CY 2026 Medicare Physician Fee Schedule Final Rule Summary and the Quality Payment Program

On October 31, the Centers for Medicare & Medicaid Services (CMS) released the Medicare Physician Fee Schedule (MPFS) final rule and fact sheet for CY 2026 (CMS-1832-F). 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 addenda, including Addendum B, which lists the final relative value units (RVUs) for each CPT® and HCPCS code can be found here. The list of codes subject to the negative 2.5% efficiency adjustment is included in the data files.

CMS finalized significant policy changes that align with the administration's efforts to curb fraud, waste, and abuse, and advance the agency's Make American Healthy Again initiative. Some of the changes include new payment policy to negatively adjust work RVUs account for efficiency gains over time, creation of policy to cut practice expense amounts for services performed in the facility setting, expansion of behavioral health initiatives, and making permanent changes to some telehealth provisions.

Note that the page numbers listed in this document refer to the of the display copy final rule. Also, new CPT codes now have final code numbers assigned.

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 alternative payment model (APM) and the other for those not in a qualifying APM. The conversion factor for the former will increase to $33.57, an increase of 3.77%, and the latter to $33.40, an increase of 3.62%. These increases reflect the 2.5% increase to the conversion factor included in the reconciliation package adopted by Congress in July, and a 0.49% positive update to account for the redistributive effects of the finalized changes to work RVUs.

Specialty Level Impact of the Final Policy Changes – p. 1,738
CMS finalized two policies, an indirect practice expense calculation which creates a site of service payment differential and an efficiency adjustment, which place 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 final policies lead to substantial variations in the impact percentages for both facility and non-facility (office) sites of service, with the office setting seeing positive changes to payment for certain physician services, while payment for physician services provided in the inpatient setting is reduced.

Table D-B7 of the rule (**Appendix A of this summary**) estimates the specialty level impacts of the policies included in the final rule and includes impacts of rate-setting changes and changes to RVUs within the budget neutral system. The impact of the final rule's policies on group practices and individual physicians varies based on practice type, site of service, and the mix of patients and services provided.

Development of Strategies for Updates to Practice Expense Data Collection and Methodology – p. 53
Highlight: CMS thanks commenters for information on the AMA PPIS data for rate setting and remains interested in collecting data and cost shares information.

CMS is not using the AMA's Physician Practice Information Survey (PPIS) survey data for rate setting calculations. Instead, the agency will maintain the current practice expense per hour (PE/HR) data and cost shares for 2026 rate setting. The agency reiterated reasons for not incorporating the updated PPIS data including low survey response rates and lack of representativeness, small sample size, lack of comparability to previous survey data, and missing or incomplete survey 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 a service's total RVUs. Given that CMS will not use updated AMA PPIS data to update the PE/HR rates for each physician specialty, the PE/HR will remain at 2017 levels.

Updates to Practice Expense (PE) Methodology – Site of Service Payment Differential – p. 68
Highlight: Indirect practice expense RVUs for physician services performed in the facility setting will be cut by 50% under final policy.

CMS finalized payment methodology reducing indirect practice expenses (PE) by 50% within the physician payment formula. The policy states that for each service valued in the facility setting under the MPFS, the agency will 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 new policy reflects 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*."

This policy reallocates Medicare payments away from physicians who deliver services in facility-based settings and toward those who provide care in office or outpatient settings. Knowing how Medicare defines a "place of service" is critical for understanding how this policy will affect a physician's reimbursement.

Examples of facility-based settings include inpatient hospitals, on-campus and off-campus outpatient departments, hospital emergency rooms, and ambulatory surgical centers. Examples of non-facility settings include physician offices, patients' homes or private residences, assisted living facilities, pharmacies, and urgent care centers. A full list of place-of-service codes is available in the Medicare Claims Processing Manual, Chapter 12, Section 20.4.2.

The rule notes that an increasing number of physicians do not own their practices 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 by 50% will more accurately account for the costs incurred in each setting of care. The agency does agree that physicians do incur some indirect costs for services provided in the facility setting stating that "*this is why we retained allocating significant amounts of indirect PE RVUs per work RVUs in the facility setting*." The agency believes that 50% is an overpayment for the indirect costs incurred in facility settings.

