Inside CMS' final rule changes for 2026

CMS finalizes rule changes for 2026

On October 31, 2025, CMS issued a final rule for the Medicare Physician Fee Schedule (PFS), for calendar year 2026. The Outpatient Prospective Payment System (OPPS), and ambulatory surgical centers (ASCs) issued final rules November 21. The updates include new payment policies, quality programs, and care delivery models to modernize Medicare, improve care quality, reduce waste, and strengthen provider accountability.

Notable impacts

- CMS finalized a major increase to the PFS conversion factor, including a secondary conversion factor designed to encourage participation in qualifying alternative payment models.
- CMS will phase out the Inpatient Only (IPO) list over three years. In 2026, 285 procedures — largely musculoskeletal — will be removed.
- CMS introduced a new mandatory payment model, the Ambulatory Specialty Model, targeting early intervention and preventative care for conditions such as heart failure and lower back pain.
- CMS made significant changes to the reimbursement methodology for skin substitutes beginning in 2026. Most skin substitutes will be reimbursed at a standardized flat-rate of $127.28/cm² instead of having product-specific reimbursements.

What changes are in the rules?

Physicians to potentially see highest payment increase in a decade

Under the Medicare Access and CHIP Reauthorization Act (MACRA), CMS must implement two separate conversion factors for the PFS — one for qualifying APM participants and one for nonqualifying participants[1] For the 2026 Medicare PFS, CMS has finalized conversion factors of:

- **Qualifying APMs:** $33.59 (up 3.77% from 2025)
- **Nonqualifying APMs:** $33.42 (up 3.26% from 2025)

Under the One Big Beautiful Bill Act (OBBBA), each conversion factor includes a one-year 2.5% temporary increase. Qualifying APMs will receive an additional 0.75% increase while nonqualifying APMs will receive an additional 0.25% increase. The PFS update also includes an estimated 0.55% increase to work RVUs, along with a -2.5% efficiency adjustment tied to changes in the methodology of the Medicare Economic Index.

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Modifications to the Quality Program (QP) determination methodology

For the 2026 Medicare PFS, CMS will expand QP determinations to include both entity-level and individual-level qualification in advanced APMs. This change could increase the number of clinicians who meet APM thresholds and qualify for QP status.

Currently, most QP determinations are made at the entity level, not individually. This means that some eligible clinicians who could earn QP status at an individual level may miss out if they are included in at the entity level instead.[2]

CMS will add QP determinations at the individual level for all advanced APM participants, starting with the 2026 QP performance period. Under the changes, a clinician will achieve QP status if they meet or exceed the appropriate threshold for patient count or payment amount during the performance year at either the entity level or the individual level.[2] To qualify as a QP, clinicians must receive either at least 50% of Medicare Part B payments or see at least 35% of Medicare patients through an advanced APM entity during the QP performance period.[3]

These changes are expected to result in more providers qualifying as QPs for the purposes of APMs. Currently, CMS estimates that between 375,000 and 482,200 eligible clinicians will qualify as QPs during the 2026 performance period.[4]

New payment model, practice expense methodology to impact specialist reimbursement

Beyond the PFS, CMS says it is implementing broader payment reforms to promote value, transparency, and proactive care — and will impact how providers are reimbursed across settings.

The new Ambulatory Specialty Model, which launches in January 2027, emphasizes early intervention, data sharing, and preventive care beginning with lower back pain.

CMS is also changing its practice expense methodology, including:

- Discontinuing reliance on the American Medical Association's Relative Value Scale Update Committee (RUC) survey.[5]
- Applying a 2.5% reduction to work RVUs for non-time-based services to reflect efficiency gains.[5]

CMS will utilize hospital outpatient data to inform for cost assumptions for technical services paid under PFS; therefore, reimbursement for office-based services could be significantly impacted. This new data will be used for 2026 rate setting for radiation therapy and remote monitoring.

CMS moving away from the RUC's guidance, as well as the proposed changes to RVU, will likely negatively impact specialist reimbursement. The RUC previously faced criticism for favoring specialist reimbursement over primary care reimbursement. Overall, specialists will likely see reduced payments even as the top-line PFS payment update improves primary care reimbursement.

New ACO limits for the Medicare Shared Savings Program

For the 2026 Medicare PFS, CMS is changing how accountable care organizations (ACOs) participate in the Medicare Shared Savings Program (MSSP), suggesting new limits for certain organizations.

