National Rural Health Association

Calendar Year (CY) 2026 Medicare Physician Fee Schedule Proposed Rule

This week, the Centers for Medicare and Medicaid Services (CMS) published its CY 2026 Medicare Physician Fee Schedule (MPFS) **proposed rule**. For more information, find CMS' fact sheet **here** or a summary below.

Comments are due by **5pm on September 12, 2025**, via regulations.gov. If you have any questions or comments that you would like addressed in NRHA's response, please contact Alexa McKinley Abel (amckinley@ruralhealth.us) by August 25. Stay tuned for a listening session on the proposed rule and a comment template to help you submit your own response.

Key Proposals

Payment. Beginning in CY 2026, there will be two different conversion factors – one for alternative payment model (APM) qualifying participants and one for non-qualifying participants.

The proposed APM conversion factor is $33.59, or an increase of 3.83% over CY 2025. The proposed non-APM conversion factor is $33.42, or an increase of 3.62% over CY 2025.

Additionally, CMS proposes a CY2026 efficiency adjustment of -2.5% for the work relative value unit (RVU), which is one of three elements that are used to help determine payment for clinicians under the MPFS. The other RVUs are practice expense and malpractice. The efficiency adjustment would apply to almost all non-time-based codes and is meant to reflect efficiency gains made in medical practice that have historically not been reflected in the work RVU.

For the practice expense RVU, which measures geographic variation in the prices of inputs for a medical practice, CMS proposes to revise the methodology to take into account the site of service. The practice expense RVU includes direct expenses like labor, supplies, and equipment, as well as indirect expenses. CMS proposes to reduce the portion of practice expense RVUs for the facility setting (i.e., hospitals) to half the amount allocated to the non-facility setting (i.e., office settings). CMS reasons that there are less private practice physicians and more working in facilities, yet the MPFS was built upon the assumption that physicians owned their own practices. Thus, changes in the methodology used for calculating payment should be tweaked to reflect this change.

Telehealth. CMS proposes several telehealth-related policies:

- Extending RHC and FQHC telehealth capabilities as distant site providers through December 31, 2026. This means that even if Congress does not extend current Medicare telehealth flexibilities past September 30, 2025, RHCs and FQHCs can still serve as distant site providers. Clinics will continue to bill telehealth services with code G2025. Payment will be based on the average amount for all PFS telehealth services.
- Making virtual direct supervision flexibilities permanent. Currently, for most services, two-way, real-time audio/video supervision will count as direct supervision. **This will also apply to rural health clinics (RHCs) and FQHCs.** Note that this does not allow audio-only direct supervision.
- Streamlining the review process for the Medicare Telehealth Services List. If finalized, CMS would only verify that services are separately payable under the MPFS, subject to Section 1834(m) of the Social Security Act, and capable of being furnished via interactive telecommunications.

- Removing frequency limitations on telehealth services for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations.
- Ending the temporary policy that allowed teaching physicians to have a virtual presence for billing services involving residents. This flexibility began during the COVID-19 PHE and will end in 2025. **However, CMS will retain its pre-public health emergency (PHE) rural exception**. For locations outside of metropolitan statistical areas, teaching physicians will retain the flexibility to be virtually present for services involving resident physicians and bill Medicare for such services.

Advanced Primary Care Management (APCM). Created in the CY 2025 MPFS rule, APCM is a new delivery model that includes three new G-codes to recognize the resource costs associated with furnishing APC services to beneficiaries. These codes would describe a set of care management services and include a broader range of services to simplify billing and documentation requirements.

This year, CMS proposes to create three new add-on codes to integrate behavioral health services into APCM. These codes would facilitate providing complementary behavioral health integration (BHI) or psychiatric Collaborative Care Model services. **These codes would be available for RHCs and FQHCs as well.**

Inflation Reduction Act (IRA) and 340B guidance. The IRA requires drug manufacturers to pay rebates to Medicare for drugs with prices that increase faster than the rate of inflation. Drugs purchased through 340B are excluded from the calculation of the rebate amounts. CMS has previously required that 340B drugs billed to Medicare Part B including a modifier to exclude them from the calculations (specifically, the "TB" modifier). Because of how 340B drugs are billed to Part D, CMS has acknowledged that requiring a claim-level modifier for Part D claims is not feasible.

CMS proposes two different approaches to allow claim-level identification of Part D claims for 340B drugs:

- CMS would use existing data sources to associate prescriber NPIs with 340B covered entities and 340B contract pharmacies. Specifically, CMS would use this data to identify 340B drugs billed to Part D based on two criteria: (1) the prescriber (determined by NPI) provides care at a 340B covered entity; and (2) the pharmacy (determined by NPI) is a contract pharmacy for that same 340B covered entity.
- In addition to the option above, CMS proposes implementing an (initially) voluntary process for 340B covered entities to submit claim-level data to CMS to identify 340B claims billed to Part D. Although this option will initially be voluntary, CMS encourages 340B covered entities to submit the data to get used to making submissions and strongly suggests that it may make reporting mandatory in the future.

