National Rural Health Association

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

On October 31, 2025, the Centers for Medicare and Medicaid Services (CMS) published its CY 2026 Medicare Physician Fee Schedule (MPFS) **final rule**. For more information, find CMS' fact sheet **here** or a summary below.

If you have any questions, please contact Alexa McKinley Abel (amckinley@ruralhealth.us).

Key Proposals

Payment. Beginning in CY 2026, CMS will implement two separate conversion factors as required by statute - one for qualifying participants in alternative payment models (APM) and one for non-qualifying participants. **The final APM conversion factor is $33.57, or an increase of 3.77% over CY 2025, while the non-APM conversion factor is $33.40, or an increase of 3.26% over CY 2025.**

Additionally, CMS finalized 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. This change reflects estimated efficiency gains that have occurred over time in medical practice but have not been captured in current payment rates. Time-based services like evaluation and management, behavioral health, care management, telehealth, and maternity care are exempt.

For the practice expense RVU, which measures geographic variation in the prices of inputs for a medical practice, CMS is finalizing updates to the methodology to take into account the site of service and modern clinical arrangements. The practice expense RVU includes direct expenses like labor, supplies, and equipment, as well as indirect expenses. The agency will recognize greater indirect costs in non-facility settings (i.e., office settings) relative to facility settings (i.e., hospitals) and will incorporate auditable hospital outpatient data to establish relative costs for technical services like radiation therapy and remote monitoring.

Telehealth. CMS finalized several telehealth-related policies:

- **Extending payment for RHC and FQHC telehealth servings, including audio-only, through December 31, 2026.** Clinics will continue to bill telehealth services with code G2025. Payment will be based on the average amount for all PFS telehealth services. Allowance of RHCs and FQHCs to serve as distance site providers must still be extended by Congress.
- Making virtual direct supervision flexibilities permanent. CMS is permanently adopting the definition of direct supervision to include real-time two-way audio/video telecommunications for most services. **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. CMS is streamlining the process for adding services to the list by removing the distinction between "provisional" and "permanent" services and focusing review on whether services can be furnished via interactive telecommunications.
- Removing frequency limitations on telehealth services for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations.
- In contrast to the policy proposed in the NRPM, CMS is finalizing continued flexibility for teaching physicians to have virtual presence in all teaching settings when the service itself is

furnished virtually. 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. 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 describe a set of care management services and include a broader range of services to simplify billing and documentation requirements.

This year, **CMS is finalizing 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 may be billed alongside the APCM base codes by the same practitioner in the same month and are available for RHCs and FQHCs as well.**

Inflation Reduction Act (IRA) and 340B guidance. In the proposed rule, CMS outlines two potential approaches to identify 340B-purchased drugs billed to Medicare Part D for the purpose of excluding them from inflation rebate calculations. The first would have used existing data sources to link prescriber NPIs and pharmacy NPIs with 340B covered entities and their contract pharmacies. The second would have established an initially voluntary process for 340B covered entities to submit claim-level data directly to CMS, with the possibility of making such reporting mandatory in future years.

In the final rule, CMS did not finalize the NPI-linkage approach. Instead, the agency adopted a claims-based methodology to remove 340B units from Part D rebate calculations beginning January, 2026, and created a voluntary 340B Part D Claims Repository for covered entities to test claim-level submissions. CMS stated that data collected through this repository will inform the development of any future mandatory reporting requirements.

In addition, CMS is finalizing new documentation and verification requirements for manufacturers' average sales price (ASP) reporting, including bundled pricing and fair value determinations for bona fide services.

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. CMS is also improving the care of chronic diseases by ensuring advanced primary care management services are able to integrate behavioral health.

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 finalized updates 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 finalizing a new, mandatory alternative payment model to improve care for beneficiaries with heart failure and low back pain beginning January 1, 2027, and run for seven years. The seven years include five performance years and two years for data submission and payment adjustments.

Clinicians will 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 finalized several updates 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 falling 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 is finalizing an extension of PHE flexibilities 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., and test asynchronous online delivery options. 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 the final rule, CMS confirmed that it will not be putting forth any new dental services to be covered by Medicare.