Finally, this change will not be phased-in over a four-year period as the agency has done for prior significant changes to the practice expense methodology. The agency notes that phasing in the policy would only allow distortions of site-of-service payments to continue, and delay increases to payments made for non-facility services.

Efficiency Adjustment – p. 182
Highlight: CMS finalizes controversial efficiency adjustment (i.e., payment cut) for nearly all services on the physician fee schedule and continues to take aim at the AMA RUC process.

CMS finalized the efficiency adjustment aimed at improving the accuracy of work RVUs and intraservice physician time estimates for non-time-based services. Specifically, CMS will 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 **will not apply** to time-based services, including evaluation and management (E/M) visits, behavioral health services, maternity global codes, and care management services. In response to comments from stakeholders, new CPT codes

(i.e., those effective January 1) will not be subject to the efficiency adjustment in 2026. Table 1 illustrates an example as to how the work RVUs and time of procedures are reduced through the efficiency adjustment. Although the reductions may appear small for each individual code, the cumulative impact over the course of a year will significantly affect overall reimbursement. Other services subject to the efficiency adjustment are listed here: Code List 2026.

Table 1. Effects of the Efficiency Adjustment Policy

CPT Code	Descriptor	Current Work RVU	Adjusted Work RVU	Current Time	Adjusted Time
95251	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report	0.70	0.68	20.00	19.63
76536	Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation	0.56	0.55	18.00	17.75

Per CMS, the efficiency adjustment is meant to account for efficiency gains over time as practitioners become more skilled at performing procedures, and therefore, are performing those procedures faster than the intraservice times recommended by the RUC and used by CMS in rate setting. The agency continues to believe that the RUC survey process is flawed due to low response rates and the perceived conflicts of interest of those who take RUC surveys and reiterated this stance in the final rule. Additionally, throughout the responses to comments, CMS repeats that they welcome empiric data to support the value of physician services, which is yet another indication that CMS does not want to rely solely on RUC survey data to set payment rates. CMS states "*we believe that robust empiric data is important to avoid some of the shortcomings of survey data in accounting for efficiencies over time*."

Many commenters stated that intraservice times are in fact increasing, contrary to CMS's position, due to ever increasing patient complexity created by increased average body mass index and a higher number of chronic conditions per patient. To counter this comment, the agency reminds stakeholders that there are codes that may be used to report services for care management and care coordination for patients with complex health needs which could be used to account for increasingly complex patients. It may be inferred that the agency believes that the use of CPT codes associated with non-complex and complex care management (CCM) and principal care management (PCM) can fill the gap left by efficiency adjustment.

The agency was persuaded by comments to remove diagnostic, prophylactic, or therapeutic intravenous infusion services from the efficiency adjustment code list. Stakeholders noted that infusion rates are recommended on the required FDA labeling for chemotherapy and other infusion drugs, and therefore cannot become more efficient or delivered at faster rate. However, the agency did not say the codes would be removed permanently indicating in the rule that "*we are removing time-based, drug administration codes from the list of codes to which the efficiency adjustment will apply in CY 2026.* Stakeholders will need to remain vigilant to ensure the codes for these services are not added to the list for 2027.

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*." This is important to note because comments submitted specifically call out that it is unreasonable for CMS to use the MEI and productivity adjustment to determine if an efficiency adjustment is warranted when the physician fee schedule does not have associated yearly payment increases, quite unlike other payment systems in the Medicare program. CMS was again unmoved by these arguments and will finalize the policy.

CMS will 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.

Geographic Practice Cost Indices (GPCIs) – p. 560
Highlight: Updated GPCI data will be phased in over two years.

CMS finalized updates to the GPCIs using more current data on wages, rent, equipment, and insurance to better reflect local cost differences and will continue to use existing MEI cost share weights for practice expense calculations in 2026.CMS finalized new GPCIs as proposed, to be phased in over two years beginning in CY 2026. In addition, CMS finalized the geographic adjustment factor (GAF) for each PFS locality.

Addenda D and E list the final CY 2026 GPCIs and GAFs by state and Medicare locality. For more information and a detailed explanation of the GPCIs, see page 560 of the final rule.

