DEPARTMENT OF HEALTH & HUMAN SERVICES
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FACT SHEET

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Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) Proposed Rule (CMS-1832-P)

On July 14, 2025, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that announces and solicits public comments on proposed policy changes for Medicare payments under the Physician Fee Schedule (PFS), and other Medicare Part B issues, effective on or after January 1, 2026.

The calendar year (CY) 2026 PFS proposed rule is one of several proposed rules that reflect a broader Administration-wide strategy to create a health care system that results in better quality, efficiency, empowerment, and innovation for all Medicare beneficiaries.

Background on the Physician Fee Schedule

Since 1992, Medicare payment has been made under the PFS for the services of physicians and other billing professionals. Physicians' services paid under the PFS are furnished in a variety of settings, including physician offices, hospitals, ambulatory surgical centers (ASCs), skilled nursing facilities and other post-acute care settings, hospices, outpatient dialysis facilities, clinical laboratories, and beneficiaries' homes. Payment is also made to several types of suppliers for technical services, most often in settings for which no institutional payment is made.

For most services furnished in a physician's office, Medicare makes payment to physicians and other professionals at a single rate based on the full range of resources involved in furnishing the service. In contrast, PFS rates paid to physicians and other billing practitioners in facility settings, such as a hospital outpatient department (HOPD) or an ASC, reflect only the portion of the resources typically incurred by the practitioner while furnishing the service.

For many diagnostic tests and a limited number of other services under the PFS, separate payment may be made for the professional and technical components of services. The technical

component is frequently billed by suppliers, like independent diagnostic testing facilities and radiation treatment centers, while the professional component is billed by the physician or practitioner.

Payments are based on the relative resources typically used to furnish the service. Relative value units (RVUs) are applied to each service for work, practice expense, and malpractice expense. These RVUs become payment rates through the application of a conversion factor. Geographic adjusters (geographic practice cost indices) are also applied to the total RVUs to account for variation in costs by geographic area. Payment rates are calculated to include an overall payment update specified by statute.

CY 2026 PFS Rate Setting and Conversion Factor

As required by statute, beginning in CY 2026, there will be two separate conversion factors: one for qualifying alternative payment model (APM) participants (QPs) and one for physicians and practitioners who are not QPs. By statute, QPs are those that meet certain thresholds for participation in an Advanced APM, which means generally that the payment model has features to ensure accountability for quality and cost of care. The update to the qualifying APM conversion factor for CY 2026 is +0.75 percent while the update to the nonqualifying APM conversion factor for CY 2026 is +0.25 percent. The changes to the PFS conversion factors for CY 2026 include these updates as required by statute, a one-year increase of +2.50 percent for CY 2026 stipulated by statute, and an estimated +0.55 percent adjustment necessary to account for proposed changes in work RVUs for some services. The proposed CY 2026 qualifying APM conversion factor of $33.59 represents a projected increase of $1.24 (+3.83%) from the current conversion factor of $32.35. Similarly, the proposed CY 2026 nonqualifying APM conversion factor of $33.42 represents a projected increase of $1.17 (+3.62%) from the current conversion factor of $32.35. Per statutory requirements, we are also proposing updates to the geographic practice cost indices (GPCIs) and malpractice RVUs.

Efficiency Adjustment

CMS historically has relied on survey data primarily provided by the AMA Relative Value Scale Update Committee (AMA RUC) to estimate practitioner time, work intensity, and practice expense, which are often reflected in the valuation of codes paid under the PFS. Only a small portion of the total codes are considered for revaluation annually, and CMS relies primarily on subjective information from surveys that have low response rates, with respondents who may have inherent conflicts of interest (since their responses are used in setting their payment rates). Research over time has demonstrated that the time assumptions built into the valuation of many PFS services are, as a result, very likely overinflated.[1] In order to mitigate these effects and take into account changes in medical practice, we are proposing to apply an efficiency adjustment to

[1] Merrell, K., C. Schur, T. Oberlander, et al. 2014. Analysis of physician time use patterns under the Medicare fee schedule. Report prepared for the Assistant Secretary for Planning and Evaluation. Washington, DC: Social & Scientific Systems and the Urban Institute.

the work RVU and corresponding intraservice portion of physician time of non-time-based services that we expect to accrue gains in efficiency over time. This would periodically apply to all codes except time-based codes, such as evaluation and management (E/M) services, care management services, behavioral health services, services on the Medicare telehealth list, and maternity codes with a global period of MMM.

