Are You Confused Yet? We are too: Let's talk the new Physician Fee Schedule rule!

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Ohio Health Information Partnership

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Two Conversion Factors?

As outlined in last year's rule, CY2026 marks the beginning of two (2) conversion factors for clinicians:

- **Qualifying APM participants** (QPs) will have a conversion factor of **+0.75%**
- **Non-qualifying APM participants** will have conversion factor of **+0.25%**

Conversion Factor

The CY2026 PFS conversion factor includes a one-year increase of +2.50% for CY2026 stipulated by statute and an estimated 0.55% adjustment necessary to account for proposed changes in work RVUs.

- The CY2026 conversion factor for a **qualifying APM participant** represents an increase of $1.24 (3.83%), increasing the current conversion factor of $32.35 up to **$33.59**

- The CY2026 conversion factor for a **non-qualifying APM participant** represents an increase of $1.17 (3.62%), increasing the conversion factor of $32.25 up to **$33.42**

Estimated Impact on Total Allowed Charges

Table 92: CY2026 PFS Estimated Impact on Total Allowed Charged by Specialty

(A) Specialty	(B) Total: Non-Facility/Facility	(C) Allowed Charges (mil)	(D) Impact of Work RVU Changes	(E) Impact of PE RVU Changes	(F) Impact of MP RVU Changes	(G) Combined Impact
ALLERGY/IMMUNOLOGY	*TOTAL*	$212	0%	7%	0%	7%
	Non-Facility	$204	0%	8%	0%	8%
	Facility	$8	0%	-11%	0%	-11%
ANESTHESIOLOGY	*TOTAL*	$1,595	0%	-1%	0%	-1%
	Non-Facility	$310	0%	7%	0%	7%
	Facility	$1,285	0%	-3%	0%	-3%
AUDIOLOGIST	*TOTAL*	$75	0%	0%	0%	-1%
	Non-Facility	$72	0%	0%	0%	0%
	Facility	$3	0%	-13%	0%	-14%
CARDIAC SURGERY	*TOTAL*	$150	-1%	-3%	0%	-3%
	Non-Facility	$27	0%	6%	0%	6%
	Facility	$124	-1%	-5%	0%	-5%
CARDIOLOGY	*TOTAL*	$5,995	0%	1%	0%	1%
	Non-Facility	$3,747	0%	5%	0%	5%
	Facility	$2,248	-1%	-6%	0%	-7%

Estimated Impact on Total Allowed Charges (cont)

