Illinois Health and Hospital Association

December 8, 2025

On Oct. 31, the Centers for Medicare & Medicaid Services (CMS) released its Calendar Year (CY) 2026 Physician Fee Schedule final rule, creating a positive payment update for physicians for the first time in six years. CMS is implementing a conversion factor required by law (H.R. 2, 2015 and H.R. 1, 2025) for qualifying alternative payment model (APM) participants and a separate conversion factor for physicians and practitioners who are not qualifying participants. Beginning CY 2026, the APM conversion factor will increase by 3.77%, while the non-qualifying APM conversion factor will increase by 3.26%.

CMS also finalized efficiency adjustments to work relative value units (RVU) and changes to the practice expense (PE) methodology to decrease facility PE RVUs. IHA expressed strong concern about these changes in its Sept. 12 comment letter to CMS, as they may unnecessarily disadvantage hospital-based physicians. Notably, the agency finalized its proposal to apply an efficiency adjustment of -2.5% to the work RVUs for non-time-based services. CMS purports that changes to PE methodology recognize greater indirect costs for practitioners in office-based settings compared to facility settings, and that it's less likely that facility-based physicians would maintain a separate office-based practice that would incur said costs.

Strongly supported by IHA, CMS finalized several telehealth coverage advancements. These include permanently allowing direct supervision to include virtual presence via audio/video real-time communications technology and allowing federally qualified health centers and rural health clinics to bill for telehealth services through 2026. Of note, the agency chose to permanently allow teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings. This was not proposed in the initial rule, but was strongly encouraged in IHA's Sept. 12 comment letter to CMS.

In response to concerns related to shielding practitioner home addresses when providing telehealth services, the agency pointed to a Frequently Asked Questions (FAQ) document providing information on how to suppress street address details so practitioners can continue to use their currently enrolled practice location instead of their home address. Specifically, physicians and practitioners can either mark the address as a "Home office for administrative/telehealth use only" location in the Provider Enrollment, Chain, and Ownership System (PECOS), which will suppress street address details, or email the Quality Payment Program (QPP) Service Center to suppress the street address and/or phone number. Although CMS used the CY 2024 and CY 2025 PFS final rules to permit a distant site practitioner to use their currently enrolled practice location for telehealth services furnished at home, CMS stated in the CY 2026 final rule that they do not believe that additional "extensions" are required via rulemaking, given the FAQ clarification. The agency shared that any future updates to this policy will be issued via sub-regulatory guidance.

Focusing on behavioral health, CMS finalized two proposals supported by IHA as opportunities to further expand and integrate behavioral health services into general healthcare. First, CMS finalized the creation of three optional add-on G-codes when an Advanced Primary Care Management base code is reported by a practitioner in the same month. These add-on G-codes are meant to facilitate the provision of complementary behavioral health integration or psychiatric Collaborative Care Model services. The agency also expanded coverage of digital therapeutics to include devices that treat attention deficit hyperactivity disorder. Digital mental health treatment devices will be covered when furnished incident to professional behavioral health services used in conjunction with ongoing behavioral healthcare treatment under a plan of care.

CMS also finalized changes impacting drug inflation rebates and data collection for the 340B Drug Pricing Program; the Ambulatory Specialty Model for beneficiaries with heart failure and low back pain; a new Advancing Health and Wellness subcategory within the Quality Payment Program; simplifications to the Merit-based Incentive Payment System (MIPS) to

facilitate future mandatory participation in MIPS Value Pathways; and Medicare Shared Savings Program eligibility and financial reconciliation modifications to permit fewer assigned beneficiaries in future years, with additional safeguards. Additionally, the agency finalized several proposed changes to quality requirements, including removing the health equity adjustment to the Accountable Care Organization quality score and the Screening for Social Drivers of Health measure, permitting the Consumer Assessment of Healthcare Providers and Systems survey to be web-based beginning in 2027, and expanding the Extreme and Uncontrollable Circumstances Exception to include cyberattacks.

For more information on the PFS final rule, see the CMS fact sheet. For questions or comments on this memo, please Contact Us.