We are proposing to use a sum of the past five years of the Medicare Economic Index (MEI) productivity adjustment percentage to calculate this efficiency adjustment. The MEI productivity adjustment is calculated by the CMS Office of the Actuary (OACT) each year, and we are proposing a look-back period of five years, which would result in a proposed efficiency adjustment of -2.5% for CY 2026. We are also proposing that, going forward, CMS may give preference to empiric studies of time to incorporate into service valuation, compared to low-response rate survey data, and solicit comment on the types of empiric data that CMS should consider. CMS expects that moving away from survey data would lead to more accurate valuation of services over time and help address some of the distortions that have occurred in the PFS historically.

Practice Expense

The practice expense (PE) methodology currently relies primarily on the AMA's Physician Practice Information (PPI) Survey data from 2008 that measures specialty-specific practice costs. In 2024, the AMA conducted updated survey efforts and submitted data to CMS in early 2025 for consideration in CY 2026 PFS rate setting. Due to several limitations with the data, as described in the CY 2026 PFS proposed rule, we are not proposing to implement the PE/HR data or cost shares from the AMA's PPI and Clinician Practice Information (CPI) Survey data for 2026 rate setting. Specifically, our concerns focus on small sample sizes and sampling variation, low response rates and representativeness, potential measurement error, and incomplete data submission. We modeled estimated payment impacts of the data's implementation, which we included in the proposed rule for public comment and potential consideration in future rulemaking.

While we are not proposing to incorporate the PPI and CPI Survey data into PFS rate setting for CY 2026, we are proposing significant updates to our PE methodology to better reflect current clinical practice. Specifically, we are proposing to recognize greater indirect costs for practitioners in office-based settings compared to facility settings. The original allocation methodologies assumed physicians maintained separate practice locations even if they furnished some care in hospitals. Since the methodologies were established decades ago, there has been a steady decline in the number of physicians working in private practice, with a corresponding rise in physician employment by hospitals and health systems. Therefore, we believe that the allocation of indirect costs for PE RVUs in the facility setting at the same rate as the non-facility setting may no longer reflect contemporary clinical practice.

We are also proposing to utilize data from auditable, routinely updated hospital data (i.e., from the Medicare Outpatient Prospective Payment System (OPPS)) to set relative rates and inform our costs assumptions for some technical services paid under PFS. For CY 2026, we are proposing to use this data in setting rates for radiation treatment services, and for some remote monitoring services. This approach promotes price transparency across settings, offers more predictable rate setting outcomes, and limits the influence of limited survey data.

Telehealth Services under the PFS

For CY 2026, we are proposing to streamline the process for adding services to the Medicare Telehealth Services List. We are proposing to simplify our review process by removing the distinction between provisional and permanent services and limiting our review on whether the service can be furnished using an interactive, two-way audio-video telecommunications system.

We are proposing to permanently remove frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations.

We are also proposing, for services that are required to be performed under the direct supervision of a physician or other supervising practitioner, to permanently adopt a definition of direct supervision that allows the physician or supervising practitioner to provide such supervision through real-time audio and visual interactive telecommunications (excluding audio-only). Except for services that have a global surgery indicator of 010 or 090, we are proposing that a physician or other supervising practitioner may provide such virtual direct supervision for applicable incident-to services under § 410.26, diagnostic tests under § 410.32, pulmonary rehabilitation services under § 410.47, cardiac rehabilitation and intensive cardiac rehabilitation services under § 410.49. We are also seeking additional information regarding potential concerns about patient safety and quality of care for services that have a 000 global surgery indicator and if it is necessary to exclude these services from allowing the presence of the physician (or other practitioner) to include virtual presence through audio/video real-time communications technology (excluding audio-only).

We are not proposing to extend our current policy to allow teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings through December 31, 2025. Rather, we are proposing to transition back to our pre-PHE policy, which requires that, for services provided within MSAs, teaching physicians must maintain physical presence during critical portions of resident-furnished services to qualify for Medicare payment. We would maintain the rural exception established in the CY 2021 PFS final rule metropolitan statistical area.