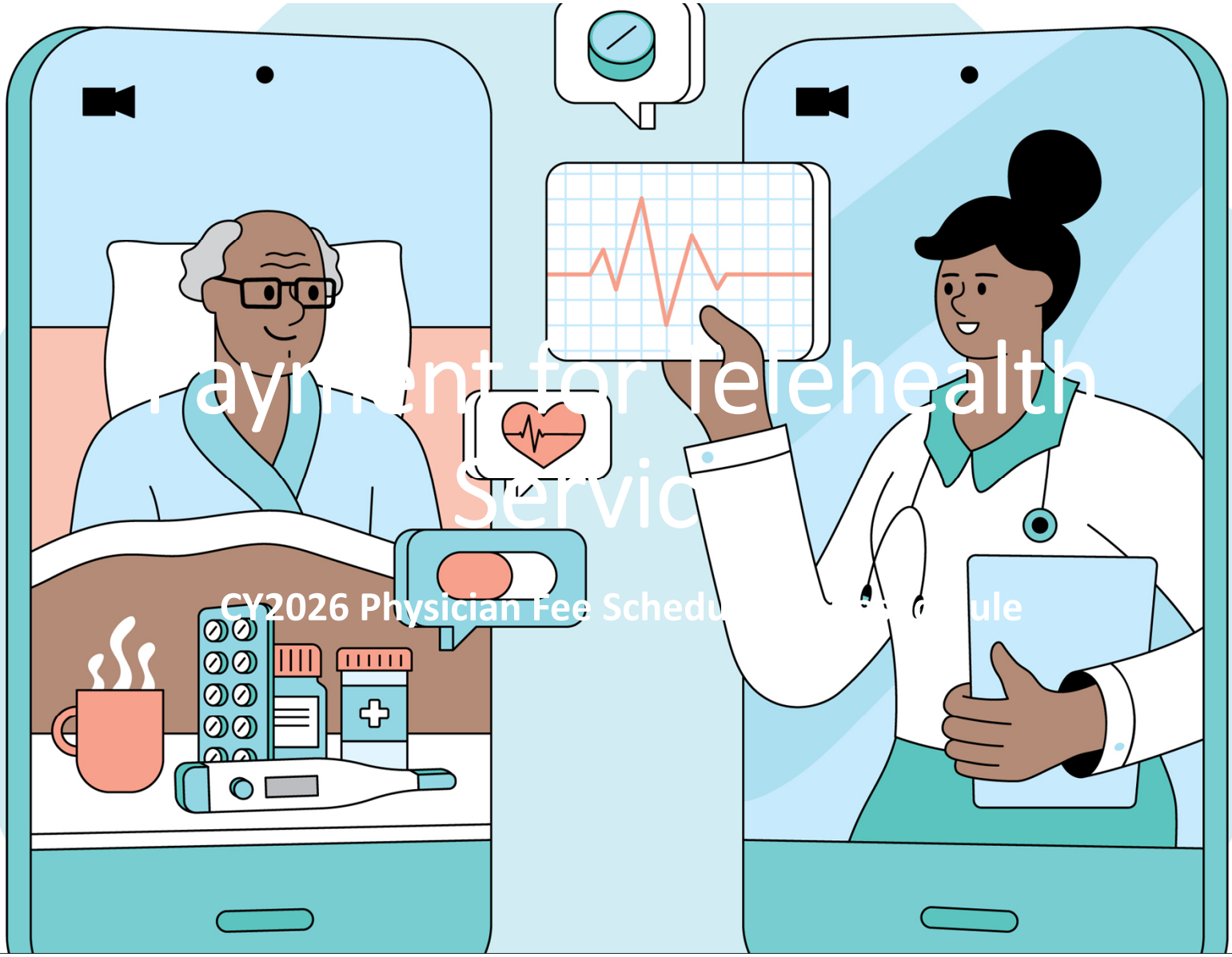
Table 92: CY2026 PFS Estimated Impact on Total Allowed Charged by Specialty

(A) Specialty	(B) Total: Non-Facility/Facility	(C) Allowed Charges (mil)	(D) Impact of Work RVU Changes	(E) Impact of PE RVU Changes	(F) Impact of MP RVU Changes	(G) Combined Impact
ENDOCRINOLOGY	*TOTAL*	$526	0%	2%	0%	3%
	Non-Facility	$425	0%	6%	0%	6%
	Facility	$101	0%	-11%	0%	-10%
FAMILY PRACTICE	*TOTAL*	$5,426	0%	3%	0%	3%
	Non-Facility	$4,367	0%	6%	0%	6%
	Facility	$1,059	0%	-9%	0%	-9%
GASTROENTEROLOGY	*TOTAL*	$1,391	0%	-3%	0%	-4%
	Non-Facility	$504	0%	6%	0%	6%
	Facility	$887	-1%	-9%	0%	-10%
GENERAL PRACTICE	*TOTAL*	$372	0%	3%	0%	3%
	Non-Facility	$298	0%	5%	0%	6%
	Facility	$73	0%	-8%	0%	-7%
GENERAL SURGERY	*TOTAL*	$1,524	0%	-3%	0%	-3%
	Non-Facility	$447	0%	6%	0%	6%
	Facility	$1,078	-1%	-7%	0%	-7%
GERIATRICS	*TOTAL*	$199	1%	1%	0%	1%
	Non-Facility	$127	1%	7%	0%	8%
	Facility	$72	0%	-10%	0%	-9%

