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CMS Proposes Payment Increase for Physicians, New Ambulatory Specialty Model for Heart Failure and Low Back Pain, and Changes to Several Payment Policies

On July 14, 2025, the Centers for Medicare & Medicaid Services (CMS) issued its proposed calendar year (CY) 2026 Physician Fee Schedule (PFS), which proposes policies for physician payment and other outpatient services covered under Medicare Part B. CMS also released a rule overview fact sheet and official press release outlining key proposals, including:

- Separate conversion factors (CF) for qualifying vs. non-qualifying alternative payment model (APM) participants, with increased payment rates for both groups,
- A 2.5 percent efficiency adjustment to work relative value units (RVU) for most non-time-based services and reallocate indirect practice expense (PE) RVUs by site of service,
- Streamlining the Medicare Telehealth List review by removing steps and adding services,
- Reinstating pre-COVID teaching physician requirements while maintaining the rural exception,
- New remote therapeutic monitoring (RTM) and remote physiological monitoring (RPM) codes,
- Expanded billing for the Complex Patient E/M add-on code G2211,
- New HCPCS codes for Advanced Primary Care Management (APCM) services,
- Policies to improve care for chronic illnesses and behavioral health,
- Changes to the payment system for skin substitutes,
- Clarifications on price concessions, bona fide service fees (BFSF), and units sold at maximum fair price (MFP) for Average Sales Price (ASP) reporting,
- A mandatory Ambulatory Specialty Model (ASM) for chronic care quality and cost accountability,
- Updates to the Medicare Part B and Part D Inflation Rebate Programs,
- Updates to the Shared Savings Program (SSP) and the Quality Payment Program (QPP), and
- Alignment of the Medicare Diabetes Prevention Program (MDPP) with Centers for Disease Control and Prevention (CDC) standards.

There are no proposals to modify the existing requirements for drug manufacturers to provide a refund to CMS for certain discarded drugs. CMS solicits feedback related to Software as a Service (SaaS), APCM and prevention, the QPP, and reducing Medicare administrative burden.

Comments are due September 12, 2025.

CMS PROPOSES SEPARATE CONVERSION FACTORS FOR SERVICES FURNISHED BY QUALIFYING VS. NON-QUALIFYING APM PARTICIPANTS, INCREASED PAYMENT RATES FOR 2026

Pages 3-54 of published rule

CMS proposes to codify a statutory increase to Medicare Part B payments to physicians and other health professionals for 2026. These payments cover services such as office visits, surgeries, and diagnostic or therapeutic procedures. Medicare determines payment rates through the PFS, which assigns RVUs to each service based on physician work, PE, and malpractice costs. These RVUs are then multiplied by a CF to calculate final payment amounts.

For 2026, there will be two separate CFs, as required by statute:[1] one CF for qualifying APM participants (QPs) and one for non-qualifying APM (non-QP) participants. Both CFs will be derived from the single 2025 CF, adjusted separately based on update rates specified by statute. CMS proposes a CF of $33.5875 (3.83 percent increase) for QPs, and $33.4209 (3.62 percent increase) for non-QPs. Both reflect the 2025 CF multiplied by a 0.55 percent positive budget neutrality adjustment[2], a statutory update of 0.75 percent for QPs (0.25 percent for non-QPs)[3], and an additional one-time 2.50 percent increase for 2026, also required by law.[4]

This is the first year CMS will implement separate CFs based on QP status. The policy results in a higher CF for QPs due to a larger update. Payment rates in 2026 would therefore vary depending on a provider's QP status.

Table 1. Physician Fee Schedule CF Comparison[5]

2025 CF	2026 Proposed CF	
	Qualifying APM Participant	Non-Qualifying APM Participant
$32.3465	$33.5875	$33.4209

Proposed Update to Efficiency Adjustment

Pages 48-52 of the published rule

CMS also proposes a new "efficiency adjustment" that would reduce work RVUs and associated intraservice physician time by 2.5 percent for most non-time-based services. This adjustment reflects anticipated productivity gains from improvements in clinician experience, workflows, and technology. Time-based services would be excluded. Specialties that rely more heavily on time-based codes could see small RVU increases, while procedural or diagnostic specialties may see slight reductions. CMS anticipates that most specialties would see no more than a one percent change in total RVUs.

[1] Section 1848(d)(1)(A) of the Social Security Act
[2] Section 1848(c)(2)(B)(ii)(II) of the Social Security Act
[3] Section 1848(d)(19) of the Social Security Act
[4] Section 71202 of the One Big Beautiful Bill Act – OBBB, H.R. 1
[5] See Table 88 and Table 89 on page 450 of the published rule.

Proposed Site of Service Payment Differential

Pages 21-23 of the published rule

CMS proposes adjusting the methodology for allocating indirect PE RVUs based on the site of service. Specifically, for services valued in the facility setting, CMS would reduce the portion of indirect PE RVUs tied to work RVUs to half the amount used for non-facility services. This change would increase PE RVUs for specialties that primarily deliver care in non-facility settings (e.g., offices) and decrease PE RVUs for those working mostly in facility settings (e.g., hospitals). The proposal is budget neutral and would not affect the overall CF, as it only redistributes PE RVUs between settings.