Potentially Misvalued Services Under the Physician Fee Schedule – p. 85
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 (FNA) services represented by CPT codes 10021, 10004, 10005, and 10006 were nominated as misvalued in the proposed rule, with the nominating party requesting that the work RVUs be restored to the 2019 levels. CMS finalized its assertion that FNA services are not misvalued but did support the RUC placing FNA services on its list of services that must be reviewed by specialty societies.

Payment for Medicare Telehealth Services under Section 1834(m) of the Act – p. 135
Highlight: CMS modified the process to add services to the telehealth list and made permanent direct supervision of incident-to services.

Modification of the Medicare Telehealth Services List and Review Process – p. 136
CMS finalized the proposal 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 assessed whether the elements of the requested service map to those of services on the list with permanent status, while step 5 had previously assessed 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. Moving forward, 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 139 of the final 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 A-D1, page 143 in the final rule.

Group Behavioral Counseling for Obesity – p. 145
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

requirements to be placed on the telehealth services list and, after receiving positive comments in support of the proposal, finalized the proposal to add the service to the Medicare Telehealth Services List.

Telemedicine E/M Services – p. 151
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 is not adding these services.

Frequency Limitations on Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations – p. 154
CMS will permanently remove frequency limitations on furnishing services via telehealth for the codes listed on page 156 of the final 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. 158
CMS will 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 will apply this definition to the applicable cardiac, pulmonary, and intensive cardiac rehabilitation services.

Changes to Teaching Physicians' Billing for Services Involving Residents with Virtual Presence – p. 165
CMS had proposed 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. However, the agency received many comments in support of allowing teaching physicians to have a virtual presence, arguing that the policy has been effective, safe and educationally sound. The agency is finalizing to permanently allow teaching physicians to have a virtual presence in all teaching settings, only in clinical instances where the service is a telehealth visit (i.e., a 3-way telehealth visit, with the teaching physician, resident, and patient in separate locations). This will continue to allow teaching physicians to have a virtual presence during the key portion of the Medicare telehealth service3 for all residency training locations.

Telehealth Originating Site Facility Fee Payment Amount Update – p. 170
For CY 2026, the final payment amount for HCPCS code Q3014 (*Telehealth originating site facility fee*) is $31.85.

Distant Site Requirements – p. 162
CMS received comments requesting that the agency provide clarification on policies related to telehealth. Several commenters expressed concern with the expiration of the flexibility for telehealth practitioners to use their currently enrolled address instead of their home address. The agency issued a FAQ that provides additional information on how to suppress street address details as providers continue to use their currently enrolled practice location instead of their home address and does not believe that additional extensions are required through rulemaking. Any future updates to this policy will be made through subregulatory guidance.

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, 98984, 98985, 98986, 98979, 99091, 99453, 99454, 99457, 99458, 99473, 99474, 99445, and 99470) – p. 330
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. CMS finalized these services, associated RVUs and practice inputs and hence the codes will be ready for use beginning January 1, 2026. Appendix B of this summary provides final code numbers and descriptors for these services.

Evaluation and Management (E/M) Visit Complexity Add-on – p. 414
Highlight: CMS expands use of G2211 allowing its use with home and residence E/M services.

The agency broadened 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 homebound patients are often seen on a monthly or weekly basis due the nature or seriousness of their illnesses. This frequent interaction leads to the development of a trusted, longitudinal relationship between the provider and the patient.

Comment Solicitation on Payment Policy for Software as a Service (SaaS) – p. 447
CMS highlights that there is 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 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 MPFS payment of in CY 2022.

CMS requested comment on how to consider paying for SaaS under the MPFS. The agency appreciated the feedback from commenters and may consider for future rulemaking.

Request for Information on Prevention and Management of Chronic Disease – p. 450
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 requested feedback on how to enhance support for the prevention and management of chronic disease, including through proposals that increase physical activity, access to medically tailored meals, and reimbursement for intensive behavioral therapy.

CMS sought feedback on 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 appreciates the feedback received and will consider the comments for potential future rulemaking.

Social Determinants of Health Risk Assessment - HCPCS code G0136 - 460
Highlight: CMS does not delete G0136 but instead reframes the data to be captured by the code.

CMS proposed 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 stated that the work associated with G0136 may already be accounted for in other types of services like evaluation and management visits.