Estimated Impact on Total Allowed Charges (cont)

Table 92: CY2026 PFS Estimated Impact on Total Allowed Charged by Specialty

(A) Specialty	(B) Total: Non-Facility/Facility	(C) Allowed Charges (mil)	(D) Impact of Work RVU Changes	(E) Impact of PE RVU Changes	(F) Impact of MP RVU Changes	(G) Combined Impact
HEMATOLOGY/ONCOLOGY	*TOTAL*	$1,537	0%	0%	0%	0%
	Non-Facility	$984	0%	6%	0%	6%
	Facility	$552	0%	-11%	0%	-11%
INDEPENDENT LABORATORY	*TOTAL*	$545	0%	-1%	0%	-1%
	Non-Facility	$531	0%	-1%	0%	-1%
	Facility	$14	-1%	-1%	0%	-3%
INFECTIOUS DISEASE	*TOTAL*	$537	0%	-7%	0%	-6%
	Non-Facility	$85	0%	7%	0%	7%
	Facility	$452	0%	-10%	0%	-9%
INTERNAL MEDICINE	*TOTAL*	$9,378	0%	-2%	0%	-1%
	Non-Facility	$4,649	0%	6%	0%	6%
	Facility	$4,729	0%	-9%	0%	-8%
INTERVENTIONAL PAIN MGMT	*TOTAL*	$825	0%	3%	0%	3%
	Non-Facility	$645	0%	7%	0%	6%
	Facility	$180	-1%	-8%	0%	-9%
INTERVENTIONAL RADIOLOGY	*TOTAL*	$437	-1%	2%	0%	2%
	Non-Facility	$259	0%	7%	0%	7%
	Facility	$178	-2%	-6%	1%	-7%