CHANGES TO TELEHEALTH POLICIES PROPOSED

CMS is proposing changes to simplify telehealth policies by streamlining the approval process, expanding covered services, and making certain pandemic-era flexibilities permanent. Notably, stakeholders, including the American Telemedicine Association, have expressed support for the telehealth measures in this proposed rule, particularly the expansion of virtual care through updates to the MDPP, the inclusion of digital therapeutics for attention deficit hyperactivity disorder (ADHD) in the updated digital mental health treatment (DMHT) codes, and the addition of new payment codes for remote monitoring.[6]

Changes to the Medicare Telehealth Services List Review Process

Pages 36-38 of the published rule

CMS proposes streamlining the Medicare Telehealth Services List review process by simplifying the current five-step evaluation. In response to stakeholders' concerns that the existing process is unclear and requires clinical evidence that is often difficult to provide, CMS would eliminate Steps 4 and 5, which involve comparing the service being considered to existing services that have already been permanently approved, and assessing whether the telehealth version provides the same clinical benefit as in-person care. CMS believes these steps are unnecessary, as patients and providers can determine the appropriateness of telehealth delivery.

CMS is proposing to keep Steps 1 through 3, which includes confirming that the service is separately payable under the PFS, meets the statutory requirements under Section 1834(m) of the Social Security Act, including provider eligibility, geographic and site limitations, and technology standards, and assessing whether the service can be effectively delivered via interactive telecommunications without compromising quality or clinical benefit.[7]

Additionally, CMS proposes eliminating the "permanent" and "provisional" service designations and treating all services on the list as permanent, while retaining the ability to remove services if needed.

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[6] https://www.americantelemed.org/press-releases/first-look-at-2026-draft-medicare-physician-fee-schedule-demonstrates-positive-steps-forward-for-virtual-care-says-ata-action/

[7] An interactive telecommunications system is defined under § 410.78(a)(3).

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Additions to the Medicare Telehealth Services List

Pages 38-41 of the published rule

CMS outlines several proposed additions to the Medicare Telehealth Services List. Many of these services were initially added on a temporary basis during the COVID-19 Public Health Emergency (PHE) and later retained provisionally. Table 2 reflects CMS's proposed determinations on requests received for additions to the Medicare Telehealth Services List. CMS received many requests for services to be transitioned from provisional to permanent; however, if the above proposal is finalized, all services on the list would be permanent. Therefore, CMS is not addressing these requests in this proposed rule.

Table 2. Categorization of Services Requested to be Added to the Medicare Telehealth List

Proposed Additions	Services Proposed Not to Be Added
Multiple-Family Group Psychotherapy • CPT code 90849 **Group Behavioral Counseling for Obesity** • HCPCS code G0473 **Infectious Disease Add-On** • HCPCS code G0545 **Auditory Osseointegrated Sound Processor** • CPT code 92622, 92623	**Dialysis** • CPT codes 90935, 90937, 90945, 90947 **Home INR Monitoring** • HCPCS code G0248 **Telemedicine E/M** • CPT codes 98000-98015

Extended Telehealth Flexibilities, Including Frequency Limitation Suspensions and Direct Supervision Requirements

Pages 41-45 of the published rule

CMS proposes several updates for frequency limitations on Medicare telehealth subsequent care services in inpatient and nursing facility settings, as well as critical care consultations. Historically, there were limitations on the frequency of these services when delivered via telehealth. For example, subsequent hospital care was limited to once every three days, and follow-up visits in nursing facilities were allowed only once every fourteen days. These restrictions were temporarily waived during the COVID-19 Public Health Emergency (PHE) to ensure continued access to care, and the suspension remained in effect through CY 2024 and 2025. In this proposed rule, CMS seeks to make this change permanent by removing the frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations.

CMS proposes that for services that are required to be performed under direct supervision of a physician, that instead of requiring physical presence of the physician or practitioner, virtual presence through audio/video real-time communications will be allowed, if the physician or practitioner is "immediately available." Under this proposal there are several exclusions such as global surgery indicator of 010 or 090. CMS is also proposing to allow Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to use audio/video communications to meet direct supervision requirements for their applicable services and supplies.

Lastly, CMS is proposing to revert to the pre-COVID policy where teaching physicians must have physical presence when residents are performing services in order to qualify for Medicare payments. If finalized as proposed, the rural exception that was established in the CY 2021 PFS Final Rule will remain.

Telehealth Originating Site Facility Fee Payment Amount Update

Pages 45-46 of the published rule

Under statute, CMS must annually update the telehealth originating site facility fee based on the percentage increase in the Medicare Economic Index (MEI). Based on a proposed 2.7 percent MEI increase, the Medicare telehealth originating site facility fee for CY 2026 is $31.85 for HCPCS code Q3014.

AGENCY ANGLES TO EXPAND REMOTE PATIENT MONITORING

Pages 82-87 of the published rule

CMS proposes several new RTM and RPM codes for CY 2026. These codes allow providers to track adherence to therapy plans and digital therapeutic interventions (RTM), or relevant physiological parameters (e.g., blood pressure - RPM). These codes are intended to support providers in tracking patients' adherence to therapy plans and digital therapeutic interventions (RTM), as well as monitoring relevant physiological parameters, such as blood pressure (RPM). Under the proposal, the new codes would reduce the minimum data collection requirement for reimbursement from 16 days to two days and introduce shorter-duration treatment management codes that allow billing for 10 minutes of care coordination per month, provided there is at least one clinical staff interaction with the patient during that period.

