these groups assess their need to participate as subgroups.

Core Elements Request for Information (RFI) – p. 918
CMS is considering a policy requiring MVP participants to report on one designated “Core Element” quality measure per MVP, in addition to selecting three other required quality measures. This policy aims to emphasize and increase reporting on select quality measures that are most important to clinicians and patients and reflect care that is at the crux of the MVP’s applicable specialty, medical condition, or episode of care. Core Elements could be, but would not necessarily be, outcomes measures. Through this, CMS aims to improve comparability, drive quality, and highlight measures meaningful to clinicians and patients.
CMS is considering proposing the Core Elements policy in the CY 2027 MPFS proposed rule, using feedback received on the proposed rule to inform future rulemaking for implementation prior to the eventual sunset of traditional MIPS at a date yet to be determined. Should CMS propose implementing Core Elements in MVPs, the agency would propose

Core Elements for existing MVPs via notice and comment rulemaking. When new MVPs are proposed, CMS would identify the MVP's Core Elements at that time through notice and comment rulemaking. Given the existing quality measure gaps for certain specialists and subspecialists, there may be clinicians for whom there would not be an applicable and available Core Element.

CMS seeks feedback on the following questions related to MVP Core Elements beginning on p. 920 of the proposed rule.

- One of the key goals of Core Elements is to provide patients with enough information across different clinicians to compare specialist performance on foundational measures within a clinical area. Are there other ways to ensure MVP reporting results provide comparative performance data for patients on critical measures?
- One of CMS' concerns is that Core Elements specified for a few collection types, such as electronic clinical quality measures (eCQMs) or Qualified Clinical Data Registry (QCDR) measures, would limit clinician choice and may unintentionally force clinicians to report via intermediaries. One possible solution would be to include Core Elements with several different collection types, when possible, to provide clinicians with some choice of collection type. Are there other flexibilities or options that could reduce this limitation?
- CMS is considering policies to increase the likelihood that clinicians have an applicable and available Core Element. CMS requests feedback on ways to include measures that are applicable for more clinicians. CMS also requests feedback on ways to avoid disadvantaging clinicians without an applicable Core Element, such as attesting to no applicable and available Core Element.
- CMS is interested in receiving feedback on specific measures that should or should not be considered for the Core Elements requirement.
- CMS understands the Core Elements requirement places a new restriction on MVP reporting. The agency requests feedback on whether the Core Elements reporting requirement would impact clinicians' decision to report an MVP while traditional MIPS remains a reporting option.

Medicare Procedural Codes RFI – p.921

CMS seeks feedback on the use of Medicare procedural billing codes to assign clinicians to an MVP. This approach aims to facilitate specialty reporting of MVPs most relevant to their scope of care. Specifically, CMS is considering an approach that would identify relevant procedural codes for each MVP, where applicable, and then require clinicians to report that MVP based on their billing of those procedural codes. CMS would prioritize linking MVPs with high-utilization and high-cost procedures. For example, the hip replacement surgery procedural codes would be linked to the Improving Care for Lower Extremity Joint Repair

MVP and the relevant quality measures to encourage clinicians to report measures that are relevant to their scope of care.

CMS seeks feedback on the questions related to the use of Medicare procedural codes to suggest or assign MVPs beginning on p. 924 of the proposed rule.

- If the agency requires clinicians to participate in a specific MVP, how should clinicians be notified?
- If the agency does not suggest or assign MVPs to clinicians, how else can they encourage specialty reporting of relevant MVPs based on the scope of care provided?
- What data sources should CMS consider using to assign clinicians to an MVP? To appropriately determine the relevance of the measures and activities in an MVP to the scope of care provided by the clinicians, CMS is considering using procedural billing codes from Medicare Part B claims data.
- The MIPS determination period is used to determine MIPS eligibility and begins the calendar year two years prior to the applicable performance period. Would it be appropriate to align with that timeline and use the procedural billing codes from Medicare Part B claims data from two years prior to the performance year in which a clinician would report the particular MVP?
- CMS is considering setting a volume threshold that clinicians must meet to be assigned to a particular MVP. For example, CMS may consider a threshold of 20 cases to be assigned to the MVP, given the case minimum requirement of 20 cases for most measures. What would be an appropriate volume threshold for the procedural billing codes?
- If CMS suggests or requires the reporting of a particular MVP, the agency will limit clinicians' current flexibility to choose an MVP. Additionally, it would take time for CMS to identify effective approaches to operationalize this concept. Given these constraints, how long would clinicians need to prepare for a suggested MVP based on Medicare Part B claims data? How long would clinicians need to prepare for a required MVP based on Medicare Part B claims data?

Well-being and Nutrition Measures RFI – p. 925

CMS seeks input on well-being and nutrition measures for future years in the QPP. Specifically, the agency seeks 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. CMS requests input and comments on the applicability of tools and constructs that assess for the integration of complementary and integrative health, skill building, and self-care.

