



Capitol Insights Newsletter November 7, 2025

Author(s): Matt Reiter and Luke Schwartz

What Happened in Congress This Week?

The federal government remains shut down and the shutdown is now the longest federal government shutdown in United States history. While there are reports that Senators are beginning to negotiate a solution to the funding impasse, the House has not returned to DC and has been out of session since before the shutdown began.

High-Level Summary: CY 2026 Medicare Physician Fee Schedule Final Rule

On October 31st, CMS published the **CY 2026 Medicare Physician Fee Schedule (PFS) Final Rule**. Below is a high-level summary of the key provisions of the Final Rule.

Conversion Factor

Clinicians have not received regular, statutory updates since Congress created the Medicare Quality Payment Program (QPP) in 2015. Beginning in 2026, CMS is statutorily required to begin implementing a 0.75% update for clinicians who participate in Advanced Alternative Payment Models (Advanced APMs) and a 0.25% update for clinicians who either participate in the Merit-based Incentive Payment System (MIPS) or who are exempt from the Medicare QPP.

Additionally, the PFS implemented the one-time 2.5% increase for 2026 that was included in the One Big Beautiful Bill Act. The CFs also include a 0.49% budget neutrality increase.

CMS finalized a **2026 PFS Conversion Factor (CF)** of 33.5675 for Advanced APM participants and 33.4009 for all other clinicians. Both CFs are an increase from the 2025 finalized CF of 32.3465.

Similarly, the Anesthesia CF is 20.5998 for Advanced APM clinicians and 20.4976 for all other clinicians. The 2025 finalized Anesthesia CF was 20.3178. The anesthesia CFs include a -2.30% practice expense and malpractice adjustment.

Table B-B7 on page 1,738 of the Final Rule estimates the cumulative impacts of the PFS for each specialty.

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1009 Duke St. Alexandria, VA 22314
(202) 544-1880 | Fax: (202) 545-5913
administrator@capitolassociates.com



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Efficiency Adjustment

CMS is critical of what it characterizes as inaccurate data that informs the American Medical Association's (AMA's) relative value units (RVUs) that are used to determine reimbursement rates. For example, CMS says the AMA's time values are "overinflated." Medicare is not required to use the AMA's RVUs but they are influential.

That being said, CMS ultimately accepted 90% of the AMA/Specialty Society RVS Update Committee's (RUC's) relative value recommendations in the 2026 PFS.

To account for inaccurate RVUs, CMS finalized a new -2.5% "efficiency adjustment" to "the work RVU and corresponding intraservice portion of physician time of certain non-time-based services. This adjustment would periodically 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."

Changes to Practice Expense Value Updates

CMS finalized the practice expense (PE) methodology updates as proposed, implementing adjustments to better reflect current clinical practice patterns. Specifically, the Final Rule adopts changes to recognize higher indirect costs for office-based (non-facility) practitioners compared to those in facility settings and incorporates routinely updated hospital cost data from the Medicare Hospital Outpatient Prospective Payment System (OPPS) to inform rates for certain technical services, such as radiation treatment and some remote monitoring services. These policies were finalized largely as proposed, with no substantive differences noted from the proposed rule.

Notably, as indicated in the Proposed Rule, CMS opted not to use data from the AMA's Physician Practice Information (PPI) survey to inform Practice Expense (PE) updates due to concerns about small sample sizes and sampling variation, low response rates and representativeness, potential measurement error, and incomplete data submission. CMS also did not use the AMA's Clinician Practice Information (CPI) survey data to inform PE updates.

Telehealth

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CMS finalized several updates to Medicare telehealth policies for CY 2026. Specifically, CMS finalized the proposed streamlining of the process for adding services to the Medicare Telehealth Services List, thus eliminating the distinction between provisional and permanent categories. CMS additionally finalized the permanent removal of frequency limitations for subsequent inpatient, subsequent nursing facility, and critical care telehealth visits. CMS also finalized, as proposed, the permanent adoption of a definition of “direct supervision” that allows supervising practitioners to provide such supervision virtually through real-time audio-video communication (excluding audio-only) for certain services.

In response to public feedback (and beyond what was proposed), CMS finalized a policy to permanently allow teaching physicians to have a virtual presence in all teaching settings, but only when the service itself is furnished virtually.

Ambulatory Specialty Model (ASM)

The Ambulatory Specialty Model (ASM) was finalized as proposed and will be implemented in 2027.

Click [here](#) to view the ASM Fact Sheet.

Policies to Improve Care for Chronic Illness and Behavioral Health Needs

CMS finalized the creation of optional add-on codes for Advanced Primary Care Management (APCM) services beginning in CY 2026. This includes three new G-codes that may be billed in the same month as the APCM base code to support the provision of complementary behavioral health integration (BHI) or Collaborative Care Model (CoCM) services. This closely aligns with existing BHI and CoCM code structures.

CMS also expanded payment policies for digital mental health treatment (DMHT) devices to include those used in treating Attention Deficit Hyperactivity Disorder (ADHD). While CMS sought comment on potential future coding for other digital therapy devices and broader digital mental health tools, those additional policies were not finalized and will be considered in future rulemaking.

Payment for Skin Substitutes

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CMS implemented changes in how it reimburses for skin substitutes. CMS defines skin substitutes as “a category of products that are most commonly used in outpatient settings for the treatment of diabetic foot ulcers and venous leg ulcers.”

