ACEP's First Take from the Combined 2026 Medicare Physician Fee Schedule (PFS) and MACRA Quality Payment Program (QPP) Proposed Rule

On July 14, 2025, the Centers for Medicare & Medicaid Services (CMS) released the **Calendar Year (CY) 2026 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies Proposed Rule (CMS-1832-P)**, which includes changes related to Medicare physician payment and the Quality Payment Program (QPP), among other issues.

The proposed conversion factor (CF) is $33.5875 for physicians who meet certain participation thresholds in Advanced Alternative Payment Models (APMs) and $33.4209 for other clinicians. These Calendar Year (CY) 2026 Resource-Based Relative Value Scale amounts represent increases of 3.8% and 3.3%, respectively, from the final CY 2025 CF of $32.3465. Most emergency physicians will receive the lower CF since they do not participate in Advanced APMs. The proposed CF update is primarily based on three factors:

1. Statutory update in the Medicare Access and CHIP Reauthorization Act (MACRA): 0.25% for non-QPs and 0.75% for QPs
2. A 0.55% positive budget neutrality adjustment;
3. A 2.5% one-year payment increase from the One Big Beautiful Bill Act

Due to the proposed changes to practice expense (described below), the relative value units (RVUs) associated with the codes that emergency physicians bill will decrease by -2 percent when billed in facilities. The decrease in the value of these codes will negate some of the increase from the higher CFs; leading to an overall positive adjustment of around 1-2%, depending on the level of ED E/M code billed.

<u>Physician Fee Schedule</u>

- **Efficiency Adjustment and Practice Expense Changes:** 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. In a departure from current rate setting, CMS is proposing an efficiency adjustment, using a sum of the past five years of the Medicare Economic Index (MEI) productivity adjustment percentage to calculate this efficiency adjustment. The MEI productivity adjustment is calculated by the CMS Office of the Actuary (OACT) each year, and CMS is proposing a look-back period of five years, which would result in a proposed efficiency adjustment of -2.5% for CY 2026. The adjustment would apply to the work RVU and corresponding intraservice portion of physician time of non-time- based services. This would 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. The efficiency adjustment does not apply to ED E/M codes.

  In a hit to emergency medicine, CMS is proposing significant updates to the practice expense (PE) methodology by increasing indirect costs for practitioners in office-based settings compared to facility settings. Lowering indirect PE in the facility setting will also lower payments for emergency medicine.

- **Payment for Services in Urgent Care Centers:** In the CY 2025 PFS proposed rule, CMS sought comment on urgent care centers, noting that interested parties describe that hospital EDs are often used by beneficiaries to address non-emergent urgent care needs that could be appropriately served in less acute settings, but where other settings, such as physician offices, urgent care centers or other clinics, are not available or readily accessible. ACEP provided comments in our response to that proposed rule. In this year's rule, CMS seeks comments regarding whether separate coding and payment is needed for E/M visits furnished at urgent care centers, including whether or not an add-on code

would be appropriate or if a new set of visit codes would be more practical.

- **Telehealth**
  - ***ED E/M Codes***: CMS is proposing to streamline the process for adding services to the Medicare Telehealth Services List by removing the distinction between "provisional" and "permanent" services and limiting review on whether the service can be furnished using an interactive, two-way audio-video telecommunications system. In tandem with this proposal, CMS proposes to make permanent all the telehealth codes that are currently on the provisional list – including all five ED E/M code levels 1-5 (CPT codes 99281-99285), the critical care codes, and the observation codes. CMS is also proposing to permanently remove frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations.
  - ***Direct supervision:*** CMS is proposing, for services that are required to be performed under the direct supervision of a physician or other supervising practitioner, to permanently adopt a definition of direct supervision that allows the physician or supervising practitioner to provide such supervision through real-time audio and visual interactive telecommunications (excluding audio-only). However, they are not proposing to extend the current policy to allow teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings through December 31, 2025. Rather, they are proposing to transition back to the pre-public health emergency (PHE) policy, which requires that, for services provided within metropolitan statistical areas (MSAs), teaching physicians must maintain physical presence during critical portions of resident-furnished services to qualify for Medicare payment, while maintaining the rural exception established in the CY 2021 PFS final rule.

- **Prevention and Management of Chronic Disease – Request for Information (RFI):** In conjunction with the Trump Administration Executive Order, "Establishing the President's Make America Healthy Again Commission," CMS is soliciting feedback on a number of questions related to support management for prevention and management of chronic disease.

- **Ambulatory Specialty Model:** CMS is proposing the new Ambulatory Specialty Model (ASM), a mandatory payment model focused on specialty care for beneficiaries with heart failure and low back pain. The model aims to enhance the quality of care and reduce low-value care by improving upstream chronic disease management. Specialists would be rewarded for effective disease management, adhering to clinical guidelines for care, and coordinating with other providers involved in the management of their patients' care. ASM would begin on January 1, 2027, and run for five performance years through December 31, 2031. ASM's payment years run from January 1, 2029, through December 31, 2033. While not focused on emergency medicine, this model signals CMS desire to enact mandatory payment models that impact clinicians.

Quality Payment Program

CMS introduces policies that impact the 2026 performance year in the Quality Payment Program (QPP). The QPP includes two tracks: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). MIPS includes four performance categories: Quality, Cost, Improvement Activities, and Promoting Interoperability. Performance on these four categories (which are weighted) roll up into an overall score that translates to an upward, downward, or neutral payment adjustment that providers receive two years after the performance period (for example, performance in 2026 will impact Medicare payments in 2028).