CY 2026 MVP Development and Maintenance – p. 927

CMS proposes to adopt the following six new MVPs:

- Diagnostic Radiology
- Interventional Radiology
- Neuropsychology
- Pathology
- Podiatry
- Vascular Surgery

For a detailed description of each new MVP proposed for the CY 2026 performance period and 2028 MIPS payment year and future years, please see Appendix 3, Group A on p. 1717 of the proposed rule.

CMS proposes modifications to the following 21 existing MVPs, in alignment with proposals to update the quality measure and improvement activity inventories:

- Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
- Advancing Cancer Care
- Advancing Care for Heart Disease
- Advancing Rheumatology Patient Care
- Complete Ophthalmologic Care
- Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
- Dermatological Care
- Focusing on Women's Health
- Gastroenterology Care
- Improving Care for Lower Extremity Joint Repair
- Optimal Care for Kidney Health
- Optimal Care for Patients with Urologic Conditions
- Patient Safety and Support of Positive Experiences with Anesthesia
- Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV
- Pulmonology Care
- Quality Care for Patients with Neurological Conditions
- Quality Care for the Treatment of Ear, Nose, and Throat Disorders
- Quality Care in Mental Health and Substance Use Disorders
- Rehabilitative Support for Musculoskeletal Care
- Surgical Care
- Value in Primary Care

For a detailed description of the proposed modifications to previously finalized MVPs for the CY 2026 performance period and 2028 MIPS payment year and future years, please see Appendix 3, Group B on p. 1749 of the proposed rule.

Third Party Intermediaries Support of MVPs – p. 930
CMS recognizes that some Qualified Clinical Data Registries (QCDRs) and qualified registries may have difficulties programming new measures and preparing their systems to support MVP reporting within the brief timeframe from when the agency issues the MPFS final rule and its effective date. The agency has heard concerns from QCDRs and qualified registries regarding feasibility of meeting this requirement. Therefore, CMS proposes that QCDRs, and qualified registries would have one year after a new MVP is finalized before they are required to fully support that MVP, to provide more time to implement necessary system updates to capture the measures and activities finalized for inclusion. CMS invites comments on this proposal.

APM Performance Pathway – p. 932
The APM Performance Pathway (APP) was designed as a reporting and scoring pathway available only to MIPS eligible clinicians identified on the Participation List or Affiliated Practitioner List of an APM Entity participating in a MIPS APM. Because the APP is a feature within MIPS and therefore the quality measures used within the APP and APP Plus quality measure sets are all MIPS measures, any updates CMS applies to MIPS measures also are incorporated into the APP and APP Plus quality measure sets, accordingly. Therefore, CMS proposes changes to the APP and APP Plus quality measure sets to maintain alignment with the MIPS quality measure inventory. For more details, please refer to Tables 54-57 of the proposed rule.

MIPS Performance Category Measures and Activities – p. 958

MIPS Quality Performance – p. 958
For the CY 2026 performance period/MIPS 2028 payment year, CMS proposes a quality measure inventory of 190 measures—187 for traditional MIPS and three exclusive to MVPs. The proposed removals target outdated or low-value process measures, while new additions emphasize outcome measures and eCQMs.

The new MIPS quality measures proposed for the CY 2026 Performance Period/2028 MIPS Payment Year and Future Years include the following:

- Patient Reported Falls and Plan of Care (p. 1,391)
- Prevalent Standardized Kidney Transplant Waitlist Ratio (PSWR) (p. 1,394)
- Diagnostic Delay of Venous Thromboembolism in Primary Care (p. 1,398)
- Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes (p. 1,401)

- Hepatitis C Virus (HCV): Sustained Virological Response (SVR) (p. 1,403)

Additional information on the proposed new MIPS quality measures is available on the page numbers listed above.

Additionally, CMS proposes revising the definition of a "high priority measure" to exclude health equity. CMS believes that its definition of health equity was “confusing and that health disparities are best addressed through efforts to improve overall healthcare quality for all beneficiaries.”

MIPS Cost Performance – p. 967
For the CY 2026 performance period/2028 MIPS payment year, CMS proposes to:

- Modify the Total Per Capita Cost (TPCC) measure;
    - The TPCC measure assesses the overall cost of care delivered to a patient with a focus on the primary care they receive from their provider(s). CMS proposes to modify the TPCC measure candidate event and attribution criteria. Specifically, CMS proposes to:
        - Exclude candidate events initiated by advanced practice providers if all other clinicians in the group are excluded based on specialty;
        - Require the second service used to initiate a second candidate event to be an E/M or related primary care service within 90 days of the first service, provided by the same TIN; and
        - Ensure the second service used to initiate a candidate event is delivered by a clinician not excluded based on specialty criteria.
- Update the list of care episodes and patient condition groups and codes to reflect coding changes identified through CMS’ annual maintenance process for MIPS cost measures; and
- Adopt a 2-year informational-only feedback period for new cost measures, where a measure would not impact MIPS cost performance category scores, final scores, or payment adjustments until the third year it is implemented.