However, after considering stakeholder comments, CMS has decided to keep HCPCS code G0136 and replace the terms *evidenced-based social determinants of health risk assessment* with *physical activity and nutrition*. The code's descriptor now reads - *Administration of a standardized, evidence-based assessment of physical activity and nutrition, 5-15 minutes, not more often than every 6 months*. This change, per CMS, refocuses the goal of the type of assessment that must be conducted to report this service and is intended to support CMS' efforts to address the root causes of chronic disease through the evaluation of essential lifestyle factors. Per the agency "*while the root causes of chronic disease are often multi-factorial and holistic, tailored interventions may be optimal, and assessing risk related to the root causes of many chronic conditions begins with assessing essential, common behaviors such as physical activity levels and nutrition (that is, diet composition*)."

CMS emphasizes that this assessment should be used to inform the diagnosis and treatment plan during an associated E/M or behavioral health visit, and practitioners are expected to incorporate the results into their medical decision-making and refer patients to relevant resources. The service has a work RVU of 0.18 and may be provided via telehealth.

Community Health Integration (CHI) Services - HCPCS Code G0019 p. 465
Highlight: CMS removes the term "social determinants of health" from the code descriptor for G0019.

Effective January 1, 2026 CMS will replace the term "social determinants of health" with the term "upstream drivers of health" in the descriptor for HCPCS code G0019 (*Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address upstream driver(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating visit)*. CMS believes the term upstream drivers "*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. 471
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.

Medicare Diabetes Prevention Program (MDPP) – p. 1,110
Highlight: MDPP online delivery flexibilities are being extended until December 31, 2029, and CMS finalized 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 added 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 finalized the proposal to extend 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 finalized a new G-code, G9871, that will be used to describe the online sessions.

CMS finalized 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 amended the definition of online sessions so 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 finalized 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 extended the flexibilities of a hybrid or online care model for four more years, which would extend the flexibilities to December 31, 2029. This policy 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 finalized 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 finalized the policy 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 policy 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 finalized the proposal 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 extension of the 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 finalized the proposal 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 finalized 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. CMS revised the language around make-up sessions to clarify that make-up sessions can be done with in-person, distance learning, or online delivery.

Medicare Prescription Drug Inflation Rebate Program – p. 1,146
Highlight: CMS finalizes 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 finalized the proposal to describe how the agency would identify the payment amount in the benchmark quarter if data were unavailable to calculate the payment amount in that quarter. CMS also finalized policy to calculate 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 finalized the proposal to use a claims-based methodology to implement this section.

CMS established 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 finalized the proposal to identify DCAPS as Part B rebatable drugs and will calculate rebates based on the current methodology.

Updates to the Quality Payment Program and Medicare Promoting Interoperability Program – pg. 1,431

CMS has revised the definition of MVP participant, subgroup reporting requirements, MVP registration, and performance category scoring. Additionally, the policies outlined in this final rule aim to support CMS' goal of phasing out traditional MIPS and transitioning to MVP reporting. However, CMS has not determined an official date for the sunset of traditional MIPS. CMS also finalized the creation of a new **"Advancing Health and Wellness"** subcategory within the **Improvement Activities** performance category. This supports the agency's goal of promoting preventive care and proactive health management.

Changes to MVP Reporting

- MVP Participant Definition (page 1,446): 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.
- Subgroup Reporting Requirements (page 1,454): A multispecialty group that meets the requirements of a small practice (2 to 15 clinicians) is not required to report using subgroups, although it may do so voluntarily. To report an MVP as a group, CMS finalized that the group must attest to being either a single specialty group or a multispecialty group that qualifies as a small practice.
- MVP Registration (page 1,449): Subgroups must register under an MVP but need not attest to specialty composition. Registration timelines and procedures remain consistent with previous policy.

Requests for Information

CMS thanked commenters for their feedback on multiple RFIs, including those on (1) Core QPP and MVP design elements, (2) the use of Medicare procedural codes within MVPs, and (3) the potential development of well-being and nutrition-related measures. CMS stated it will consider this input in future policymaking and rulemaking activities.