Initial response to the proposal has been positive. The American Telemedicine Association expressed early support, and an opinion piece in *McKnights Long-Term Care News* described the changes as a "real game-changer" for physical therapy, occupational therapy, and speech-language pathology.

If finalized as proposed, the RTM codes would be classified as New Technology through 2030, with coverage to be reassessed after three years of utilization data becomes available. In contrast, the RPM codes would not receive New Technology designation and are instead scheduled for resurvey after one year of use, with revaluation planned for the January 2028 American Medical Association (AMA)/Specialty Society Relative Value Sales (RVS) Update Committee (RUC) meeting.

CMS PROPOSES TO ALLOW G2211 TO BE BILLED WITH HOME OR RESIDENCE E/M VISITS

Pages 144-145 of the published rule

In the CY 2024 PFS Final Rule, CMS finalized the change in status for the office and outpatient (O/O) E/M visit complexity add-on code, HCPCS code G2211, to make it separately payable by assigning an "active" status indicator. This code is billed in addition to the standard codes for O/O E/M visits, and provides extra payment meant to capture the effort required by clinicians to build a longitudinal relationship with patients. Payment of G2211 was not allowed for home or residence visits under the original finalized policy, but stakeholders have recommended that CMS either create a distinct complexity add-on payment code for home-based E/M visits or expand the use of G2211 to include E/M visits in settings such as nursing facilities, assisted living facilities, and beneficiaries' homes.

CMS recognizes that home or residence visits often require a long-term plan, at least monthly visits, and consistent follow-up, in which there is more cost associated with building trust and a long-term relationship. Therefore, CMS is proposing to allow HCPCS code G2211 to be billed as an add-on code with the home or residence E/M visits codes. If finalized, this change would increase reimbursement for clinicians providing ongoing, relationship-based care in home or residence settings.

CMS PROPOSES ENHANCED CARE MANAGEMENT UPDATES

Pages 145-151 of the published rule

CMS is proposing to create optional add-on codes for APCM services that would facilitate offering complementary behavioral health integration (BHI) services. CMS would remove the time-based requirements of the existing BHI and Psychiatric Collaborative Care Model (CoCM) services as CMS believes that this would reduce documentation requirements, and therefore practitioner burden. These optional add-on codes would be considered a “designated care management service” and thus could be provided by auxiliary personnel when under the supervision of the billing practitioner.

CMS is proposing to establish three new HCPCS G-codes to be billed as add-on services when the APCM base code is reported by the same practitioner in the same month. These proposed codes are GPCM1, GPCM2, and GPCM3 and would be add-on codes based on existing CPT codes 99492, 99493, and 99484, respectively. CMS is proposing a direct crosswalk to the current work RVU values for CPT codes 99492 for GPCM1, 99493 for GPCM2, and 99484 for GPCM3. CMS is also proposing a direct crosswalk to the current direct PE units for CPT codes 99492, 99493, and 99484 to HCPCS codes GPCM1, GPCM2, and GPCM3 respectively.

CMS also proposes adopting the APCM add-on codes to support billing for BHI and CoCM services when RHCs and FQHCs deliver advanced primary care. Further, services that are considered care management services would be designated as care coordination services eligible for separate payment in RHCs and FQHCs.

Request for Information

CMS is seeking public input on whether parts of APCM services should be considered preventive and potentially exempt from Medicare cost sharing. Though not currently classified as preventive, some APCM elements, like health risk assessments and self-management support, overlap with services defined under section 1861(hhh)(1) of the Act. CMS is evaluating if these should be integrated with offerings like the Annual Wellness Visit or depression screening.

CMS is also exploring enhancements to APCM payment structures, particularly within Medicare SSP Accountable Care Organizations (ACO), where stronger primary care teams are linked to greater savings. Proposals include new prospective monthly payments, integrating these into existing benchmarks, and adjusting operational processes like consent. Feedback is requested on these options and ways to improve APCM coding and payment to better reflect primary care’s role in prevention and chronic disease management.

AGENCY PROPOSES POLICIES AIMED AT IMPROVING CARE FOR CHRONIC ILLNESS AND BEHAVIORAL HEALTH NEEDS

Updates to Payment for DMHT

Pages 152-154 of the published rule

Effective January 1, 2025, CMS finalized three HCPCS G-codes for DMHT devices to be billed by physicians and practitioners authorized to furnish services for the diagnosis and treatment of mental illness: G0552, G0553, and G0554.[8] In this rule, CMS proposes to expand the payment policies for these codes to include devices classified as digital therapy devices for ADHD under §882.5803 of section 510(k) of the FD&C Act or granted De Novo authorization by the FDA.

CMS seeks feedback on establishing coding and payment policies for the following categories:

- Computerized behavioral therapy devices for treating symptoms of gastrointestinal conditions;
- Digital therapy devices to reduce sleep disturbance for psychiatric conditions; and
- Computerized behavioral therapy device for the treatment of fibromyalgia symptoms.

