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2026 Proposed Rule Medicare Physician Fee Schedule and Shared Savings Program

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Housekeeping

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Who We Are

- APG represents ~340 physician organizations
- Nearly 260,000 physicians and other clinicians that serve nearly 90 million patients
- Capitation / Delegation is the destination
- “Taking Responsibility for America’s Health”

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Agenda

- Medicare Physician Fee Schedule (PFS)
- Medicare Shared Savings Program (MSSP)
- Quality Payment Program (QPP)
- Other: New Model, Part B Drugs, Inpatient-only, & RFIs

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Overview

The 910-page PFS & MPPS proposed rule was released on July 14 and comments are due September 12

APG's top-line summary: Mixed bag including **the physician pay raise + RFIs, changes to MSSP, a new model, and policies to address fraud, waste, and abuse**

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Medicare Physician Fee Schedule

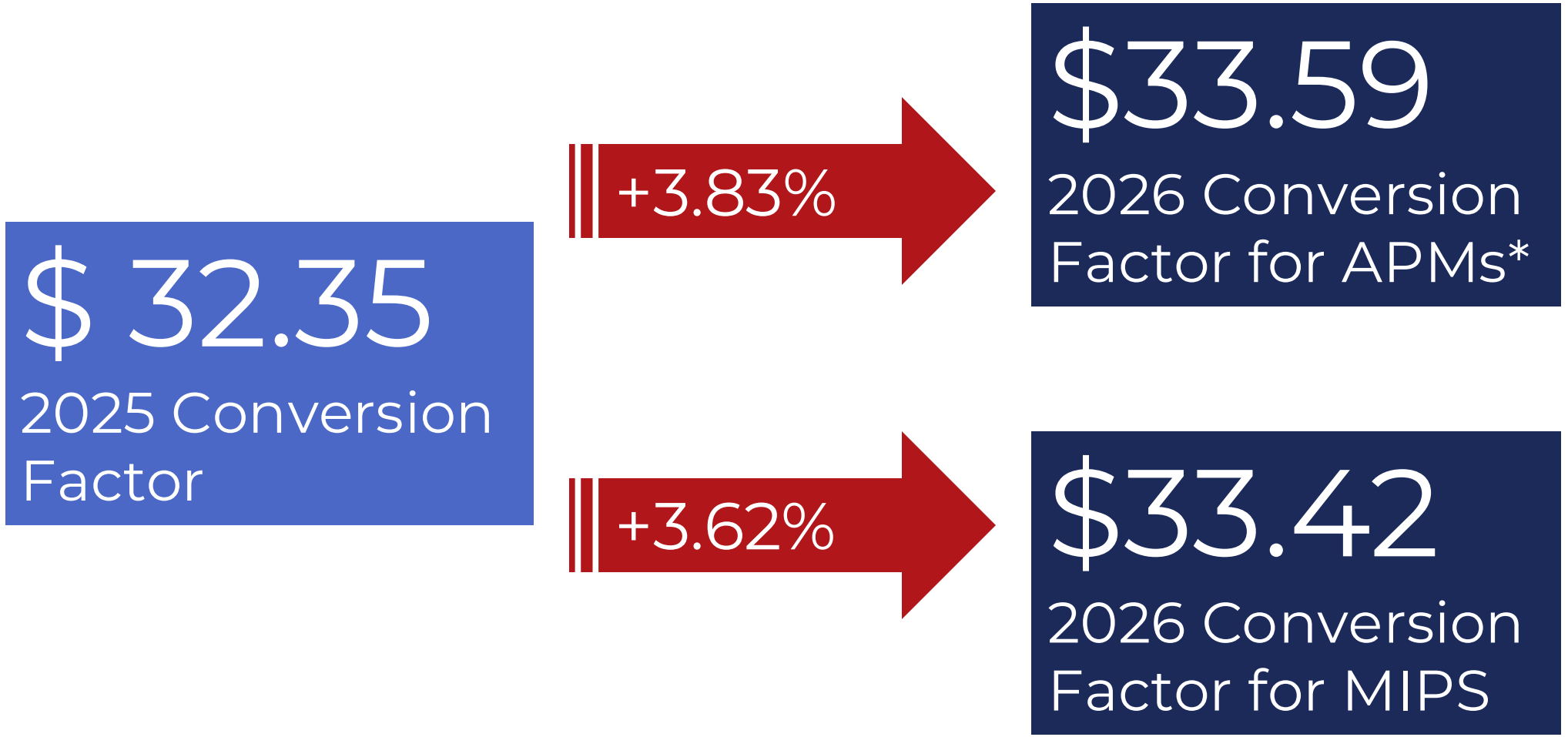
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Key PFS Proposals