Appendix A: CY 2026 PFS Estimated Impact on Total Allowed Charges by Specialty – p. 1,738

(A) Specialty	(B) Total: Non-Facility/Facility	(C) Allowed Charges (mil)	(D) Impact of Work RVU Changes	(E) Impact of PE RVU Changes	(F) Impact of MP RVU Changes	(G) Combined Impact
ALLERGY/IMMUNOLOGY	*TOTAL*	$213	0%	7%	0%	7%
	Non-Facility	$205	0%	8%	0%	8%
	Facility	$8	0%	-11%	0%	-11%
ANESTHESIOLOGY	*TOTAL*	$1,602	0%	-1%	0%	-1%
	Non-Facility	$311	0%	7%	0%	7%
	Facility	$1,290	0%	-3%	0%	-3%
AUDIOLOGIST	*TOTAL*	$75	0%	-1%	-1%	-1%
	Non-Facility	$72	0%	0%	-1%	0%
	Facility	$3	0%	-13%	-1%	-14%
CARDIAC SURGERY	*TOTAL*	$151	-1%	-3%	0%	-3%
	Non-Facility	$27	0%	7%	0%	6%
	Facility	$124	-1%	-5%	0%	-5%
CARDIOLOGY	*TOTAL*	$6,020	0%	1%	0%	1%
	Non-Facility	$3,759	0%	6%	0%	5%
	Facility	$2,261	-1%	-6%	0%	-7%
CHIROPRACTIC	*TOTAL*	$631	-1%	-1%	0%	-2%
	Non-Facility	$629	-1%	-1%	0%	-2%
	Facility	$2	-1%	-15%	0%	-17%
CLINICAL PSYCHOLOGIST	*TOTAL*	$733	3%	1%	-1%	3%
	Non-Facility	$594	3%	3%	-1%	5%
	Facility	$140	3%	-5%	-1%	-3%
CLINICAL SOCIAL WORKER	*TOTAL*	$1,019	4%	2%	-1%	4%
	Non-Facility	$879	4%	3%	-1%	6%
	Facility	$141	4%	-5%	-1%	-2%
COLON AND RECTAL SURGERY	*TOTAL*	$147	-1%	-2%	0%	-2%
	Non-Facility	$53	0%	7%	0%	7%
	Facility	$94	-1%	-7%	0%	-7%
CRITICAL CARE	*TOTAL*	$338	0%	-5%	0%	-4%
	Non-Facility	$55	0%	7%	0%	7%
	Facility	$283	0%	-7%	0%	-7%
DERMATOLOGY	*TOTAL*	$3,905	0%	-2%	0%	-2%
	Non-Facility	$3,763	0%	-1%	0%	-1%
	Facility	$142	-1%	-13%	0%	-14%
DIAGNOSTIC TESTING FACILITY	*TOTAL*	$920	0%	2%	0%	0%