MIPS Improvement Activities Performance Category – p. 983
For the CY 2026 performance period/2028 MIPS payment year, CMS proposes to:

- Add three new improvement activities into two existing subcategories, modify seven improvement activities, and remove eight improvement activities.
- Add a new subcategory titled “Advancing Health and Wellness.” CMS believes this proposed addition would emphasize the agency’s priority of overall health promotion and address broader aspects of healthcare that go beyond the direct treatment of diseases.

- Remove the “Achieving Health Equity” subcategory. CMS states that this proposal would not de-emphasize their focus on improving access, enhancing care coordination, and strengthening patient engagement. Rather, the removal would be aligned with other QPP programs that have shifted focus to identifying improvement objectives on topics of prevention, nutrition, and well-being.

MIPS Promoting Interoperability Performance Category – p. 994
For the CY 2026 performance period/2028 MIPS payment year, CMS proposes updates to the MIPS Promoting Interoperability category, including:

- Modifying the Security Risk Analysis and High Priority Practices Safety Assurance Factors for Electronic Health Record (EHR) Resilience (SAFER) Guide measures; and
- Introducing a new optional bonus measure, the Public Health Reporting Using Trusted Exchange Framework and Common Agreement™ (TEFCA™) measure.

RFI Regarding Data Quality – p. 1,054
CMS is concerned that gaps and discrepancies in data accuracy, completeness, reliability, and consistency undermine the integrity of health information exchange. The agency believes MIPS eligible clinicians should be able to seamlessly exchange high-quality health information with patients, providers, and payers across health systems. CMS wants to encourage and support MIPS eligible clinicians’ use of modern technologies and standards to ensure data are usable, complete, accurate, timely, and consistent. Therefore, they seek public comment.

Additional CY 2026 Modifications to the Quality Payment Program – p. 1,057

MIPS Final Score Methodology – p. 1,057
For the CY 2026 performance period/2028 MIPS payment year, the scoring weights for each performance category are as follows: 30 percent for the quality performance category; 30 percent for the cost performance category; 15 percent for the improvement activities performance category; and 25 percent for the Promoting Interoperability performance category. These weights remain unchanged from the CY 2025 performance period.

MIPS Performance Threshold – p. 1,078
To determine a MIPS payment adjustment factor for each MIPS eligible clinician for a year, CMS compares the MIPS eligible clinician’s final score for the given year to the performance threshold established for that same year. The performance threshold is the final score needed to avoid a negative MIPS payment adjustment.

CMS proposes to continue using the mean of the final scores for all MIPS eligible clinicians from the CY 2017 performance period/2019 MIPS payment year to establish the performance threshold as 75 points for the CY 2026 performance period/2028 MIPS payment year through

the CY 2028 performance period/2030 MIPS payment year. CMS believes this will continue to provide stability and predictability for MIPS eligible clinicians, allowing MIPS eligible clinicians to gain experience with MVPs and experience with MVPs and other new MIPS policies, and continuing to support solo, small, and rural practices.

Advanced APMs – p. 1,098
CMS proposes to revise the methodology for calculating QP status, which determines whether clinicians in Advanced APMs qualify for incentive payments and are exempt from MIPS reporting. Currently, QP determinations are made at the APM Entity level, giving all eligible clinicians within the entity the same status based on group performance. Under the proposal, CMS would calculate QP status at the individual clinician level, offering a more tailored assessment of each clinician's Advanced APM participation. Eligible clinicians will qualify as QPs if they meet or exceed the payment or patient count thresholds either individually or at the APM Entity level during the QP Performance Period.

Additionally, CMS proposes to use Covered Professional Services to identify Attribution-eligible beneficiaries when calculating QP status. CMS believes that this complements the proposal to add individual level calculations to QP determinations. CMS believes these changes would better reflect clinician-level participation and streamline the QP determination process.

Appendix A: CY 2026 PFS Estimated Impact on Total Allowed Charges by Specialty – p. 1,191

(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%
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%
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%

(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
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%
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%
	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%
	TOTAL	$1,124	0%	0%	0%	0%

Appendix B: Proposed CY 2026 Remote Monitoring Codes – p. 232

Code	Long Descriptor
99453	No changes for CY 2026
99XX4	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial: device(s) supply with daily recording(s) or programmed alert(s) transmission, 2-15 days in a 30-day period
99454	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, 16-30 days in a 30-day period
99091	No changes for CY 2026
99XX5	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring 1 real-time interactive communication with the patient/caregiver during the calendar month; first 10 minutes
99457	No changes for CY 2026
99473	No changes for CY 2026
99474	No changes for CY 2026
99458	No changes for CY 2026
98975	No changes for CY 2026
98XX4	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of respiratory system, 2-15 days in a 30-day period
98976	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of respiratory system, 16-30 days in a 30-day period
98XX5	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of musculoskeletal system, 2-15 days in a 30-day period
98977	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of musculoskeletal system, 16-30 days in a 30-day period
98XX6	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of cognitive behavioral therapy, 2-15 days in a 30-day period
98978	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of cognitive behavioral therapy, 16-30 days in a 30-day period
98XX7	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least 1 real-time interactive communication with the patient or caregiver during the calendar month; first 10 minutes
98980	No changes for CY 2026
98981	No changes for CY 2026