CMS also seeks input on establishing coding and payment for the broader category of digital tools to maintain or encourage a healthy lifestyle, including clinical use cases and justification for their use. Additionally, CMS invites feedback on a specific request to create a new G-code to report administration of an FDA authorized eye-tracking technology to aid in diagnosing autism spectrum disorder (ASD) in pediatric patients.

Comment Solicitation on Payment Policy for Software as a Service

Pages 155-156 of the published rule

CMS has received feedback highlighting the lack of a consistent payment policy for SaaS and AI-based medical devices, which can delay patient access even after FDA authorization. In response, CMS is seeking comments to better understand how these technologies impact various care settings and how they should be priced.

Prevention and Management of Chronic Disease – RFI

Pages 156-158 of the published rule

Aligned with President Trump's Executive Order "Establishing the President's Make America Healthy Again Commission,"[9] CMS is soliciting public input on improving chronic disease prevention and management, acknowledging that many Americans live with one or more chronic conditions. While Medicare covers several preventive services, CMS is exploring whether existing payment structures adequately support time- and resource-intensive interventions, such as those addressing root causes like physical inactivity, poor nutrition, and social isolation. The agency is particularly interested in

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[8] See page 152 of the published proposed rule for code descriptors.

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

feedback on services not well captured by the current PFS such as community-based interventions, motivational interviewing, medically-tailored meals, and digital therapeutics.

CMS is also seeking feedback on creating separate coding and payment for services like motivational interviewing and health coaching, which have demonstrated effectiveness in improving behavior change and health outcomes.

Community Health Integration and Principal Illness Navigation for Behavioral Health

Pages 158-160 of the published rule

CMS clarifies that Clinical Social Workers (CSWs), Marriage and Family Therapists (MFTs), and Mental Health Counselors (MHCs) meet the requirements to perform Community Health Integration (CHI) and Principal Illness Navigation (PIN) services if under supervision of a billing practitioner. CMS also proposes to allow CPT code 90791 (*Psychiatric diagnostic evaluation*) or Health Behavior Assessment and Intervention (HBAI) services to serve as initiating visits for CHI services.

CMS also proposes to remove G0136 (*Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5 to 15 minutes*) from the Medicare Telehealth Services List as it is already described in other existing codes. Additionally, based on comments received in response to the CY 2024 PFS Proposed Rule, CMS proposes to change the long descriptor of G0019 to better fit the purpose of CHI services. Specifically, CMS proposes to replace the term "social determinants of health (SDOH)" with the term "upstream driver(s)."

CMS CHANGES PAYMENT SYSTEM FOR SKIN SUBSTITUTES

Pages 161-171 of the published rule

CMS states that existing payment policies for skin substitutes are unsustainable due to dramatic price increases for these products and proposes paying for certain skin substitutes as incident-to supplies when they are used during a procedure paid under the physician office (non-facility) setting or under the outpatient department setting. Incident-to supplies are those furnished as an integral part of the physician's professional services during diagnosis or treatment.[10]

CMS proposes to group skin substitutes based on their FDA regulatory category[11] **and to use a single payment rate for all skin substitutes at $125.38/cm^2**. Skin substitutes licensed under section 351 of the Public Service Act would be excluded and continue to be paid as a biological product.

CMS currently considers skin substitutes to be biologicals under Medicare Part B and establishes a unique billing code and payment for each product. Skin substitutes are paid similar to biological drugs under 1847A of the Act, therefore requiring the manufacturers to submit ASP data to CMS every quarter. However, since skin substitutes are not like typical biologicals and do not have National Drug Codes (NDCs), it has been difficult for CMS to operationalize calculating payment for these products.

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[10] 42 CFR 410.26

[11] See "Skin Substitute Products by FDA Regulatory Category" file on the CMS website

CMS may consider bundling payment for skin substitutes with other related application procedures in future rulemaking and seeks comment on how the agency can properly recognize innovative skin substitute products through payment policies under the PFS.

CMS PROPOSES REQUIRING USE OF MODIFIER -54 TO IMPROVE GLOBAL SURGERY PAYMENT ACCURACY

Pages 171-173 of the published rule

CMS establishes valuation and payment for several thousand physician services which they refer to as "global surgical packages" under the PFS. Each package is made up of a HCPCS defined surgical procedure and its related services. Due to limited usage, CMS proposes to require reporting of modifier -54 (*Surgical care only*) in all cases where the surgeon does not intend to provide post-operative care for more accurate documentation.

Continuing from the CY 2025 PFS Final Rule, CMS is seeking comments on ways to improve the accuracy of payment for global surgical packages, specifically the procedure shares.