(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	$919	0%	2%	0%	0%
	Facility	$2	-1%	0%	1%	-1%
EMERGENCY MEDICINE	*TOTAL*	$2,422	0%	-3%	1%	-1%
	Non-Facility	$221	0%	7%	0%	7%
	Facility	$2,201	0%	-4%	1%	-2%
ENDOCRINOLOGY	*TOTAL*	$528	0%	2%	0%	3%
	Non-Facility	$426	0%	6%	0%	6%
	Facility	$102	0%	-11%	0%	-10%
FAMILY PRACTICE	*TOTAL*	$5,461	0%	3%	0%	3%
	Non-Facility	$4,394	0%	6%	0%	6%
	Facility	$1,067	0%	-9%	0%	-9%
GASTROENTEROLOGY	*TOTAL*	$1,397	0%	-3%	0%	-4%
	Non-Facility	$505	0%	6%	0%	6%
	Facility	$891	-1%	-9%	0%	-10%
GENERAL PRACTICE	*TOTAL*	$378	0%	3%	0%	3%
	Non-Facility	$304	0%	5%	0%	6%
	Facility	$74	0%	-8%	0%	-7%
GENERAL SURGERY	*TOTAL*	$1,536	0%	-3%	0%	-3%
	Non-Facility	$449	0%	6%	0%	6%
	Facility	$1,086	-1%	-7%	0%	-7%
GERIATRICS	*TOTAL*	$201	1%	1%	0%	1%
	Non-Facility	$129	1%	8%	0%	8%
	Facility	$72	0%	-10%	0%	-9%
HAND SURGERY	*TOTAL*	$261	0%	0%	0%	-1%
	Non-Facility	$142	0%	5%	0%	5%
	Facility	$119	-1%	-7%	0%	-7%
HEMATOLOGY/ONCOLOGY	*TOTAL*	$1,549	0%	0%	0%	0%
	Non-Facility	$995	0%	6%	0%	6%
	Facility	$555	0%	-11%	0%	-11%
INDEPENDENT LABORATORY	*TOTAL*	$551	0%	-1%	0%	-1%
	Non-Facility	$537	0%	-1%	0%	-1%
	Facility	$14	-1%	-1%	0%	-3%
INFECTIOUS DISEASE	*TOTAL*	$541	0%	-7%	0%	-6%
	Non-Facility	$86	0%	7%	0%	7%
	Facility	$455	0%	-10%	0%	-9%
INTERNAL MEDICINE	*TOTAL*	$9,446	0%	-2%	0%	-1%
	Non-Facility	$4,686	0%	6%	0%	6%
	Facility	$4,760	0%	-9%	0%	-8%
INTERVENTIONAL PAIN MGMT	*TOTAL*	$829	0%	3%	0%	3%
	Non-Facility	$647	0%	7%	0%	6%
	Facility	$182	-1%	-8%	0%	-9%
INTERVENTIONAL RADIOLOGY	*TOTAL*	$440	-1%	3%	0%	2%
	Non-Facility	$260	0%	9%	0%	7%
	Facility	$180	-2%	-5%	0%	-7%
MULTISPECIALTY CLINIC/OTHER PHYS	*TOTAL*	$157	0%	-2%	0%	-2%
	Non-Facility	$78	0%	5%	0%	5%
	Facility	$78	0%	-9%	0%	-9%
NEPHROLOGY	*TOTAL*	$1,633	0%	0%	0%	1%
	Non-Facility	$976	1%	6%	0%	7%
	Facility	$657	0%	-9%	0%	-9%
NEUROLOGY	*TOTAL*	$1,319	0%	1%	0%	1%
	Non-Facility	$836	0%	6%	0%	6%
	Facility	$483	0%	-9%	0%	-9%
NEUROSURGERY	*TOTAL*	$687	-1%	-5%	0%	-5%
	Non-Facility	$116	0%	5%	0%	6%
	Facility	$571	-1%	-7%	0%	-7%
NUCLEAR MEDICINE	*TOTAL*	$48	-1%	0%	0%	-1%
	Non-Facility	$21	0%	1%	0%	1%
	Facility	$27	-1%	-1%	0%	-3%
NURSE ANES / ANES ASST	*TOTAL*	$1,064	0%	-2%	0%	-1%
	Non-Facility	$20	0%	9%	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
	Facility	$1,044	0%	-2%	0%	-1%
NURSE PRACTITIONER	*TOTAL*	$7,750	0%	0%	0%	1%
	Non-Facility	$5,104	0%	5%	0%	5%
	Facility	$2,647	0%	-9%	0%	-9%
OBSTETRICS/GYNECOLOGY	*TOTAL*	$543	0%	-1%	0%	-1%
	Non-Facility	$371	0%	4%	0%	4%
	Facility	$172	-1%	-10%	1%	-10%
OPHTHALMOLOGY	*TOTAL*	$4,457	0%	-1%	0%	-2%
	Non-Facility	$3,153	0%	3%	0%	3%
	Facility	$1,304	-1%	-12%	0%	-13%
OPTOMETRY	*TOTAL*	$1,365	0%	2%	0%	2%
	Non-Facility	$1,301	0%	3%	0%	3%
	Facility	$64	0%	-13%	0%	-13%
ORAL/MAXILLOFACIAL SURGERY	*TOTAL*	$45	0%	0%	0%	0%
	Non-Facility	$34	0%	4%	0%	4%
	Facility	$11	-1%	-10%	0%	-11%
ORTHOPEDIC SURGERY	*TOTAL*	$3,283	0%	-3%	0%	-3%
	Non-Facility	$1,450	0%	5%	0%	5%
	Facility	$1,833	-1%	-9%	0%	-9%
OTHER	*TOTAL*	$55	0%	-1%	0%	0%
	Non-Facility	$43	0%	1%	0%	3%
	Facility	$11	0%	-9%	0%	-9%
OTOLARNGOLOGY	*TOTAL*	$1,129	0%	1%	0%	0%
	Non-Facility	$895	0%	3%	0%	3%
	Facility	$233	-1%	-11%	0%	-12%
PATHOLOGY	*TOTAL*	$1,178	-1%	-2%	0%	-2%
	Non-Facility	$624	-1%	-1%	0%	-2%
	Facility	$554	-1%	-2%	0%	-3%
PEDIATRICS	*TOTAL*	$54	0%	1%	0%	2%
	Non-Facility	$35	0%	5%	0%	7%
	Facility	$19	0%	-8%	0%	-7%
PHYSICAL MEDICINE	*TOTAL*	$1,142	0%	-2%	0%	-2%
	Non-Facility	$543	0%	6%	0%	6%
	Facility	$600	0%	-9%	0%	-9%
PHYSICAL/OCCUPATIONAL THERAPY	*TOTAL*	$6,205	0%	-1%	0%	-1%
	Non-Facility	$6,205	0%	-1%	0%	-1%
	Facility	$	-1%	-6%	-1%	-7%
PHYSICIAN ASSISTANT	*TOTAL*	$3,938	0%	0%	0%	1%
	Non-Facility	$2,720	0%	4%	0%	4%
	Facility	$1,218	0%	-8%	0%	-8%
PLASTIC SURGERY	*TOTAL*	$290	-1%	-4%	0%	-4%
	Non-Facility	$128	0%	3%	0%	4%
	Facility	$161	-1%	-9%	0%	-10%
PODIATRY	*TOTAL*	$1,875	0%	1%	0%	2%
	Non-Facility	$1,663	0%	3%	0%	3%
	Facility	$211	0%	-8%	0%	-9%
PORTABLE X-RAY SUPPLIER	*TOTAL*	$80	0%	-1%	0%	-1%
	Non-Facility	$77	0%	-1%	0%	-1%
	Facility	$3	-1%	-1%	0%	-2%
PSYCHIATRY	*TOTAL*	$835	1%	0%	0%	0%
	Non-Facility	$505	1%	6%	0%	6%
	Facility	$330	1%	-9%	0%	-9%
PULMONARY DISEASE	*TOTAL*	$1,233	0%	-2%	0%	-1%
	Non-Facility	$538	0%	7%	0%	7%
	Facility	$695	0%	-8%	0%	-8%
RADIATION ONCOLOGY AND RADIATION THERAPY CENTERS	*TOTAL*	$1,507	-1%	-1%	0%	-1%
	Non-Facility	$1,009	0%	-1%	0%	-1%
	Facility	$498	-1%	-1%	0%	-2%
RADIOLOGY	*TOTAL*	$4,515	-1%	-1%	0%	-2%
	Non-Facility	$1,972	0%	0%	0%	1%
	Facility	$2,543	-2%	-2%	0%	-3%