For ACOs considered to be inexperienced with performance-based risk initiatives, participation in the MSSP under a one-sided model would be limited to five years, down from the current seven-year maximum.[5] Inexperienced ACOs would also have to progress to higher levels of risk and potential reward through a glide path under a two-sided model by their second agreement period.

For ACOs experienced with performance-based risk initiatives, track participation is moved to BASIC track E or Enhanced for subsequent agreement period.

According to CMS, the goal of this change is to increase participation in two-sided risk arrangements.[6]

CMS adds new price transparency and quality reporting requirements

Under the 2026 OPPS rule, hospitals must update their machine-readable files to include percentile pricing starting Jan. 1, 2026. Hospitals will be required to publish 10th, 50th (median), and 90th percentile of the allowed amounts for services at their facilities when payer-specific negotiated charges are based on percentages or algorithms. They are also required to disclose the number of allowed amounts used to determine the percentiles to more accurately show the distribution of actual prices hospitals receive for an item or service.

CMS is also updating its quality reporting to prioritize measurable outcomes, such as chronic disease management and patient safety. Providers will also be required to submit more detailed data on quality measures. These changes will apply to the Hospital Outpatient Quality Reporting, Rural Emergency Hospital Quality Reporting, and Ambulatory Surgical Center Quality Reporting Programs.[7]

Changes to reimbursements for skin substitutes

CMS is changing how skin substitutes are reimbursed, as well as aligning reimbursement for the OPPS/ASC and PFS.

Currently, Medicare reimburses skin substitutes using an average sales price model, which means that each product has its own unique billing code and payment limit. This has led to a wide variation in reimbursement for skin substitutes, with some products reaching as high as $2000/in².[8] Between 2019 and 2024, Medicare spending on skin substitutes jumped from $252 million to over $10 billion.[9]

Starting in 2026, CMS proposed skin substitutes be reimbursed as incident-to-supplies instead of biologicals, with a proposed flat rate of $127.28/cm².[8] According to CMS, this change could reduce spending on skin substitutes by an estimated 90%.[9]

Site neutrality expansion, changes to the Inpatient Only list, and more

CMS increased payment rates by 2.6% for both outpatient care facilities and ASCs in 2026. This payment increase includes a 3.3% market basket update, and a -0.7-percentage point productivity adjustment.

CMS expanded site-neutral payments to align drug infusion administration reimbursement with the PFS, which will lead to an estimated $210 million in savings for CMS.

CMS will phase out the Inpatient Only (IPO) list over three years. In 2026, 285 procedures, largely musculoskeletal procedures, will be removed from the IPO list.[6] Of these procedures, 271 will be added to the ASC Covered Procedure list.

Several telehealth enhancements were also made, including:

- Streamlining additions to the Medicare Telehealth List
- Permanently removing frequency limits for inpatient, nursing facility, and critical care visits
- Allowing virtual direct supervision via real-time audio-visual technology

How providers can prepare for these rules

1. Evaluate the financial impact of these changes.

Reimbursement shifts, dual conversion factors, and site-neutral payments will impact providers' revenue and margin.

Higher-than-expected PFS unit cost increases could hike claim expenses for Medicare Advantage plans. This could be challenging for Accountable Care Organizations, especially those participating in alternative payment models (APM), since fewer APM-qualified providers are included in the benchmarks.

2. Prepare for site-of-service and APM shifts.

Although CMS' proposal to phase out the IPO list and expand coverage for ASCs presents cost-savings opportunities for the agency, hospital providers will lose preferential reimbursement and risk their market share.

Going forward, providers should find ways to adapt to this continued shift to outpatient care by assessing their ambulatory networks, capacity management, and competitive risks.

3. Ensure you can meet new transparency and quality reporting requirements.

Providers will need to update their IT systems/workflows and enhance their operational readiness so that they can comply with new requirements while minimizing disruption to care delivery.

4. Review historical ACO participation to optimize the path to downside risk in the MSSP.

ACOs currently participating in the MSSP should review their historical participation to determine when they will be required to move to downside risk in their MSSP ACOs.

5. Determine if new providers will qualify for the QP threshold under the new rules.

This will ensure that providers looking to qualify as Advanced APMs will meet the required threshold under the proposed changes.

Hands-on support to realize your full potential

Optum Advisory is here to help your organization understand, measure, and plan for the impact of these changes. Our experts can also help you realize your full potential within CMS' new mandatory, episode-based model.

Get in touch at **advisory.com/optum-support**

Endnotes

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