Comment Solicitation on Strategies for Improving Global Surgery Payment Accuracy

For CY 2026, as part of an iterative process towards improving the accuracy of global surgical service valuation and payment, we are soliciting public comment to ascertain what next steps we

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

Policies to Improve Care for Chronic Illness and Behavioral Health Needs

Six in ten Americans have at least one chronic disease, and four in ten have two or more chronic diseases. Per President Trump's Executive Order, "Establishing the President's Make America Healthy Again Commission,[2]" the Administration is directing our focus towards understanding and drastically lowering chronic disease rates, including thinking on nutrition, physical activity, healthy lifestyles, over-reliance on medication and treatments, the effects of new technological habits, environmental impacts, and food and drug quality and safety. As such, focusing on the prevention and management of chronic disease is a top priority for us. We are broadly soliciting feedback to help us better understand how we could enhance our support management of the prevention and management of chronic disease.

Behavioral health conditions are some of the most common chronic health conditions nationwide. Even patients with physical chronic health conditions frequently experience related behavioral health concerns and achieve better management and improvement of their physical chronic conditions when these behavioral health concerns are also addressed. Evidence demonstrates that integrating behavioral health with primary care leads to improvements, including reduced depression severity, and enhanced overall patient's experience of care.[3] For CY 2026, we are proposing to create optional add-on codes for Advanced Primary Care Management (APCM) services that would facilitate providing complementary behavioral health integration (BHI) or psychiatric Collaborative Care Model (CoCM) services. We are proposing the establishment of three new G-codes to be billed as add-on services when the APCM base code is reported by the same practitioner in the same month. The services of the proposed add-on codes are meant to be directly comparable to existing CoCM and BHI codes. We are also requesting information related to APCM and prevention, seeking comments on how CMS should consider application of cost sharing for APCM services, particularly, if we were to include preventive services within the APCM bundles.

To further support access to digital mental health treatment (DMHT) devices furnished incident to professional behavioral health services used in conjunction with ongoing behavioral health care treatment under a behavioral health treatment plan of care, we are proposing to expand our payment policies for DMHT services to also make payment for devices used in the treatment of

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[2] https://www.whitehouse.gov/presidential-actions/2025/02/establishing-the-presidents-make-america-healthy-again-commission/

[3] Balasubramanian, Bijal, Deborah Cohen, Katelyn Jetelina, Miriam Dickinson, Melinda Davis, Rose Gunn, Kris Gowen, Frank DeGruy 3rd, Benjamin Miller, Larry Green. "Outcomes of Integrated Behavioral Health with Primary Care." J Am Board Fam Med. 2017 Mar-Apr;30(2):130-139.doi: 10.3122/jabfm.2017.02.160234.

Attention Deficit Hyperactivity Disorder (ADHD). We are also requesting feedback about establishing coding and payment policies for other digital therapy devices classified under other FDA regulations. Moreover, we are seeking comments on the possibility of establishing additional separate coding and payment for a broader based set of services describing digital tools used by practitioners intended as complements to mental health treatment plans of care.

Skin Substitutes

Currently, most skin substitutes are paid as if they are biologicals under the average sales price (ASP)-based payment methodology described in section 1847A of the Social Security Act. Using this methodology, each skin substitute product receives a unique billing code and payment limit. This has led to significant growth in spending under Medicare Part B for skin substitutes in the non-facility setting. According to Medicare claims data, Part B spending for these products rose from $252 million in 2019 to over $10 billion in 2024, a nearly 40-fold increase. Most of that increase is directly attributable to increases in stated prices for specific products.

For CY 2026, we are proposing to pay for skin substitute products as incident-to supplies when they are used as part of a covered application procedure paid under the PFS in the non-facility setting or under the OPPS in the hospital outpatient department setting. CMS is also proposing to align skin substitute categorization consistent with their FDA regulatory status, such as 361 Human Cells, Tissues, and Cellular and Tissue-Based Products (HCT/P) and the device types: Pre-Market Approvals (PMAs) and 510(k)s. CMS believes grouping and paying for skin substitute products based on relevant product characteristics, consistent with their FDA regulatory status, recognizes the clinical and resource differences in product types and would incentivize competition to create more innovative products, while also resulting in significant savings to the Medicare Trust Fund. We note that for CY 2026, CMS is proposing to use a single payment rate reflecting the highest average for these three categories of skin substitute products to ensure we are not underestimating the resources involved with furnishing these services. In future years, we intend to propose payment rates that differentiate between the three FDA regulatory categories. CMS is proposing to implement these policy changes in both the hospital outpatient department and physician office settings to remain consistent across different settings of care. The proposed payment policy for skin substitutes in the hospital outpatient setting is provided in the CY 2026 Outpatient Prospective Payment System (OPPS)/ Ambulatory Surgical Center (ASC) proposed rule.