- PFS payment update
- Determination of RVUs and GPCIs
- Proposed valuation for potentially misvalued services
- Skin substitutes
- Payment for telehealth services
- E&M visits
- Enhanced care management
- Medicare Diabetes Prevention Program

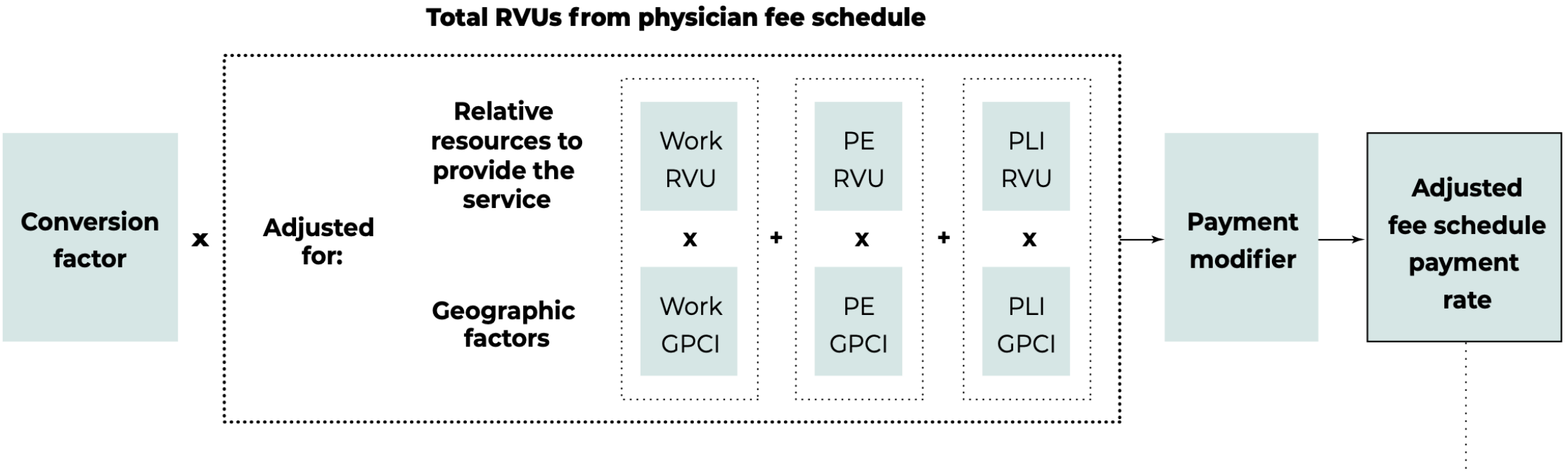
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Fee Schedule Payment Update



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Determination of RVUs and GPCIs



Source: MedPAC

Determination of RVUs and GPCIs

- **Work RVUs** – apply a productivity adjustment for services expected to become more efficient over time of -2.5% for 2026
- **PE RVUs** – in 2026 recognize greater costs for providers in office-based vs facility settings and *eventually* replace AMA Physician Practice Information survey data
- **MP RVUs** – no major changes; refine which specialties require imputed data on premiums
- **GPCIs** – periodic review and and adjustment per statute, see Addendum D and E

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2026 Impact of PFS by Select Specialties

Specialty	Change	Specialty	Change
Allergy/Immunology	+7%	Cardiac surgery	-3%
Clinical social worker	+4%	Dermatology	-2%
General practice	+3%	Internal medicine	-1%
Neurology	+1%	OB/gynecologist	-1%
Nurse practitioner	+1%	Ophthalmology	-2%
PA	+1%	Orthopedic surgery	-3%
Psychiatry	0%	PT/OT	-1%

Valuation for potentially misvalued services

- CMS values thousands of individual service codes with input from AMA's RUC
- Statute requires CMS to review potentially misvalued codes
- MedPAC has identified numerous reasons RVUs become misvalued over time
- CMS accepts public nominations for codes that should be re-valued

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Payment for skin substitutes