FOR AVERAGE SALES PRICE, CMS PROPOSES NEW GUIDANCE ON PRICE CONCESSIONS AND BONA FIDE SERVICE FEES AND CLARIFIES INCLUSION OF UNITS SOLD AT MAXIMUM FAIR PRICE

CMS calculates the payment limits for drugs payable under Medicare Part B on a quarterly basis using the manufacturer's ASP, as defined in § 414.902 and using the methodology in section 1847A of the Act. Manufacturers must report ASP data to CMS and, per section 1847A(c)(3) of the Act and § 414.804(a)(2), are required to deduct price concessions such as volume discounts, prompt pay discounts, cash discounts, free goods that are contingent on any purchase requirement, chargebacks, and rebates (excluding rebates under the Medicaid Drug Rebate Program and the Medicare Prescription Drug Inflation Rebate Program). However, BFSFs are not considered price concessions and, therefore, are not deducted when calculating the manufacturer's ASP.

Price Concessions and Bona Fide Service Fees

Pages 189-194 of the published rule

In response to a December 2022 report by the Office of Inspector General (OIG) titled, "Manufacturers May Need Additional Guidance to Ensure Consistent Calculations of Average Sales Prices,"[12] which called for more guidance on ASP reporting and calculations, CMS proposes new definitions and requirements related to price concessions and BFSFs. Proposed changes include:

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[12] Manufacturers May Need Additional Guidance to Ensure Consistent Calculations of Average Sales Price, Office of Inspector General, U.S. Department of Health and Human Services. December 2022. https://oig.hhs.gov/documents/evaluation/3215/OEI-BL-21-00330-Complete%20Report.pdf

- **Bundled Arrangements:** Add regulatory text defining "bundled arrangement" and provide non-exhaustive examples to clarify when certain fees are considered price concessions, along with guidance for pricing drug bundles consistent with Medicaid rules;
- **Revised BFSF Definition:** Specify acceptable methodologies for calculating fair market value (FMV), set timelines for FMV reassessment, and clarify what constitutes sufficient evidence that a BFSF is not passed on to an affiliate, client, or customer; and
- **Reasonable Assumptions:** Starting January 1, 2026, require submission of reasonable assumptions with quarterly ASP data, including documentation of FMV methodology, periodic FMV reviews, and certification that fees are not passed on to an affiliate, client, or customer of an entity.

Units Sold at Maximum Fair Price

Pages 194-195 of the published rule

Under the Medicare Drug Price Negotiation Program, CMS negotiates an MFP for certain high-expenditure, single-source drugs payable under Medicare Part B and covered under Part D (i.e., selected drugs). In this proposed rule, CMS clarifies that, because the statute does not explicitly exclude these sales, units of selected drugs sold at the MFP must be included in the calculation of a manufacturer's ASP, effective January 1, 2026.

These proposed clarifications and new reporting requirements may increase transparency and compliance burdens for manufacturers. Including units sold at MFP in ASP calculations could also affect pricing strategies and Medicare Part B reimbursement for high-expenditure drugs.

CMS PROPOSES INCLUDING TISSUE PROCUREMENT COSTS IN PAYMENT AND ASP FOR AUTOLOGOUS CELL AND GENE THERAPIES

Pages 195-196 of the published rule

Consistent with current payment policies for Chimeric Antigen Receptor (CAR) T-cell therapies, CMS proposes to not pay separately for individual steps involved in manufacturing autologous cell-based immunotherapies or gene therapies, such as raw material collection or related labor. CMS considers these manufacturing steps to be included in the payment for the drug or biological itself, as reflected in the billing and payment code for the product.

Beginning January 1, 2026 (for sales occurring on or after that date), CMS also proposes that any preparatory procedures for tissue procurement paid by the manufacturer must be included in the calculation of the manufacturer's ASP. Additionally, payments made by the manufacturer to an entity for tissue procurement would not qualify as BFSFs, as CMS considers these services integral to the product's manufacture and therefore part of its total price.

CMS PROPOSES MANDATORY MODEL TO HOLD INDIVIDUAL CLINICIANS ACCOUNTABLE FOR CHRONIC CARE QUALITY AND COSTS

Page 207-276 of the published rule

CMS proposes the Ambulatory Specialty Model (ASM), a mandatory APM to improve care for Medicare beneficiaries with heart failure and low back pain while reducing unnecessary spending. The model would begin on January 1, 2027, and span seven years: five performance years followed by two years for data submission and payment adjustments, ending in 2033.

ASM seeks to enhance care quality and coordination among specialists through a more targeted and accountable payment approach. It builds on the MIPS Value Pathways (MVP) framework but introduces key changes. Rather than selecting their own measures, participating clinicians would report on a fixed set of condition- and specialty-specific measures. Performance would be assessed against peers managing the same condition, allowing for more relevant comparisons.

Clinicians would be evaluated across four categories: quality, cost, improvement activities, and Promoting Interoperability. The model also includes patient-reported outcome measures. Based on performance, clinicians would receive positive or negative adjustments to their Medicare Part B payments, applied two years after the performance year, as under MIPS.

ASM would require participation at the individual clinician level rather than the group level. This approach is intended to level the playing field for smaller practices and increase transparency in identifying low-value care, such as unnecessary surgeries or imaging. The model also encourages closer coordination with primary care and supports preventive care and chronic condition management.

Participation would be mandatory for eligible clinicians in selected geographic areas. To be included, clinicians must:

- Bill under the Medicare PFS;
- Have a targeted specialty designation (e.g., cardiology for heart failure; orthopedic surgery, pain management, or rehabilitation for low back pain);
- Meet a minimum volume threshold of at least 20 attributed episodes based on MIPS episode-based cost measures;
- Practice in a selected geographic area, based on stratified random sampling of Core-Based Statistical Areas (CBSAs) and metropolitan divisions.