Drugs and Biological Products Paid Under Medicare Part B

Requiring Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts

By statute, manufacturers are required to pay Medicare a refund for specified discarded amounts of certain single-dose container or single-use package drugs under Part B. In this proposed rule, we reviewed two applications for increased applicable percentage for specific products for CY 2026, but we are not proposing increased applicable percentages for either drug.

Average Sales Price: Price Concessions and Bona Fide Service Fees

For purposes of calculating the manufacturer's average sales price (ASP), we are proposing new guidance regarding pricing concessions and bona fide service fees (BFSFs). First, we are proposing to define the term bundled arrangement and provide clarity to manufacturers on how to account for bundled price concessions when calculating the manufacturer's ASP. We are also proposing new regulations specifying circumstances in which certain fees must be considered price concessions. Second, we are proposing revisions to the definition of BFSF; specifically, we propose to (1) specify the methodologies that should be used to calculate fair market value in certain circumstances and (2) to require verification from manufacturers that a BFSF is not passed on. Third, we are proposing that reasonable assumptions for the calculation of the manufacturer's ASP be required as a part of the quarterly ASP data submissions to CMS.

Average Sales Price: Units Sold at Maximum Fair Price

We are clarifying in this proposed rule that units of selected drugs sold at the maximum fair price are included in the calculation of the manufacturer's ASP described in section 1847A(c) of the Social Security Act (the Act) effective January 1, 2026.

Autologous Cell-based Immunotherapy and Gene Therapy Payment

In this proposed rule, we propose that preparatory procedures for tissue procurement required for manufacturing an autologous cell-based immunotherapy or gene therapy be included in the payment of the product itself and that, beginning January 1, 2026, any preparatory procedures for tissue procurement required for manufacturing an autologous cell-based immunotherapy or gene therapy that were paid for by the manufacturer be included in the calculation of the manufacturer's ASP.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

We are proposing to adopt the optional add-on codes proposed under the PFS for APCM that would facilitate billing for BHI and Psychiatric Collaborative Care Model (CoCM) services when RHCs and FQHCs are providing advanced primary care. We are also proposing to require RHCs and FQHCs to report individual codes that make up both the CoCM and the Communications Technology-Based Services (CTBS) and Remote Evaluation Services, HCPCS codes G0512 and G0071, respectively.

We are proposing to adopt services that are that are established and paid under the PFS and designated as care management services as care coordination services for purposes of separate payment for RHCs and FQHCs. We believe this proposal would better align Medicare policy across settings of care and improve transparency and predictability for RHCs and FQHCs.

In addition, we are proposing for RHC and FQHC services and supplies requiring direct supervision, to permanently adopt a definition of direct supervision that allows the physician or

supervising practitioner to provide such supervision through real-time audio and visual interactive telecommunications (excluding audio-only).

We are also proposing policies for non-behavioral health visits furnished via telecommunication technology that allow RHCs and FQHCs to bill for RHC and FQHC services furnished using telecommunication technology by reporting HCPCS code G2025 on the claim, including services furnished using audio-only communications technology through December 31, 2026.

Medicare Prescription Drug Inflation Rebate Program

The Inflation Reduction Act of 2022 (IRA) (Pub. L. 117–169, enacted August 16, 2022) established requirements under which drug manufacturers must pay inflation rebates if they raise their prices for certain drugs payable under Part B and/or covered under Part D faster than the rate of inflation. In this proposed rule, CMS is proposing new policies for the Medicare Part B Drug Inflation Rebate Program and Medicare Part D Drug Inflation Rebate Program (collectively referred to as the "Medicare Prescription Drug Inflation Rebate Program") that include, but are not limited to, establishing a claims-based methodology to remove 340B units from Part D rebate calculations starting on January 1, 2026. Additionally, establishing a Medicare Part D Claims Data 340B Repository (hereinafter, "340B repository") for voluntary submissions by covered entities for Part D claims with dates of service on or after January 1, 2026 to allow CMS to begin usability testing for the 340B repository.

Request for Information (RFI) on Streamlining Regulations and Reducing Administrative Burdens in Medicare

Additionally, CMS is seeking public input on approaches and opportunities to streamline regulations and reduce burdens on those participating in the Medicare program through a standalone RFI available at https://www.cms.gov/medicare-regulatory-relief-rfi. The public should submit all comments in response to this RFI through the provided weblink.