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On July 14, 2025, the Centers for Medicare & Medicaid Services (CMS) released the proposed rule for the Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS). This proposal outlines key updates to Medicare payment policies and reflects broader efforts to improve quality, efficiency, and innovation in care delivery. **Comments are due to CMS by September 12, 2025.**

Medicare Physician Fee Schedule

CY 2026 PFS Ratesetting and Conversion Factor(s)

Beginning in 2026, there will be two separate conversion factors for Qualifying APM Participants (QPs) and non-QP clinicians. The update to the qualifying APM conversion factor (which applies to PFS payments for QPs) for CY 2026 is 0.75 percent while the update to the nonqualifying APM conversion factor (which applies to PFS payments for all other clinicians) for CY 2026 is 0.25 percent. The change to the PFS conversion factors for CY 2026 includes 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 budget neutrality adjustment necessary to account for proposed changes in work RVUs. Thus, the CY 2026 qualifying APM conversion factor represents a projected increase of $1.24 (3.83%) from the current conversion factor of $32.35, for a total of $33.59. Similarly, the CY 2026 nonqualifying APM conversion factor represents a projected increase of $1.17 (3.62%) from the current conversion factor of $32.35, for a total of $33.42.

TABLE 92: CY 2026 PFS Estimated Impact on Total Allowed Charges by Specialty

(A)	(B)	(C)	(D)	(E)	(F)	(G)
Specialty	**Allowed Charges Non-Facility/Facility**	**Allowed Charges (mil)**	**Impact of Work RVU Changes**	**Impact of PE RVU Changes**	**Impact of MP RVU Changes**	**Combined Impact***
VASCULAR SURGERY	**TOTAL**	**$929**	**0%**	**5%**	**0%**	**5%**
	Non-Facility	$656	0%	9%	0%	9%
	Facility	$273	0%	-6%	1%	-6%

Practice Expenses

CMS is not adopting the AMA's updated 2024 PPI and CPI survey data for CY 2026 due to concerns over data quality, including small sample sizes and incomplete submissions. However, **CMS is proposing updates to better reflect current practice patterns—such**

as recognizing higher indirect costs for office-based care and using hospital data (*e.g., OPPS*) to set rates for services like radiation therapy and remote monitoring. Since the current practice expense 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, CMS believes 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. The proposed changes aim to improve accuracy, transparency, and alignment with today's care delivery landscape.

Valuation of Specific Codes for CY 2026

In addition to new CPT codes for thoracic branched endovascular services and implantation and removal of baroreflex activation therapy, the proposed rule includes 46 new CPT codes for lower extremity revascularization. The new code set was driven by technological advances, a change in practice settings, and the need to better differentiate between straightforward and complex lesions. New codes include the use of intravascular lithotripsy as well as treatment of inframalleolar lesions. Additionally, interventions will be categorized as "straightforward" or "complex" allowing for the variability of time and effort in treating patients with varying severity of disease. The Rule reflects CMS' acceptance of the RUC-recommended work values and practice expense inputs for the lower extremity codes. Conversely, CMS is proposing to significantly lower the RUC-recommended work values for thoracic branched endovascular services.

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. In order to mitigate these effects and take into account changes in medical practice, CMS has proposed the application of an "efficiency adjustment" to the work RVU and corresponding intraservice portion of physician time of non-time-based services. 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.

To calculate the adjustment, CMS proposes using a sum of the past five years of the Medicare Economic Index (MEI) productivity adjustment percentage. The MEI productivity adjustment is calculated by the CMS Office of the Actuary (OACT) each year, and rule proposes utilizing a

look-back period of five years, which would result in a proposed efficiency adjustment of -2.5% for CY 2026. To implement this efficiency adjustment, CMS proposes to decrease the work RVUs and make corresponding changes to the intraservice physician time for codes describing non-time-based services by a factor equal to the MEI productivity adjustment, equivalent to if this factor had been applied every year over the past 5 years. **The impact of the proposed "Efficiency Adjustment" is substantial and is a key factor contributing to the published differential between non-facility/facility.**

If finalized for CY 2026, CMS proposes to apply the efficiency adjustment to the intraservice portion of physician time and work RVUs every 3 years. This timing would imply that the next efficiency adjustment after CY 2026 would be calculated and applied in CY 2029 PFS rulemaking, reflecting efficiency gains measured from 2027 through 2029. CMS is proposing to update and apply the proposed efficiency adjustment with a cadence of every 3 years to align with the other updates under the PFS, including updates to the Geographic Practice Cost Index (GPCI) and Malpractice (MP) RVUs, to allow for streamlining so that interested parties can expect updates on a similar timeframe.

Global Surgical Payment RFI

For CY 2026, as part of an iterative process toward improving the accuracy of global surgical service valuation and payment, CMS is soliciting public comment to determine what next steps could be taken to improve the accuracy of payment for global surgical packages. They are specifically seeking comments 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. CMS is also seeking comments and stakeholder input as to current practice standards and division of work between surgeons and providers of post-operative care.

Skin Substitutes

CMS is proposing to shift payment for skin substitutes from the current ASP-based biologicals model to an "incident-to" supply model when used in covered procedures. This change responds to a dramatic rise in recent Medicare Part B spending—from $252 million in 2019 to over $10 billion in 2024—largely driven by price increases.

For CY 2026, CMS proposes grouping skin substitutes by FDA regulatory categories (*e.g., 361 HCT/Ps, PMAs, and 510(k)s*) and using a single payment rate based on the highest average among these groups. This aims to better reflect clinical differences and encourage innovation, while reducing Medicare costs. CMS plans to differentiate payment rates by category in future years and apply the policy consistently across physician offices and hospital outpatient settings.

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RFI on Streamlining Regulations & Reducing Administrative Burdens in Medicare
Lastly, 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.

Other Updates
CMS is also proposing updates to the Geographic Practice Cost Indices (GPCIs), malpractice relative value units (RVUs), and work RVUs for certain services. These changes aim to better reflect the resources required to deliver care across different settings and specialties.

Additionally, the rule includes proposals to enhance the Medicare Shared Savings Program, including changes to ACO participation timelines, quality reporting requirements, and financial reconciliation policies. These updates are intended to encourage broader participation in two-sided risk models and improve care coordination for Medicare beneficiaries

You can access the full CMS proposed rule and fact sheets HERE.

Quality Payment Program (QPP)
The CY 2025 (PFS) Proposed Rule, includes proposed policies for the Quality Payment Program (QPP). Proposals relating to the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs), as well as several Requests for Information (RFIs) are included in the Proposed Rule.

Key QPP policies that we are proposing in the CY 2026 PFS Proposed Rule include:

- Introducing 6 new MVPs for the 2026 performance year that are related to diagnostic radiology, interventional radiology, neuropsychology, pathology, podiatry, and vascular surgery.
- Introducing a 2-year informational-only feedback period for new cost measures, allowing clinicians to receive feedback on their score(s) and find opportunities to improve performance before a new cost measure affects their MIPS final score.
- Maintaining the current performance threshold policies, leaving the performance threshold set at 75 points through the 2028 performance year.
- Introducing Qualifying APM Participant (QP) determinations at the individual level, in addition to existing determinations at the APM entity level.

You can access additional information about changes to the QPP HERE.