These proposals would apply to any covered entities that dispense 340B drugs billed to Medicare Part D, *including through contract pharmacies.*

Behavioral health. Beginning in CY 2024, marriage and family therapists (MFTs) and mental health counselors (MHCs) became eligible to bill Medicare directly for their services. The same year, CMS created new codes for comprehensive health integration (CHI) and principal illness navigation (PIN) services performed by auxiliary personnel. These codes are designed to help address beneficiaries' unmet social needs related to their medical conditions.

This year, CMS is clarifying that clinical social workers (CSWs), marriage and family therapists (MFTs), and mental health counselors (MHCs) meet the requirements to perform CHI and PIN services if they are 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 Community Health Integration services.

Ambulatory Specialty Model (ASM). CMS is proposing a new, mandatory alternative payment model to improve care for beneficiaries with heart failure and low back pain. This model would begin on January 1, 2027, and last for seven years. The seven years include five performance years and two years for data submission and payment adjustments.

Clinicians would be evaluated across four categories: quality, cost, improvement activities, and promoting interoperability. The model also includes patient-reported outcome measures.

Selected clinicians would be required to participate in ASM. To be included, clinicians must:

- Bill under MPFS
- Work in the following specialties
    - Cardiology for heart failure.
    - Anesthesiology, pain management, interventional pain management, neurosurgery, orthopedic surgery, or physical medicine and rehabilitation for low back pain.
- Have historically treated at least 20 Traditional Medicare beneficiaries with heart failure or low back pain over a 12-month period
- Practice in a selected geographic area, based on stratified random sampling of Core-Based Statistical Areas (CBSAs) and metropolitan divisions.

Find more information on the model website or fact sheet.

Medicare Shared Savings Program (MSSP). CMS proposes several changes to the MSSP program that may be of interest to rural providers participating in the program:

- Limiting ACOs inexperienced with performance-based risk to a single five-year agreement period in the BASIC Track, which is one-sided risk (shared savings only).
    - Inexperienced ACOs must transition to two-sided risk in its second agreement period.
- Clarifying and codifying that ACOs must have at least 5,000 assigned beneficiaries in benchmark year 3 in order to enter a new agreement period starting on or after January 1, 2027.
    - ACOs could fall below the 5,000 beneficiary threshold in benchmark years 1 and 2 but would be restricted to the BASIC Track and barred from the ENHANCED Track, which involves two-sided risk.
- Capping shared savings and losses for ACOs with fewer than 5,000 assigned beneficiaries in any year by using a more conservative calculation based on the year with the lowest beneficiary count.
- Revising the definition of primary care services used for beneficiary assignments. CMS would add the new APCM codes described above that support BHI and psychiatric Collaborative Care Model services.

- Eliminating the health equity adjustment for ACOs. Currently, ACOs can receive a health equity adjustment to the MIPS Quality performance category score if they report all-payer eCQMs/MIPS CQMs, are high performing on quality, and serve a high proportion of underserved beneficiaries. This would be removed beginning in CY 2026.

Medicare Diabetes Prevention Program (MDPP). CMS launched MDPP in 2018 as an additional preventive service covered by Medicare. In 2023, NRHA analyzed the organizations eligible to participate in MDPP and found that just under 250 of 1,500 were located in rural ZIP codes. Please find more information on this in our CY 2024 MPFS comment. NRHA believes that rural participation in MDPP by both beneficiaries and eligible organizations is low despite the need in rural communities.

In order to increase participation in MDPP, CMS proposes to extend flexibilities allowed during the PHE through December 31, 2029 and to test an asynchronous delivery modality that will allow MDPP organizations to deliver services online. Flexibilities from the PHE include delivering MDPP session via distance learning and allowing beneficiaries to self-report weight. Prior to the PHE, the majority of the MDPP was performed in person. Allowing distance learning will promote access to MDPP for rural beneficiaries who may have a limited number of in-person options nearby.

Dental services. In the CY 2023 MPFS final rule, CMS clarified that Medicare may pay for certain dental services "inextricably linked to" the clinical success of other covered medical services. Since then, CMS has added new services to this list through each MPFS rulemaking cycle. Such services include dental services related and necessary to the treatment of head and neck cancer or for patients with end-stage renal disease. In this proposed rule, CMS announced that it will not be putting forth any new dental services to be covered by Medicare.