Medicare Proposes Physician Payment Increase for 2026: Key Changes Physicians Should Know

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In a significant policy reversal, Medicare's newly released 2026 proposed rule includes a 3.83% or 3.62% increase in physician payment rates, depending on participation in an Advanced Payment Model (APM) under the Quality Payment Program. Qualifying APM participants (QPs) will enjoy 3.83%, while non-QPs – the vast majority of physicians - will receive 3.62%. The payment update, driven largely by the recently enacted 2.5% increase in the current administration's "One Big Beautiful Bill," marks a shift from years of reductions. In 2025, the Centers for Medicare & Medicaid Services (CMS) finalized the current 2.83% reduction, the fifth consecutive year of cuts.

Announced on July 14, 2025, the revisions are *proposals,* yet provide a powerful signal as to the federal government's intention. Historically, many of the proposals move into permanent status later in the fall.

Few Changes to the Quality Payment Program

Physicians participating in the Merit-Based Incentive Payment Program (MIPS) will see minimal changes in 2026. The performance threshold remains at 75 points. The limited changes reflect a focus on program stability rather than new policy development, a welcome relief and perhaps a justified one as the program's potential payouts have been minimal with the exception of last year. However, limited changes are proposed. For example, ten quality measures are dropped and five new outcomes measures are planned including prescreening for diabetes.

New 'Efficiency Adjustment' Reduces RVUs for Many Codes

One of the most consequential proposals is the introduction of an "efficiency adjustment" to the Medicare Physician Fee Schedule (PFS). CMS is proposing a 2.5% reduction to intra-service time and work relative value units (RVUs) for nearly all non-time-based codes. This adjustment reflects presumed efficiencies gained over time, applying the cumulative Medicare Economic Index productivity adjustment from the past five years. Time-based codes and certain excluded services would not be affected, thereby effectively shifting the benefit to physicians who rely heavily on evaluation and management codes.

Practice Expense Methodology: Shift Toward Site Neutrality

CMS is proposing significant updates to its practice expense methodology, aimed at better recognizing indirect costs for office-based practitioners compared to those practicing in facility settings. The agency cites concerns about the surveys overseen by the American Medical Association that inform the changes; for example, sampling

variation and low sample size. Specifically, the federal agency plans to reduce payment differentials by site of service – effectively tipping the scales away from facility-based practices (place of service [POS] 19 and 22) towards office practices (POS 11). With the proliferation of hospital-based clinics, this news comes as no surprise.

Using hospital cost data, CMS intends to calculate more accurate reimbursement rates for services typically delivered in facility settings. As a component of this assessment, the agency proposes to reduce the portion of facility practice expense RVUs allocated based on work RVUs to *half* the rate of non-facility RVUs starting in 2026.

Virtual Direct Supervision Becomes Permanent

Telemedicine remains a focus. CMS proposes to make permanent its current waiver allowing direct supervision through real-time audio/video communications. If finalized, this will permanently allow physicians to supervise services virtually. The exception for teaching physicians, however, will not be extended. Teaching physicians must maintain physical presence during critical portions of resident-furnished services to qualify for Medicare payment.

The clock is still ticking for telemedicine, as the March 2025 law that temporarily extended the telemedicine flexibilities—including reimbursement for services provided to patients in their homes, audio-only visits, expanded provider types, etc. – ends with the federal fiscal

year of September 30, 2025.

An exception is proposed: federally qualified health centers (FQHCs) and rural health clinics (RHCs) would retain the ability to perform – and bill for - telemedicine services through 2026. Further, digital mental health treatment (DMHT) is proposed to expand for devices used in the treatment of Attention Deficit Hyperactivity Disorder (ADHD).

Ambulatory Specialty Care Model Targets Chronic Conditions

A notable proposal is the introduction of a mandatory Ambulatory Specialty Care Model. This payment model focuses on two key conditions: heart failure and low back pain.

Specialists frequently treating these conditions would be included in the model, which aims to improve care through better chronic disease management.

CMS noted the model's intent to "enhance quality of care by improving upstream chronic disease management." More details are expected in the final rule but cardiologists and orthopedic surgeons should be on the alert.

Skin Substitutes Reclassified to Reduce Spending

Another proposed change affects skin substitutes. CMS plans to classify these products as "incident-to supplies" rather than biologicals when used as part of a covered procedure. This reclassification – which effectively means that the products will no

longer be paid in certain circumstances - is intended to reduce Medicare spending on skin substitutes by nearly 90%, according to the agency's estimates. Spending rose to over $10 billion in 2024, a nearly 40-fold increase in just five years.

Behavioral Health Integration Supported via New Add-On Codes

Addressing behavioral health needs, CMS proposes optional add-on codes to incorporate in the government's new Advanced Primary Care Management.

These codes are designed to facilitate integration of behavioral health services, particularly through the Collaborative Care Model.

Behavioral health conditions remain among the most common chronic diseases nationwide; CMS emphasized that these codes aim to strengthen care integration for patients with these conditions.

Looking Ahead

The 2026 Medicare Physician Fee Schedule signals CMS's dual priorities: stabilizing payment programs while introducing targeted changes that promote efficiency and care transformation. The 2.5% payment increase stands as the most immediate financial change for physicians. However, the efficiency adjustment and practice expense reforms suggest longer-term shifts away from procedures and hospital-based practices.

Physicians should review the proposed rule closely, as the cumulative effects of these changes may differ based on specialty and site of care. Public comments are open through September 9, 2025. The final rule is expected to be released on or around November 1.

For more information, visit: cms.gov/newsroom/fact-sheets/calendar-year-cy-2026-medicare-physician- fee-schedule-pfs-proposed-rule-cms-1832-p

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