Payment for Telehealth Servic

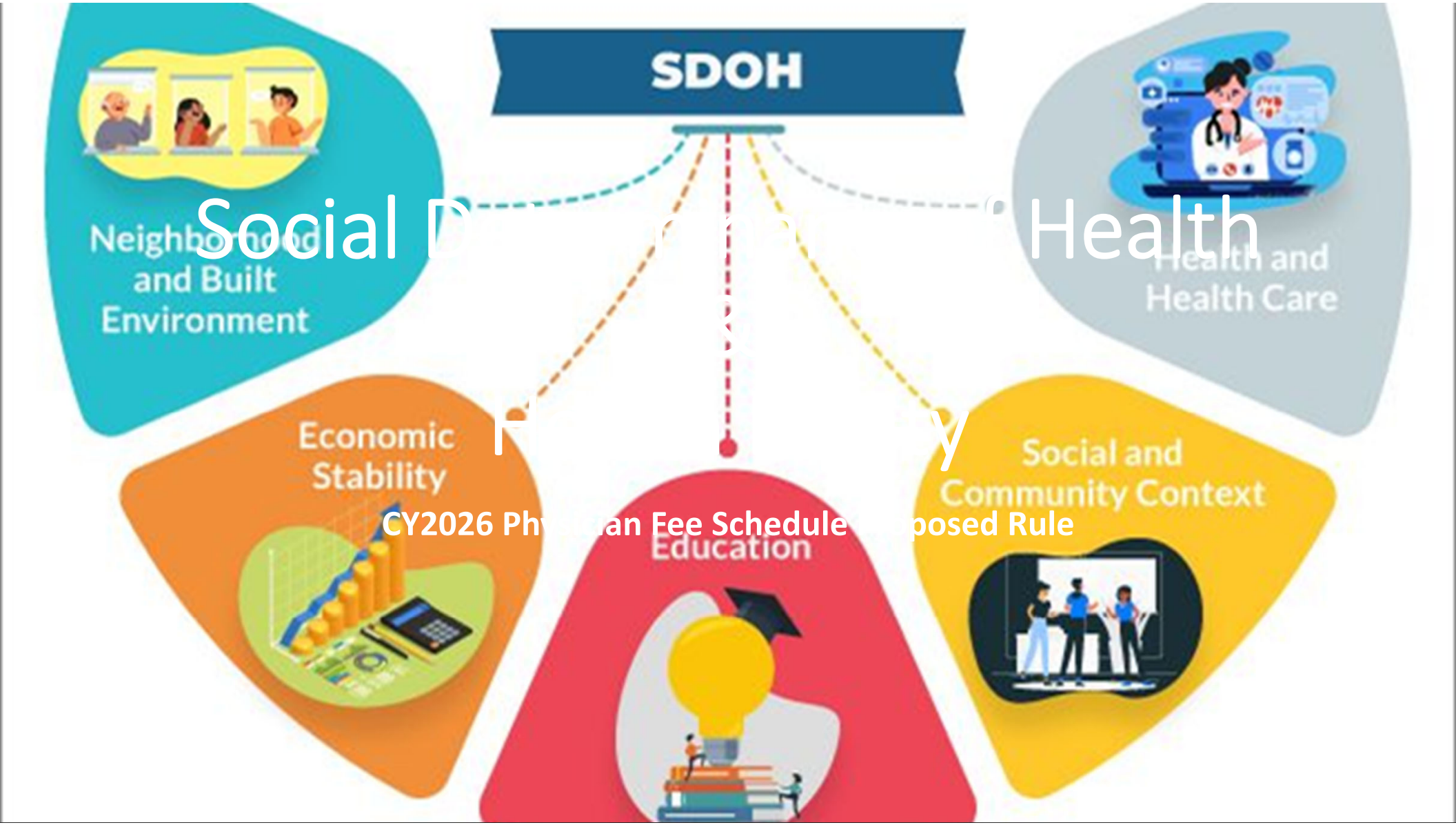
CY2026 Physician Fee Schedu ule

Medicare Telehealth Services

CMS is modifying the criteria used for adding and removing services from the Telehealth services list.

- If this change is finalized, all current codes on the telehealth services list (both provisional or permanent) will remain on the Medicare Telehealth Services list.
- This proposed change would make all COVID-19 flexibilities related to telehealth become permanently available.

Telehealth originating site facility fee for CY2025 is **$31.85**



Social D[illegible] Health

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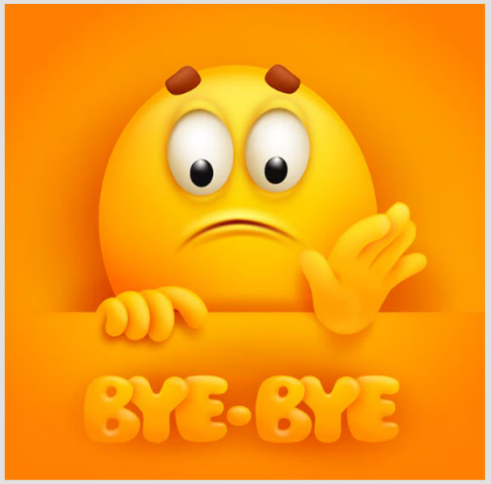
CY2026 Ph[illegible]an Fee Schedule [illegible]posed Rule

SDOH & Health Equity Proposed Changes

CMS introduced an add-on code for the Annual Wellness Visits (**G0136**) related to performing an SDOH assessment in the CY2023 PFS final rule.

Current administration has ended several SDOH-related programs, such as the Hospital Commitment to Health Equity structural measures and continues this trend with the PFS.

G0136: Annual wellness visit SDOH add-on code – **proposed for removal**.