- Medicare spending on skin substitutes has grown from $256M in 2019 to > $10B in 2024
- Currently, skin substitutes are paid as biologicals, as much as $2,000 per square inch
- CMS proposes to pay for skin substitutes as incident-to supplies, a change expected to reduce spending on these products by nearly 90%
  - Will use a single payment rate set at the highest average for FDA's 3 categories of skin substitutes
  - For 2026, payment would be $125 per square centimeter

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Payment for Telehealth Services Proposals

- Streamline process for allowing Medicare to pay for telehealth services
- Permanently remove frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations
- Permanently adopt a definition of direct supervision that allows the practitioner to provide such supervision through real-time audio and visual interactive telecommunications
- Transition back to pre-PHE policy, which requires that, for services provided within MSAs, teaching physicians must maintain physical presence during critical portions of resident-furnished services

Evaluation & Management Visits Proposal

- Allow HCPCS code G2211 to be billed as an add-on code with the home or residence evaluation and management visits code family (CPT codes 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350)

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Last Year: Enhanced Care Management

- Created codes for Advanced Primary Care Management (APCM) services

GPCM1	GPCM2	GPCM3
• For patients with ≤ 1 chronic condition • ≈ $10	• For patients with ≥ 2 chronic conditions • ≈ $50	• For QMBs with ≥ 2 chronic conditions • ≈ $110

*QMB (Qualified Medicare Beneficiary)

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Enhanced Care Management Proposals

- Integrate behavioral health into Advance Primary Care Management (APCM) with add on codes for:
  - Behavioral health integration (BHI)
  - Psychiatric collaborative care model (CoCM)
- Removes the need to document time spent

Medicare Diabetes Prevention Program

- Test a fully online, asynchronous MDPP option, through 2029
- Live, online interaction with a coach still required
- Programs must ensure that participants' submitted weights meet guardrails
- Other technical changes, e.g., defining "online session"

Medicare Shared Savings Program

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Summary of MSSP Changes

- Limit participation to one sided risk to first agreement period (1/1/2027)
- ACOs required to change participant list with Change of ownership
- Modify eligibility Requirements and financial reconciliation if < 5000
- Change definition of Primary Care Services

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Limiting participation of one-sided risk

01

Currently, Inexperienced ACO participants can have up to 7 years under the Basic track before they need to transition to risk

02

Only 10.5% remain in one sided risk after 5 years and transitioned ACO to higher risk generated higher levels of net savings

03

Beginning 1/1/2027, inexperienced ACOs will only be in a one-sided track for the first agreement period

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Change of ownership (CHOW) scenarios

Currently, ACO can only update participant list during the annual change request cycle

Exception will be made when the surviving TIN (after CHOW) has NO Medicare billing claims history . Must be done within 30 days. effective 1/1/2026

SNF CHOW (for affiliate list) with TIN changes

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Modify eligibility requirements and financial reconciliation if < 5000

Current	Proposed
• Must have at least 5000 benes in all 3 benchmark years	• Must have at least 5000 bene in third benchmark year but can be less in BY 1 and 2 • Only Basic Track • Begins 1/1/2027 with new agreements

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Primary care services definition

Addition of Enhanced Care Model Management Services add on codes for APCM (GPCM1-3)-mainly behavioral health.

Delete SDOH Risk assessment services

APCM: Advanced Primary Care Management code

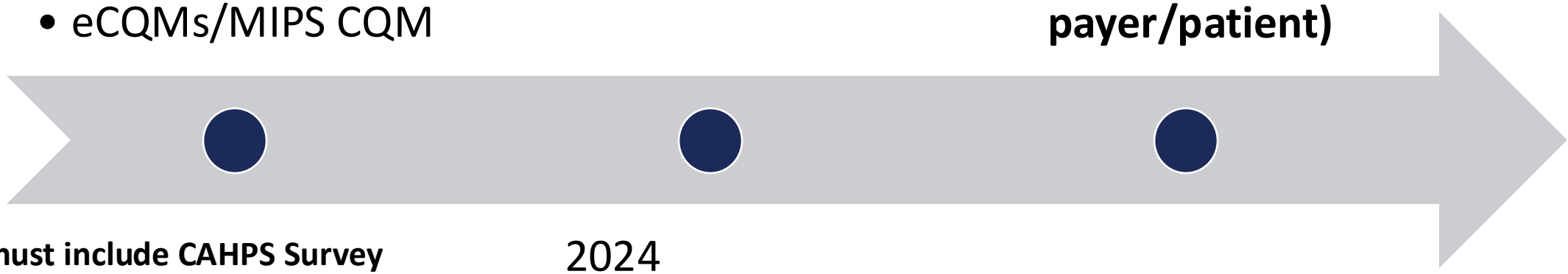
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Summary of Quality Changes in MSSP