Geographic areas will be selected to ensure variation in spending, volume, and market type. CMS would exclude areas such as U.S. territories and CBSAs with too few eligible clinicians. Assignment would be based on the clinician's service ZIP code.

By focusing on heart failure and low back pain (two high-cost, high-volume conditions), CMS aims to test whether a condition-specific, peer-comparison model can reduce fragmented or duplicative care.

CMS PROPOSES SEVERAL CHANGES TO THE MEDICARE INFLATION REBATE PROGRAM

Pages 282-294 of the published rule

Under the Inflation Reduction Act of 2022 (IRA) (Pub. L. 117–169), drug companies must pay inflation rebates if they raise their prices for certain Part B and Part D drugs faster than the rate of inflation. In this rule, CMS is proposing several new policies for the Medicare Part B Drug Inflation Rebate Program and Medicare Part D Drug Inflation Rebate Program.

For Medicare Part B, proposed policies:

- Clarify that Drugs Covered as Additional Preventive Services (DCAPS) will be treated as Part B rebatable drugs, with rebates calculated in alignment with the methodology described in §§ 427.300 through 427.402 and rebate reports issued in line with §§ 427.500 through 427.505;
- Establish how CMS would identify the payment amount benchmark quarter if the necessary data are not available;
- Outline how CMS would calculate the payment amount in the benchmark quarter if no published payment limit exists; and
- Define the methodology for calculating the payment amount in the payment amount benchmark quarter 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.

For Medicare Part D, proposed policies:

- Clarify the payment amount benchmark period for certain subsequently approved drugs;
- Clarify the calculation of the benchmark period manufacturer price or annual manufacturer price (AnMP) when monthly units are available but Average Manufacturer Price (AMP) is unavailable for a given quarter;
- Adopt a claims-based methodology, for claims with dates of service on or after January 1, 2026, and with respect to an applicable period, to exclude units of a Part D rebatable drug for which a manufacturer provided a discount under the 340B Program; and
- Establishing a 340B repository to receive voluntary submissions of certain data elements from 340B covered entities with dates of service on or after January 1, 2026.

This proposal, along with CMS's efforts to clarify the definition and treatment of BFSFs in ASP calculations, reflects a broader push to improve transparency and accuracy in drug pricing and rebate programs. Together, these changes may increase reporting requirements and compliance complexity for pharmaceutical manufacturers, while also enhancing CMS's oversight of pricing and rebate obligations under Medicare Part B and Part D.

CMS PROPOSES MAJOR OVERHAUL OF ACO PARTICIPATION AND QUALITY RULES IN SHARED SAVINGS PROGRAM

Pages 294-343 of the published rule

CMS outlines a series of reforms to the Medicare MSSP, aiming to strengthen accountability, streamline program operations, improve quality measurement, and accelerate the transition to value-based care. These changes are set to begin with agreement periods starting January 1, 2027.

CMS estimates that the combined impact of the proposed changes, outlined below, would result in a net reduction in Medicare spending of $20 million over ten years.

Five-Year Limit on One-Sided Risk for ACOs, Mandated Transition to Two-Sided Risk in Second Agreement Period

Pages 304-308 of the published rule

CMS proposes to limit ACOs inexperienced with performance-based risk to a single five-year agreement period in the one-sided (shared savings only) BASIC track (Levels A–D). Currently, these ACOs may remain in one-sided risk for up to seven performance years across two agreement periods. Under the proposal, they would be required to transition to two-sided risk (BASIC Level E or ENHANCED) at the start of any second agreement period.

In their first agreement period, inexperienced ACOs would retain the option to start at any level of the BASIC track, including Level E, or the ENHANCED track, unless they have fewer than 5,000 assigned beneficiaries in either of their first two benchmark years, in which case they would be prohibited from entering the ENHANCED track. These smaller ACOs could still participate in the BASIC track, but CMS cites concerns over population instability and financial risk as justification for this restriction.

CMS indicates that this policy shift aligns with its broader strategy to accelerate movement toward value-based care and improve accountability for cost and quality outcomes. The agency sees two-sided risk models as stronger incentives for care transformation and cites growing interest in higher-risk tracks. For example, in 2025, 71 percent of SSP ACOs participate in two-sided risk arrangements, up from 18 percent in 2018.

For ACOs, this shift may increase financial risk and operational demands but aligns with CMS's goal to accelerate value-based care adoption and improve Medicare program savings.

Mid-Year Change of Ownership Updates for ACO Participants and SNF Affiliates

Pages 308-312 of the published rule

To prevent disruptions in care coordination and ACO operations, CMS proposes to allow ACOs to update their certified participant list and SNF affiliate list during a performance year if a participant or SNF affiliate experiences a Change of Ownership (CHOW) resulting in a new Medicare-enrolled Tax Identification Number (TIN) with no prior billing history. Currently, ACOs can only update these lists during the annual change request cycle, even if the change affects eligibility or operational continuity.