Skin substitute products are reimbursed as biologics under an average sales price (ASP)-based methodology, where each product receives a unique billing code and payment limit. This has led to significant growth in spending under Medicare Part B for skin substitutes in the non-facility setting. According to Medicare claims data, Part B spending for these products rose from \$252 million in 2019 to over \$10 billion in 2024, a nearly 40-fold increase. Most of that increase is directly attributable to increases in stated prices for specific products.

For CY 2026, CMS finalized, as proposed, major changes to the payment methodology for skin substitute products beginning in CY 2026. Under the Final Rule, these products will now be paid as incident-to supplies when used in covered application procedures under both PFS and OPFS. Consistent with the proposed rule, CMS finalized a single blended payment rate of approximately \$127.28 for CY 2026. These policies were finalized largely as proposed.

Quality Payment Program (QPP)

CMS additionally confirmed that the performance threshold will remain at 75 points through the 2028 performance year. The maximum payment adjustment remains at $\pm 9\%$.

CMS finalized several updates to the Quality Payment Program for the 2026 performance year. Six new MIPS Value Pathways (MVPs) were finalized for reporting beginning in 2026:

- Diagnostic Radiology
- Interventional Radiology
- Neuropsychology
- Pathology
- Podiatry
- Vascular Surgery

CMS maintained the existing category weights for MIPS:

- Quality (30%)
- Cost (30%)

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- Promoting Interoperability (25%)
- Improvement Activities (15%)

For the Advanced Alternative Payment Models (APMs) track, CMS reaffirmed that clinicians qualifying as QP or Partial QP participants will remain exempt from MIPS reporting and payment adjustments, with qualifying participants continuing to receive the 0.75% fee schedule increase established under current law. CMS also reiterated its commitment to evolving the QPP to better reward high-quality care and expand participation in Advanced APMs.

In response to feedback on Requests for Information (RFIs), CMS retained existing benchmarking and data completeness standards, maintained flexibility between electronic and traditional quality reporting, and continued advancing toward digital quality measurement without making it mandatory.

Conclusion

CMS finalized most of its proposed policies, with only a few exceptions and technical changes to the proposed version of the policies.

The CY 2026 PFS is among the most impactful PFS Final Rules in several years. The finalized 2026 PFS Conversion Factor (CF) is the first positive increase to the CF in years, largely due to statutory policies passed by Congress.

While a CF increase is a “win” in and of itself, the 2026 PFS’s impact cannot be judged on the CF alone. Other policies in the PFS make it a “mixed bag” of policies that will impact each specialty, and each practice in different ways.

Of particular note, CMS is embracing HHS Secretary Robert F. Kennedy’ Jr.’s desire to distance CMS from the American Medical Association’s (AMA) RUC process for determining relative value units (RVUs) for Medicare services. CMS criticizes the quality and accuracy of the data that informs the AMA’s process and acts on this criticism through implementing policies such as an efficiency adjustment for the physician work (PW) RVUs and by shifting indirect cost in the practice expense (PE) RVUs away from hospital-based services and toward office-based services.

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Many commercial payers use Medicare's RVUs to determine their payment rates, which means these changes could have broader impacts beyond Medicare.

Lastly, CMS's creating a mandatory payment demonstration for heart disease and lower back conditions will have major implications for practices in the selected geographic areas.

Understanding how this PFS impacts each medical practice requires close analysis of new CMS policies. Table D-B7 on page 1,738 of the Final Rule estimates the cumulative impacts of the PFS for each specialty.

Top Stories in Healthcare Policy

Eli Lilly and Novo Nordisk reached agreements with the Trump administration to cut prices on their weight-loss drugs in exchange for tariff relief and faster FDA reviews for new products. The deals mark a major policy shift by allowing Medicare to cover weight-loss drugs for the first time, specifically for patients with obesity and related conditions, at prices as low as \$245 a month, with \$50 copays for Medicare beneficiaries. In return, the companies will get a three-year exemption from upcoming pharmaceutical import tariffs. The move, following similar deals with Pfizer and other drugmakers, gives Trump a platform to showcase efforts to lower healthcare costs amid voter concerns over inflation and high drug prices.

The Centers for Medicare & Medicaid Services (CMS) announced the GENEROUS Model, a new initiative to lower prescription drug costs in Medicaid by letting participating states buy certain drugs at prices similar to those in other developed countries (also known as “most favored nation” drug pricing). The program will begin in 2026 and aims to cut spending and improve access to needed medications through consistent and transparent coverage rules. Notably, participation in the program is voluntary—both drug manufacturers and states must apply to participate in the program.

Eight drug manufacturers have been approved by The Health Resources and Services Administration (HRSA) to participate in the 340B post-purchase drug rebate program. This revised model scraps the original discounts from the 340B program and offers them through a post-purchase rebate. Critics have expressed concern about the negative impact of these higher upfront costs, particularly on facilities in rural and underserved areas. Many have

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also noted that this move may increase administrative burdens on facilities, given the increased reporting and paperwork requirements.

Open Enrollment for most of the nation's Affordable Care Act state marketplaces and the federal exchange started on Saturday, and many consumers are suffering sticker shock. There are a reported triple digit percentage increase in some states, signaling the far-reaching impact of the projected expiration of ACA subsidies.

A bipartisan group of House lawmakers recently released a statement of principles on an extension to ACA subsidies.

A new survey finds that men are experiencing a multitude of mental health struggles, attributing long hours spent online, lack of social interaction, and sedentary lifestyle as causal factors.

In addition to Obamacare enrollees, companies offering employer-sponsored health insurance are expected to face an average increase of 6.5% in health costs next year. As a result, many employers plan to make some cost cutting changes, particularly through higher out of pocket costs for employees.

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