- Revise quality standard and reporting requirements-bene eligible, health equity adjustment, APP Plus changes, quality deficits
- Expand application of extreme and uncontrollable circumstances
- Rename health equity benchmark adjustment to population adjustment

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Timeline of MSSP collection changes



2023

- Web Interface or
- eCQMs/MIPS CQM

2024

- Web Interface or
- eCQMS/MIPS CQM
- Medicare CQM

2025 and beyond (until FHIR dQM is complete)

- Medicare CQM
- **eCQMs (all payer/patient)**

All must include CAHPS Survey

FHIR dQM: Fast Healthcare Interoperability Resources to digital Quality measurement

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Definition of Medicare CQM eligible beneficiaries

Medicare CQM –all beneficiaries in Medicare, not just assigned

→

Modify bene eligible to have at least 1 primary care service from ACO primary care, specific specialty designation, or Mid Level

→

Replace claims and measurement period with primary care services and performance year

→

Will lead to less patient matching. Q4 2025 will have updated definition

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Remove Health Equity Adjustment for Quality Score

- ACOs can receive up to max of 10 points added to Quality score
- Currently has Complex organization adjustment and eCQM/MIPS CQM reporting incentive
- Seen as duplicative incentives
- Only 13 out of 71 ACOs earned health equity bonus points
- Removal effective in Performance year 2025

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Complex organization adjustment for eCQMs

- Applies to Virtual Groups in an APM entity
- Must be Reporting eCQMs
- Receive one point for each submitted eCQMs (meets minimum requirement and data completeness)
- Not to exceed 10 points in each measure and can't exceed 10% of total points in Quality category

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Universal Foundation

Domain	Measure
Wellness/Prevention	• Colorectal Cancer Screening • Breast Cancer Screening • Adult immunization status
Chronic conditions	• Controlling high blood pressure • Hemoglobin A1c control
Behavioral health	• Screening for depression with follow-up plan • Initiation/ engagement of substance use disorder treatment
Seamless care coordination	• All Cause Readmission
Person-centered care	• CAHPS
Equity	• Screening for social drivers of health

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2028 APP Plus Quality Measures

Quality 001	Hemoglobin A1c	Reported	Intermediate Outcome
Quality 134	Depression	Reported	Process
Quality 236	Controlling high pressure	Reported	Intermediate Outcome
Quality 113	Colorectal screening	Reported (starts 2026)	Process
Quality 112	Breast Cancer Screening	Reported	Process
All Cause Unplanned Readmission	Hospital Readmission	Claims	Outcome
Multiple Chronic Conditions All Cause Admission	MCC Hospital Admission	Claims (starts 2026)	Outcome
CAHPS	Patient's experience	Survey (web 2026)	Pt Exp
Quality 305	substance use disorder	Reported (starts 2027)	Process
Quality 493	adult immunization	Reported (starts 2028)	Process

Eliminate SDOH screening

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Modify quality monitoring requirements to address performance deficits

Effective 1/1/2026

Fails both quality performance standard and alternative quality standard

<u>1 of 3 actions:</u>

1. warning notice
2. Corrective action plan
3. placed on special monitoring plan

Will be terminated if fails to meet both for 2 consecutive PYs or for any 3 PY in agreement period

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Expand application of extreme and uncontrollable circumstances

Add cyberattack

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Rename health equity benchmark adjustment (HEBA) to population adjustment

Upward adjusting of historical benchmark of ACOs with greater than 20% of LIS or duals (estimated to be 4% of ACOs)

Calculation of HEBA:

Percent of ACOs assigned bene in Part D LIS or dual eligible multiplied by scaler (5% assignable beneficiaries FFS costs minus higher of either regional or prior savings adjustment)

HEBA added to each enrollment type (ESRD, Disabled, aged duals, Aged non duals)

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Quality Payment Program (QPP)

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Different payments under MIPS and A-APMs

Payment year	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Performance Year	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Fee Schedule	+0.5% every year			+0.25%		0% every year					+0.25% / +0.75%	
MIPS				± 4%	± 5%	± 7%	± 9%	± 9%	± 9%	± 9%	± 9%	
A-APM				+5% every year if qualifying professional (QP)						3.5%	1.88 %	0%