- **MVPs:** The 2026 performance year is the fourth year in which a new reporting option in MIPS called MIPS Value Pathways (MVPs) is available. MVPs represent an approach that will allow clinicians to report on a uniform set of measures on a particular episode or condition in order to get MIPS credit. ***ACEP developed an emergency medicine-focused MVP that became available in 2023.***

  In this year's rule, CMS is proposing to remove 1 quality measure from the Emergency Medicine MVP, modify 1 quality measure, and remove 3 improvement activities.

  CMS is also proposing 6 new MVPs. CMS has repeatedly stated that it intends to phase out traditional MIPS and transition fully to MVPs. In other words, MVPs would become mandatory rather than voluntary. CMS has not previously laid out a specific timeline for making this transition, but sought comment in last year's proposed rule on a sunset date of 2029. In this year's rule, CMS is not officially proposing to make MVPs mandatory. However, CMS is proposing that groups would now need to attest to their specialty composition (whether they're a single specialty or multispecialty group that meets the requirements of a small practice) during the MVP registration process. (i.e., CMS wouldn't make this determination for them), as they believe this proposal would support groups in their transition to MVP reporting and would help these groups assess their need to participate as subgroups. Subgroup reporting would remain optional for multispecialty small practices.

- **Qualified Clinical Data Registries (QCDRs):** ACEP has its own QCDR, the Clinical Emergency Data Registry (CEDR). CMS is proposing that QCDRs and Qualified Registries would have one year after a new MVP is finalized before they're required to fully support that MVP, to provide more time to implement necessary system updates to capture the measures and activities finalized for inclusion

- **Performance Threshold**: CMS proposes to maintain their current performance threshold policies, keeping the performance threshold at 75 points through the CY 2028 performance period/2030 MIPS payment year.

- **MIPS Performance Categories**
  - ***Quality:*** CMS is proposing changes to the Alternative Payment Models (APM) Performance Pathway (APP) Plus quality measure set to maintain alignment with the MIPS quality measure inventory.
  - ***Cost:*** CMS is proposing to update candidate event and attribution rules for the Total Per Capita Cost (TPCC) measure. They are also proposing 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.
  - ***Improvement Activities:*** CMS is proposing to add 3 new improvement activities, modify 7 improvement activities, and remove 8 improvement activities. They are also proposing the addition of a new subcategory titled "Advancing Health and Wellness" and the removal of the "Achieving Health Equity" subcategory.
  - ***Promoting Interoperability:*** CMS is proposing changes to the High Priority Practices Safety Assurance Factors for Electronic Health Record (EHR) Resilience (SAFER) Guide measure and the Security Risk Analysis measure and proposing a new optional/bonus measure for the Public Health and Clinical Data Exchange objective, specifically the Public Health Reporting Using the Trusted Exchange Framework and Common Agreement (TEFCA) measure.

    - Additionally, CMS is proposing a measure suppression policy for the MIPS Promoting Interoperability performance category and the Medicare Promoting Interoperability Program.

- **Advanced APMs:** CMS is proposing to add a determination of all eligible clinicians in Advanced APMs for Qualifying APM Participant (QP) status at the individual level, in addition to determinations at the APM Entity level.

- **Requests for Information**
    - *Core Elements in an MVP:* CMS seeks comment on how to encourage MVP reporting on key quality measures that reflect the essential components of an MVP, which in turn may provide patients with more directly comparative clinician performance data on select quality measures. This includes a potential Core Elements MVP reporting requirement, which would identify a subset of quality measures in each MVP to comprise the MVP's Core Elements; the intended goals and ideal number of Core Elements in an MVP; and the role of measure collection types, the limitations of measure applicability for some clinicians, the policy implementation timeline, and any anticipated impacts on clinicians' transition to MVP reporting.
    - *Well-being and Nutrition Measures*: CMS seeks comments on tools and measures that assess overall health, happiness, and satisfaction in life that could include aspects of emotional well-being, social connections, purpose, and fulfillment.
    - *Procedural Codes for MVP Assignment:* CMS solicits feedback on the use of procedural billing codes to assign clinicians to an MVP to facilitate specialty reporting of MVPs most relevant to their scope of care. They seeking comments on the assignment of MVPs based on procedural codes, the eligibility determination period to establish procedural code utilization and relevant volume threshold, and anticipated impacts on clinicians' transition to MVP reporting.
    - *Transition Toward Digital Quality Measurement*: CMS includes an RFI to gather comment on continued advancements to digital quality measurement and the use of the Health Level 7® Fast Healthcare Interoperability Resources® (FHIR®) standard
    - *Query of Prescription Drug Monitoring Program (PDMP) Measure:* CMS seeks to evaluate the current Query of PDMP measure to increase integration of PDMPs into electronic health systems (EHRs).
    - *Public Health and Clinical Data Exchange Objective*: CMS includes an RFI to evaluate the measures under the Public Health and Clinical Data Exchange objective, which do not currently measure the degree to which MIPS eligible clinicians are exchanging the data specified under each measure. They seek comment on whether alternatives to the current attestation-based measures can drive further improvements in the quality and consistency of reporting to public health agencies and associated public health outcomes.
    - *Data Quality*: Finally, CMS seeks comment on the current data environment, including the quality of the data being collected and exchanged and related challenges.