2026 Medicare Physician Fee Schedule Proposed Rule

Comments due: Sept. 12, 2025

There are two new and controversial proposals in the rule that will cut most specialties and facility-based (hospital and ambulatory surgical center) practices while increasing payment to some office-based practices. The attached impact analyses were provided by CMS on their website. The impacts relate to the efficiency adjustment and the practice expense adjustment. They do not include the 2026 conversion factor increases. Note the first chart includes all physicians and other qualified health care professionals, even low volume practitioners, while the second is weighted by relative value units.

Efficiency Adjustment

- CMS proposes applying an arbitrary 2.5% decrease to the work RVUs and physician intra-service time of most services in the MPFS on the assumption that physicians have gained efficiency in providing them. This includes brand new services, surveyed for physician time and work within the past year. The decrease would be applied to 8,961 physician services.
- CMS arrives at a 2.5% efficiency adjustment by tallying the last five years' productivity adjustments in the MEI. Note that physicians do not receive an MEI-based update and that other Medicare providers receive a productivity adjustment applied to their annual baseline updates (e.g., hospital market basket minus productivity).
- CMS states that it will exempt time-based services, such as E/M, care management, maternity care, and services on the telehealth list. Only 393 services will be exempted from the decrease. Of note, although CMS states that they will exempt time-based services and services on telehealth list from the efficiency adjustment, several of these codes remain on the pending cut list.
- The adjustment impacts most specialties by reducing overall payment by 1%. The only specialties or professions to gain at least 1% from this proposal are: clinical psychology (3%), clinical social work (4%), geriatric medicine (1%), and psychiatry (1%), the individuals who perform a more significant amount of telehealth services, which CMS has exempted from efficiency adjustments.
- This proposal, combined with the AMA/Specialty Society RVS Update Committee's recommendations on individual CPT codes, results in the 0.55% budget neutrality adjustment to the conversion factor.
- This proposal is based on the premise that physician time in the RBRVS is inflated, with criticism of utilizing physician surveys to estimate physician time. The following statement was prepared related to this unfair criticism:

  Statement attributed to:

  Bobby Mukkamala, MD
  President, American Medical Association

  "The American Medical Association believes that proposals to exclude or limit the input of expert practicing physicians and health care professionals in the development of Medicare payment policy would ultimately harm patients and represents a radical departure from the time-tested CMS decision-making process. This proposal would have negative repercussions for appropriately determining the resources required for effective patient care. To label practicing physicians conflicted when all they are doing is sharing their real-world patient experiences where empirical data often do not exist is biased, unfair and a skeptical opinion of community-based physicians.

"Academic researchers and federal officials established survey protocols that are currently used to gather information from practicing physicians. They did this because they knew Medicare depended on expert physician insight to create Medicare payment policy that mirrors the evolution of science, technology, and innovations in patient care.

"There is no substitute for relying on experienced practicing physicians when creating Medicare payment policy. No one knows more about what is involved in providing services to Medicare patients than the physicians who care for them. The valuable expertise of physicians makes them an indispensable source of survey information that Medicare can count on to create payment policy. By substituting arbitrary and flawed proposals in place of front-line, real-world knowledge from expert physicians, Medicare is proposing to cut itself off from the most credible insights into the complexities of patient care, which will ultimately lead to lower quality care, inferior health outcomes and a less sustainable Medicare system."

Indirect Practice Expense Adjustment

- CMS proposes an arbitrary reduction in indirect practice expense RVUs for all services provided in the facility setting.
- The mechanism for the reduction is highly technical as CMS would reduce the portion of facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs.
- CMS cites AMA and MedPAC studies showing the growing number of employed physicians and physicians in hospital-owned practices and the shrinking number of private practices as its rationale for this proposal. CMS believes that physicians who provide services in the facility no longer maintain a separate office and receive "duplicative payments" under the MPFS and the facility fees under the outpatient or the ASC payment schedules.
- Facility-based payment to physicians will decrease overall by -7% while non-facility-based payment to physicians will increase by 4%. The results to individual physicians and specialties are proposed to be substantial.
- While CMS proposes no exceptions, it seeks comment on the impact of this proposal on maternity care.
- As the AMA explained in detail in our letter to MedPAC when the Commissioners were debating this so-called issue of "duplicative payments," this policy is likely to result in unintended consequences, including further incentivizing consolidation.
    - When a private practice physician performs a service or procedure in the facility setting, their physician practice still must handle coding and billing for the physician's claim and scheduling as well. Physician practices would still have administrative staff, and their clinical staff often perform some work supporting services that are performed in the facility.
    - The results from the 2024 Physician Practice Information (PPI) survey data showed $57 in indirect expenses per hour of direct patient care for hospital-based medicine and $62 for hospital-based surgery.
    - For surgical global codes performed in the facility setting, the bundled post-operative office visits are often performed in a physician office even though the major surgery was performed in the facility setting.