MIPS A-APM

Threshold for MIPs will remain at 75 points

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QP threshold

Payment Year Performance Year	2020 2018	2021 2019	2022 2020	2023 2021	2024 2022	2025 2023	2026 2024	2027 2025
QP Payment	25%	50%	50%	50%	50%	50%	~~75%~~ 50%	75%
QP Pt Count	20%	35%	35%	35%	35%	35%	~~50%~~ 35%	50%

Thresholds will revert to 75%/50% in 2025 Performance year without Congressional action

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Overview of APM changes

Modify methodology to calculate QP Status

Will be at individual calculation and the entity level at each snapshot

Use covered professional services to identify beneficiaries (instead of E/M)

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New specialty model, Part B drugs, Inpatient-only list, & RFIs

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Ambulatory Specialty Model (ASM)

- Mandatory model for specialists treating low back pain and congestive heart failure
- 5 years: January 2027 – December 2031
- About one quarter of core-based statistical areas and metro divisions will be selected for participation
- Performance assessed at the individual level
- Risk grows from 9% in 2027 to 12% in 2031

Part B drugs

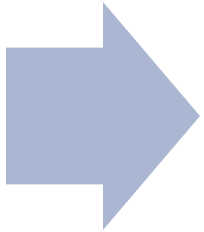
- Adding new clarification to CMS' calculation of "average sales price" (ASP).
- CMS is specifying when certain fees are considered price concessions.
- CMS is revising the definition of bona fide service fees (BFSFs).
- Payment of 106 percent of maximum fair price (MFP) in 2028 for selected drugs.
- Selected drugs with a negotiated Part B payment limit for 2026 and 2027 will not be based on the MFP unless selected for renegotiation.

Part B drugs – Autologous cell-based immunotherapies and gene therapies

- CMS clarifies that preparatory procedures for tissue procurement required for manufacturing will be included in the payment for the product itself.
- Any preparatory procedures for tissue procurement required for manufacturing that are paid by the manufacturer will be included in ASP calculation.
- Any payments by the manufacturer to an entity for tissue procurement is not considered a bona fide service fee for calculating the manufacturer's ASP.

OPPS Rule

Eliminate Inpatient only list over 3 years (starting with muscular skeletal)



Add over 500 codes to ASC list

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RFI – Fast Healthcare Interoperability Resources (FHIR) and Digital Quality Measurement (dQM)

- RFI is related to the dQM transition.
- ECQM FHIR conversion activities.
- Data standardization.
- Timeline for FHIR-based eCQM reporting.
- Measure development and reporting tools.
- FHIR reporting and data aggregation for ACOs.
- General questions.

RFI – Disease treatment

- CMS is asking how they should apply cost sharing for Advanced Primary Care Management (APCM) services
- CMS is looking to enhance their support for chronic disease prevention and management
- CMS wants input on well-being and nutrition measures for future QPP years

RFI – Query of Prescription Drug Monitoring Program (PDMP)

- Should CMS change the Query of PDMP measure (which only currently applies to Schedule II opioids) from attestation-based to performance based?
- CMS is considering a broader set of performance-based measurement concepts
- CMS is considering expanding the Query of PDMP measure to include all Schedule II drugs

RFI – Performance based measures & data quality

- CMS is interested in new measure concepts in public health allowing for better focus on data quality of public health reporting.
- CMS is considering revising scoring for the public health and clinical data exchange objective measures.
- CMS is continuing to explore opportunities to leverage FHIR-based capabilities within certified health IT to support public health reporting.
- CMS wants to encourage and support MIPS eligible clinicians use of modern technologies and standards.

RFI – Transforming MIPS: MVP strategy

- Part of CMS' goal to phase out MIPS for Most Valuable Pathways (MVPs)
- Will address the use of Fast Healthcare Interoperability Resources (FHIR)-based electronic clinical quality measures (eCQMs) in quality reporting and payment programs
- Related RFIs

Questions and Discussion

- APG members are welcome to join us for a focus group to provide feedback for the APG comment letter to CMS. We'll meet Thursday, August 21st noon – 1:00pm ET.
- APG will submit a comment letter by September 12th
- Please also contact us with questions or feedback

- Jennifer Podulka jpodulka@apg.org
- Valinda Rutledge vrutledge@apg.org

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