Effective January 1, 2026, ACOs would be required to notify CMS within 30 days of a qualifying CHOW and submit supporting documentation (e.g., legal agreements, IRS notices). Such documentation would demonstrate the CHOW and validate the absence of claims history for the new TIN. CMS would then review and may approve the update outside the normal cycle.

For ACO participants, this policy applies when a CHOW results in a new TIN with no claims history, and approval would allow CMS to update the participant list, financial reconciliation, beneficiary assignment, and quality reporting obligations for the affected TIN.

For SNF affiliates, the proposal similarly would allow updates to the SNF affiliate list mid-year to maintain eligibility for the SNF 3-day rule waiver.[13] A CHOW without timely update could jeopardize the SNF's waiver eligibility, limiting beneficiary access to post-acute care. CMS proposes that only changes involving a TIN replacement (not new affiliates) would be permitted mid-year.

Tightened Beneficiary Threshold Requirements

Pages 312-320 of the published rule

CMS proposes to codify and clarify that ACOs must have at least 5,000 assigned beneficiaries in Benchmark Year 3 (BY3) to enter a new agreement period starting on or after January 1, 2027. While ACOs could fall below 5,000 in Benchmark Years 1 or 2 (BY1 or BY2) and still qualify for participation, they would be restricted to the BASIC track and barred from the ENHANCED track due to concerns over expenditure variability in smaller populations.

To mitigate financial risk to ACOs and the Medicare Trust Funds, CMS also proposes a more conservative methodology to calculate shared savings and losses for ACOs with fewer than 5,000 assigned beneficiaries in any benchmark year. Rather than using BY3 to determine benchmark-based performance payment and loss recoupment limits, CMS would apply the lesser of two values: the standard calculation based on performance year person years or an alternative benchmark derived from the year with the fewest assigned beneficiaries. This would apply during financial reconciliation for any year of an agreement period starting in 2027 or later where the ACO fell below 5,000 assigned beneficiaries in any benchmark year.

Such ACOs would also be ineligible for the enhanced shared savings policy under § 425.605(h), which allows certain low-revenue ACOs to share in savings without meeting the minimum savings rate (MSR). CMS argues that this is necessary to prevent payments based on random variation in expenditures, rather than true performance, and to maintain statistical reliability in program results.

Updates to Primary Care Service Codes for ACO Assignment

Pages 320-322 of the published rule

CMS proposes revising the definition of primary care services used for beneficiary assignments in the SSP beginning in performance year 2026, to align with updates to the PFS. Specifically, CMS would add three new HCPCS codes (GPCM1, GPCM2, and GPCM3) related to Enhanced Care Model Management Services, designed to support the integration of BHI and CoCM services with APCM. These new codes are intended to reduce documentation and time-based burdens, thereby encouraging greater adoption of BHI and CoCM in primary care.

CMS also proposes removing HCPCS code G0136 for Social Determinants of Health (SDOH) risk assessments, citing redundancy with existing E/M services. Additionally, CMS would allow automatic substitution of replacement codes for CPT or HCPCS codes in future years. CMS seeks recommendations on additional codes appropriate for future rulemaking.

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[13] This waiver allows ACO-affiliated SNFs to admit beneficiaries without a prior three-day inpatient hospital stay.

Eliminate Health Equity Adjustment and Streamline ACO Quality Scoring

Pages 325-339 of the published rule

CMS proposes eliminating the health equity adjustment for SSP ACOs starting in performance year 2025, citing overlap with other incentives like the electronic clinical quality measure (eCQM)/MIPS clinical quality measure (CQM) reporting bonus and the Complex Organization Adjustment, which sufficiently support underserved populations. To streamline scoring, CMS would retroactively remove the adjustment, revise terminology (e.g., replacing "health equity adjustment" with "population and income adjustment"), and clarify that "quality score" refers to the ACO-level composite, while "quality performance score" applies to individual measures.

CMS also proposes to update the APP Plus quality measure set, increasing required measures from four in 2025 to seven by 2028, and removing Screening for Social Drivers of Health (Quality ID: 487) beginning in 2028 (or once the eCQM specification is available). The CAHPS for MIPS survey would shift to a web-mail-phone administration model in 2027.

Additionally, CMS proposes expanding Extreme and Uncontrollable Circumstances (EUC) policies to include cyberattacks that impact quality reporting and seeks input on its move toward digital quality measurement (dQM) using Fast Healthcare Interoperability Resources ® (FHIR®)-based eCQMs, including timing, infrastructure, standards, and data aggregation.

CMS Proposes Enforcement Actions for ACOs Failing Both Quality Standards Beginning in 2026

Pages 341-343 of the published rule

CMS proposes that starting in 2026, ACOs that fail to meet both the quality performance standard and the alternative quality performance standard may face pre-termination actions (e.g., warnings, corrective action plans, special monitoring). CMS also proposes to update the renewal application review process to consider past failure to meet either quality standard, giving the agency additional discretion in evaluating applications from ACOs with past performance concerns in line with its goal of upholding high participation standards in MSSP.