(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
RHEUMATOLOGY	*TOTAL*	$525	0%	4%	0%	4%
	Non-Facility	$470	0%	6%	0%	6%
	Facility	$55	0%	-12%	0%	-12%
THORACIC SURGERY	*TOTAL*	$290	-1%	-2%	0%	-3%
	Non-Facility	$55	0%	9%	0%	8%
	Facility	$235	-1%	-5%	0%	-5%
UROLOGY	*TOTAL*	$1,605	0%	0%	0%	0%
	Non-Facility	$1,127	0%	5%	0%	5%
	Facility	$479	-1%	-9%	0%	-10%
VASCULAR SURGERY	*TOTAL*	$934	0%	6%	0%	5%
	Non-Facility	$659	0%	11%	0%	9%
	Facility	$275	-1%	-7%	0%	-6%
TOTAL	***TOTAL***	$91,035	0%	0%	0%	**0%**
	Non-Facility	$57,776	0%	4%	0%	4%
	Facility	$33,259	0%	-7%	0%	-7%

* Column G may not equal the sum of columns D, E, and F due to rounding.

Appendix B: CY 2026 Remote Monitoring Codes – p. 332

Code	Long Descriptor
99453	No changes for CY 2026
99445	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
99470	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

Code	Long Descriptor
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
98984	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
98985	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
98986	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
98979	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