Changes to CHI Services
(Community Health Integration)

In the CY2023 PFS final rule, CMS introduced **two codes for Community Health Integration Services** intended to "*address social determinants of health that significantly impact the practitioner's ability to diagnose or treat a patient.*"

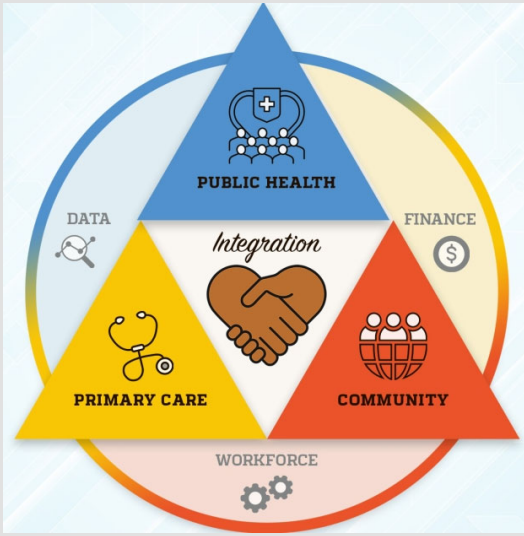
Two (2) g-codes created in 2023:

1. **G0019** – CHI services performed by certified or trained personnel
2. **G0022** – CHI services, each additional 30 minutes per calendar month

Proposed Changes to CHI Services (cont)

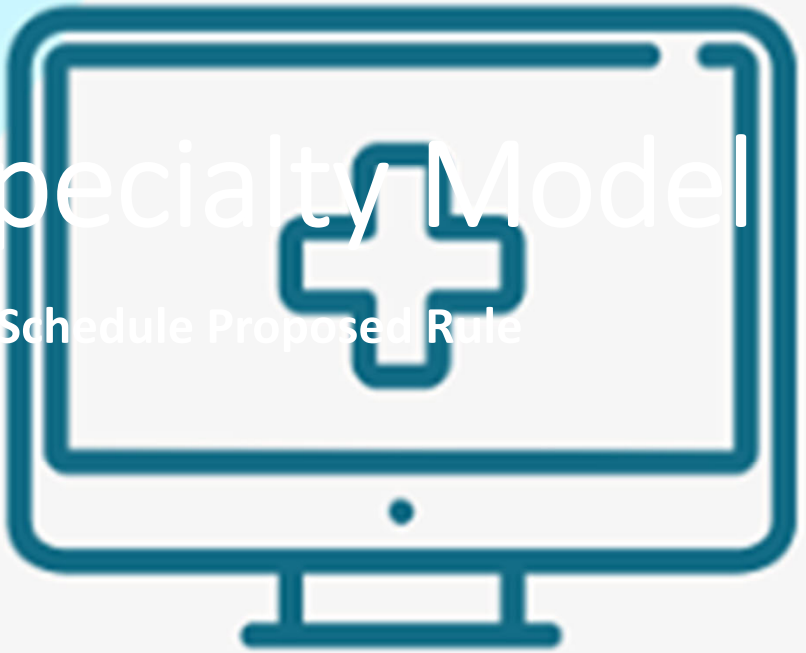
CMS proposing to replace term **"social determinants of health (SDOH)"** with the term **"upstream driver(s)"**. CMS feels the term is more comprehensive and includes a variety of factors that can impact the health of beneficiaries.

- ***Goal*** *is to move to whole-person comprehensive care that can better address upstream drivers that affect patient behaviors (such as smoking, poor nutrition, low physical activity, substance abuse, etc.) or potential dietary, behavioral, medical and environmental drivers.*
- **Proposed G0019 description** - *Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities: person-centered assessments, facilitating goals, help patients address unmet social needs [upstream driver(s)] that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating E/M visit.*



Ambulatory Specialty Model

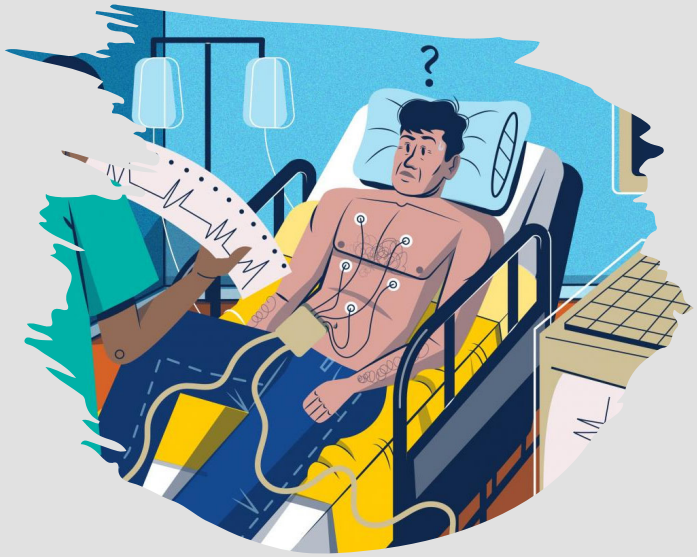
CY2026 Physician Fee Schedule Proposed Rule



