

2026 MPFS Final Rule Increases Physician Payments

On October 31, 2025, the Centers for Medicare & Medicaid Services (CMS) released its finalized Medicare Physician Fee Schedule (MPFS) for calendar year (CY) 2026, which “advances primary care management through improved quality measures, reduces waste and unnecessary use of skin substitutes, and introduces a new payment model focused on improving care for chronic disease management.”¹ This Health Capital Topics article discusses the provisions contained in the MPFS final rule, as well as stakeholder reactions.

MPFS Background

The MPFS calculates payments according to Medicare’s Resource Based Relative Value Scales (RBRVS) system, which assigns relative value units (RVUs) to individual procedures based on the resources required to perform each procedure. Under this system, each procedure in the MPFS is assigned RVUs for three categories of resources: (1) physician work (wRVUs); (2) practice expense (PE RVUs); and, (3) malpractice expense (MP RVUs). Once the procedure’s RVUs have been modified for geographic variance, they are summed, and the total is then multiplied by a conversion factor to convert the number to a dollar amount.

The conversion factor is a fixed monetary amount that is multiplied by the geographically-adjusted RVU to determine the payment amount for a given service.² The conversion factor is updated annually according to the predetermined update schedule set forth in the Medicare Access and CHIP Reauthorization Act (MACRA). While this update was 0% from 2020 through 2025, Congress occasionally overrode MACRA and mandated temporary payment increases.³ For 2026, MACRA mandates a slight annual update for those clinicians who participate in one of the two Quality Payment Program (QPP) tracks: Advanced Alternative Payment Model (APM) participants will receive a 0.75% increase; Merit-based Incentive Payment System (MIPS) participants (and other non-APM participants) will receive a 0.25% increase.⁴

MPFS Payment Rates Updated

As required by MACRA, CMS finalized two separate conversion factor increases – one for APM participants and one for nonparticipants. The 2026 MPFS conversion factor of \$33.57 for APM participants is a 3.77% increase from 2025, while the \$33.40 conversion factor for

nonparticipants is a 3.26% increase.⁵ These increases reflect:

- (1) The MACRA updates discussed above;
- (2) A one-time 2.5% increase as stipulated in the recently passed tax bill; and
- (3) A 0.49% adjustment to account for proposed wRVU changes.⁶

Notably, this is the first increase to the MPFS conversion factor in the past half-decade.⁷

Efficiency Adjustment Implemented

CMS also finalized the implementation of a -2.5% “efficiency adjustment” to wRVUs for non-time-based services, based on a five-year lookback of the Medicare Economic Index (MEI) medical practice cost inflation.⁸ This cut affects approximately 9,000 codes, but would not apply to evaluation and management services, care management services, behavioral health services or services on the Medicare Telehealth Services List.⁹ The calculation of how many wRVUs to attribute to a given procedure was historically determined by the American Medical Association’s (AMA’s) Relative Value Scale Committee (RUC), based on physician surveys.¹⁰ The agency “expects that moving away from survey data would lead to more accurate valuation of services over time and help address some of the distortions that have occurred in the PFS historically.”¹¹

Ambulatory Specialty Model (ASM) Established

In addition to payment rate changes, CMS finalized a new five-year mandatory payment model for specialists. The Ambulatory Specialty Model (ASM) would be a two-sided risk model for specialty care provided to beneficiaries with heart failure or lower back pain starting in 2027.¹² Medicare currently spends approximately \$10 billion to \$13 billion on heart failure and \$6 billion to \$8 billion on lower back pain per year.¹³ The goal of the model is “to enhance the quality of care and reduce low-value care by improving beneficiary and provider engagement, incentivizing preventive care, and increasing financial accountability for specialists.¹⁴ Participant performance will be assessed for quality, cost, improvement activities, and improving interoperability.¹⁵

Other Provisions Finalized

Other provisions CMS finalized for 2026 include:

- (1) Simplifying the process for adding codes to the Medicare Telehealth Services List by, among other things, removing the provisional/permanent services distinction and limiting agency review;
- (2) Cutting payments for skin substitutes,¹⁶ which have increased almost 40-fold over the past five years (costing CMS \$10 billion in 2024);¹⁷
- (3) Limiting how long some Medicare Shared Savings Program (MSSP) participants can stay in one-sided risk arrangements (to five years); and
- (4) Increasing the minimum number of Medicare beneficiaries that MSSP participants must cover to 5,000.¹⁸

Industry Reaction

National provider associations were generally pleased with the MPFS final rule's increases to physician payments, but critical of other provisions. The AMA president expressed measured praise with the payment increases, stating:

"That physicians are not facing a reduction in reimbursements – as we have in the past – is a significant positive for 2026 and a win for patients' access to care. Yet, this one-time correction does not keep up with increasing costs, and private practices across the country are expressing concern this rule would further put them at a disadvantage merely for treating patients at a hospital or ambulatory surgery center."¹⁹

However, the AMA spoke out against the efficiency adjustment that "would reduce payment for more than 7,000 physician services—95 percent of all services provided by physicians" and noted that it "has proposed an alternative that strengthens primary care payment while improving the accuracy of time data used in payment determinations."²⁰

The American Academy of Family Physicians (AAFP) similarly stated it was pleased with the provisions prioritizing primary care and with the pay rate increases but cautioned that "most of the increases for 2026 are temporary adjustments attributable to H.R. 1, which will expire at the end of 2026. To sustain this progress, we urge Congress to take action to prevent another payment cliff..."²¹

The Medical Group Management Association (MGMA) weighed in and stated that "[w]hile we are pleased to see a marginal increase to the 2026 Medicare conversion factors, today's final rule includes many policies that will threaten the financial sustainability of medical groups and cause significant disruption to their operations."²² The American Group Management Association also appreciated "the modest payment increase finalized by CMS for 2026," but expressed concern that this temporary relief does not address the fundamental structural problems plaguing Medicare physician reimbursement."²³

Conclusion

The 2026 MPFS final rule represents a shift in Medicare physician payment policy, marking the first conversion factor increase in five years while simultaneously introducing controversial efficiency adjustments and a new mandatory specialty payment model. While the 3.77% payment increase for APM participants provides welcome relief to physicians who have faced years of stagnant or declining reimbursement, the temporary nature of much of this increase – tied to the expiring H.R. 1 provisions – creates uncertainty about the sustainability of these increases. The efficiency adjustment and the new ASM model signal CMS's continued push toward value-based care and away from traditional fee-for-service payment structures. The divergent impacts on different specialties and practice settings, particularly given variations in service mix and payor composition, will affect healthcare organizations differently. As the physician associations unanimously noted, while 2026 brings modest improvements, the fundamental structural challenges in Medicare physician reimbursement remain unresolved, setting the stage for continued policy volatility and potential payment cliffs in subsequent years.

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