CMS PROPOSES UPDATES TO THE QUALITY PAYMENT PROGRAM

Pages 344-422 of the published rule

In the annual PFS rulemaking, CMS includes its proposals for the QPP's two tracks: MIPS and Advanced APM participation. MIPS includes three reporting options: Traditional MIPS, MIPS Value Pathways (MVP), and APM Performance Pathways (APP), each with four performance categories: quality, cost, improvement activities (IA), and promoting interoperability (PI).

MIPS Performance Measurement Proposals

CMS proposes several updates to measure/activity inventories and scoring methodologies impacting different MIPS reporting pathways, including but not limited to:

- 190 total quality measures for the 2026 performance period;

- Setting of the performance threshold through the CY2028 performance period at 75 points to provide program stability
- Implementation of five new MIPS quality measures, including three high priority measures;
- Removal of 10 MIPS quality measures;
- Substantive changes to 42 MIPS quality measures;
- Updates to the APP Plus measures set to align with the MIPS quality measure inventory;
- Modifications to the MIPS cost measure inventory;
- Updates to the operational list of care episode and patient condition groups and codes to align with changes in service and diagnosis codes used to define these groups;
- Adoption of a two-year informational-only feedback period for new cost measures, during which they will not affect MIPS cost performance category scores, final scores, or payment adjustments until the third year after introduction;
- Revision of two population-based cost measures, including Total Per Capita Cost (TPCC);
- Modification of the definition of "high priority measure" to remove references to health equity;
- Addition of the "Advancing Health and Wellness" IA subcategory, removal of the "Achieving Health Equity" IA subcategory, and addition of three new IAs; and
- Changes to two PI measures and addition of a new optional bonus measure: Public Health Reporting Using Trusted Exchange Framework and Common Agreement ™ (TEFCA ™).

The CMS Quality Payment Program Resource Library 2026 Quality Payment Program Proposed Rule Fact Sheet and Policy Comparison Table, available here, includes a complete list of quality payment program proposals.

MVP Proposals

CMS previously finalized the creation of the MVP, a reporting option for MIPS intended to provide a more cohesive participation experience by aligning activities from the four MIPS performance categories around a certain specialty, medical condition, or patient population.

CMS proposes six new MVPs for the CY 2026 performance period, including Diagnostic Radiology, Interventional Radiology, Neuropsychology, Pathology, Podiatry, and Vascular Surgery. Additionally, CMS proposes:

- Modification to all 21 existing MVPs;
- Requiring groups to attest to their specialty composition (i.e., whether they are single-specialty or multispecialty small practices) during the MVP registration process, rather than CMS making this determination;
- Allowing multispecialty small practices to report an MVP as a group, without being required to form subgroups starting in the CY 2026 performance period; and
- Giving Qualified Clinical Data Registries (QCDRs) and Qualified Registries one year after a new MVP is finalized before they are required to fully support that MVP.

The CMS Quality Payment Program Resource Library 2026 MVPs Guide, available here, includes a complete list of the measures included in the proposed MVPs and changes to the modified MVPs.

Advanced APM Proposals

Following up on the CY 2025 Proposed Rule, CMS proposes a broader approach to QP determinations. Under the proposal, CMS would perform both an individual- and APM entity-level QP calculation. CMS is also proposing to expand the definition of "attribution-eligible beneficiary" to include attribution through additional provider codes. Lastly, CMS proposes to remove the existing limit of 50 clinicians for a Medical Home Model participant.

Requests for Information

CMS is seeking public input through several RFIs focused on MVPs, a timeline for implementing FHIR standards, and the PI performance category. Topics include defining core quality measures within MVPs, incorporating well-being and nutrition metrics, and using procedure codes to better assign clinicians to relevant MVPs. CMS is also requesting feedback on its transition to FHIR-based eCQM reporting, potential updates to the Prescription Drug Monitoring Program (PDMP) measure, replacing attestation-based public health measures with performance-based alternatives, and addressing challenges related to clinical data quality and exchange.

CMS PROPOSES CHANGES TO THE MEDICARE DIABETES PREVENTION PROGRAM TO INCREASE PROGRAM UPTAKE

Pages 276-282 of the published rule

CMS proposes changes to the MDPP, an evidence-based behavioral intervention aimed at preventing or delaying type 2 diabetes in Medicare beneficiaries with prediabetes. The updates are intended to increase uptake, as less than one percent of eligible beneficiaries participate in the program, and to better align with the CDC Diabetes Prevention Recognition Program (DPRP) standards. CMS proposes adding definitions for terms including "live coach interaction," "online delivery period," and "online session," and modifying the definition of "online." The agency also proposes to amend MDPP program language to address barriers related to physical weight collection requirements, including allowing for weight documentation in the patient's medical record within two days of the MDPP session rather than on the same date of the session.

CMS further proposes extending flexibilities allowed during the PHE through 2029 and testing an asynchronous delivery modality that aligns with the CMS Innovation Center strategy to Make America Healthy Again by promoting evidence-based prevention. This modality would permit MDPP suppliers to offer program services online through 2029, eliminate the requirement to maintain in-person delivery capability during that period, and establish a new HCPCS G-code (G9871) with an associated $18 payment for asynchronous delivery. CMS clarifies that MDPP suppliers may not mix synchronous and asynchronous delivery modalities for the same beneficiary.

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