CAPITOL STREET

November 2, 2025

CMS 2026 MAHA-Friendly Physician Payment Rule

CMMI MAHA Model (5-Year/Chronic Disease), Changes to MSSP & Some Primary Care Positives, Boost for Telehealth & Mental Health, Negative for Surgeons

Relevant Companies: ALL HEALTHCARE

Our Take & Next Up

CMS finalized a surgeon-friendly rule, similar to its proposed rule in July, with a new chronic disease CMMI pilot (low back pain, heart failure), as mental health is boosted via several policies. CMS released its final 2026 physician fee schedule (PFS) Oct 31 (here). This year's final rule seeks to reduce payment differentials for physicians across settings using new data (positive for primary care, negative for specialties). New policies and payment rates start Jan. 1, 2026. We describe in a forthcoming memo updates to skin substitutes and cell & gene therapies, as well as other updates as CMS reimburses providers in a physician setting via Part B (ASP+6%).

Key Points

CMMI ASM MODEL: 5 YEAR, HIGH COST CONDITIONS

CMS finalizes the Ambulatory Specialty Model (ASM), a 5-year, mandatory, two-sided risk model under CMMI, targeting high-cost chronic conditions like heart failure and low back pain (here). It seeks to improve chronic disease management, reduce unnecessary care, and lower Medicare spending by holding specialists financially accountable for outcomes.

During the initial payment year, rates could be adjusted anywhere from -9% to +9% based on relative performance in four areas. They are quality, cost, improved care, and better interoperability.

ASM launches in January 2027 and runs through 2031. ASM would target individual outpatient specialist physicians in ~25% of core-based statistical areas (CBSAs) and metro divisions, starting with heart failure or low back pain (potentially expanded to other conditions).

ASM will allow participants to remain in other CMS Innovation Center Models and accountable care organizations (ACOs), including the Medicare Shared Savings Program. FAQs are here.

MEDICARE SHARED SAVINGS (MSSP) UPDATES

CMS finalizes a number of mixed policy updates to the Medicare Shared Savings Program (here), impacting PRVA and others. This is the ACO program that is baked into the statute, after many successful years.

- Limits ACOs to 5 years (instead of 7) in the one-sided BASIC track during their initial agreement, to promote earlier adoption of two-sided risk.
- Gives ACOs more flexibility in meeting the 5,000-beneficiary minimum during benchmark years, while adding safeguards to protect from spending fluctuations.
- Revises quality standards and reporting rules, including eliminating the health equity adjustment from ACO quality scores.
- Expands extreme and uncontrollable circumstances (EUC) policies to cover ACOs impacted by cyberattacks, such as ransomware.
- Requires ACOs to report mid-year participant list updates, such as participant ownership changes.

PHYSICIAN PAY DETAILS

This year's rule contains a broader range of pay raises and cuts to various subspecialties, and is generally negative for surgeons. The most drastic changes seen in Allergy/Immunology (+7%) and Vascular Surgery (+5%), Rheumatology (+4%), Infectious Disease (-6%), Neurosurgery (-5%), Gastroenterology (-4%), Ophthalmology (-2%) and Plastic Surgery (-4%).

Family practice and general practice would be +3% in 2026. Most other specialties hover around the -1% to +1% range, with some specialties seeing no percent change at all. The overall physician update is 3.26% (3.77% for Qualifying APM Participants), reflecting a one-time statutory boost of 2.5% (from recon bill) and an estimated 0.49% increase tied to updated work RVU assumptions.

CMS finalizes a new 'efficiency' adjustment – positive for primary care, less so for specialties. To better reflect expected productivity gains over time, the agency is finalizing application of a new adjustment to the work RVUs and corresponding intraservice portion of physician time for non-time-based services. In the final rule, however, CMS is exempting additional codes, specifically time-based codes, services on the CMS telehealth list, and new codes for CY 2026. The efficiency adjustment would be calculated using a sum of the past five years of the Medicare Economic Index (MEI) productivity adjustment percentage and will be -2.5% for CY 2026.

CMS will change its practice expense (PE) methodology using hospital outpatient data to set more precise pay, versus AMA survey data, which we see as a "poke" at the often-criticized RUC. CMS will modify its practice expense methodology by incorporating higher indirect cost rates for office-based doctors than for those in hospitals to reflect the trend of more doctors being employed by hospitals. AMA is the American Medical Association.

CMS finalizes moving from AMA survey data in favor of auditable, regularly updated hospital data to establish relative or absolute rates. For CY 2026, this data would be used in setting rates for radiation treatment services and for some remote monitoring services. For each service valued in the facility setting, CMS

would reduce the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs for CY 2026.

CMS is finalizing changes to the furnishing of Advance Primary Care Management (APCM) services in clinics – RHCs and FQHCs – for mental health. There would be add-on codes for APCM that would facilitate billing for Behavioral Health Integration (BHI) and Psychiatric Collaborative Care Model (CoCM) services when RHCs and FQHCs are providing advanced primary care.

Home-based primary care allowed, which is a plus. CMS is finalizing its proposal to allow for the use of G2211 for home-based primary care. There are many home-bound patients that receive primary care in the home.

TELEHEALTH

In a positive for telehealth, CMS finalizes a proposal to streamline the process for adding services to the Medicare Telehealth List. Under the policy, CMS would eliminate the distinction between provisional and permanent services and focus review solely on whether a service can be delivered via two-way, audio-video technology.

- CMS will also permanently remove frequency limitations for subsequent inpatient visits, nursing facility visits, and critical care consultations.
- For services requiring direct supervision, CMS will permanently allow virtual supervision via real-time audio-visual communication (excluding audio-only), with exceptions for certain surgical devices. The policy would apply to incident-to services, diagnostic tests, pulmonary rehab, and cardiac rehab services.
- CMS will end the current policy allowing virtual presence of teaching physicians for billing purposes in services involving residents.

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