Proposed Ambulatory Specialty Models: Heart Failure and Low Back Pain

CMS is proposing to implement and test two Ambulatory Specialty Models (ASM) for certain specialty groups.

- The models will run for 5 years (1/1/27 – 12/31/31) and require quality reporting to CMS.
- All specialists in an identified region will need to participate.
- Regions required to participate have not been selected yet—will be selected by the end of 2025.

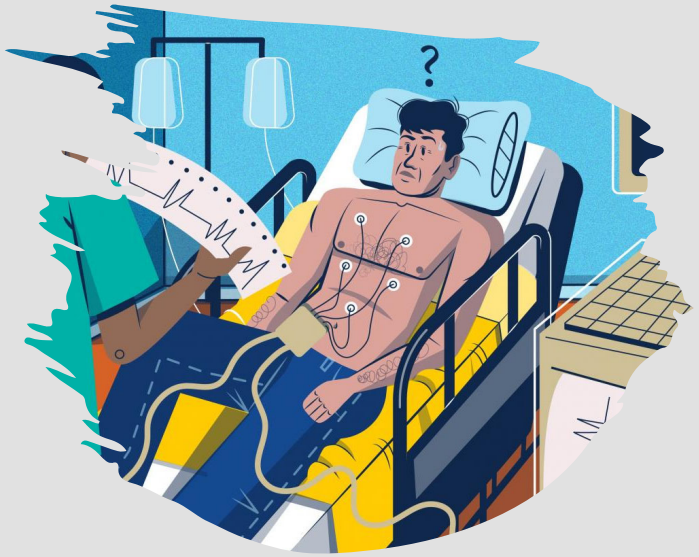


Proposed Ambulatory Specialty Models

Identified specialty groups are:

- **Heart failure model**
  - Cardiologists

- **Low back pain model:** Includes providers who practice in
  - Anesthesiology
  - Interventional pain management
  - Neurosurgery
  - Orthopedic surgery
  - Pain management
  - Physical medicine and rehabilitation



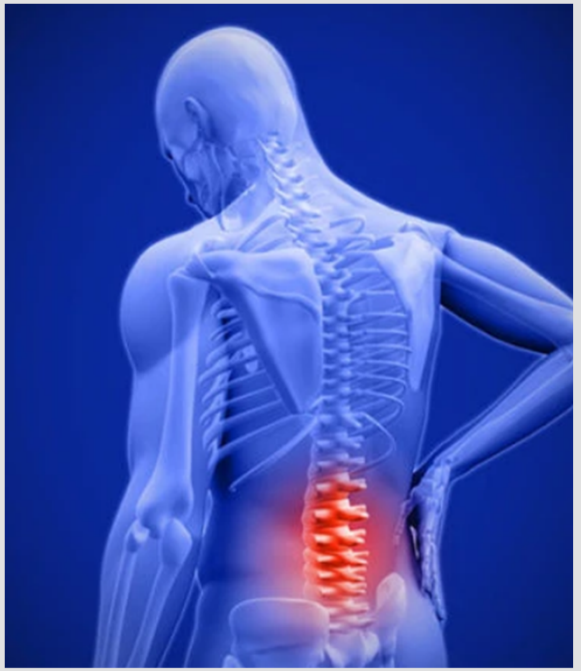
Quality Measures for ASM Models

Heart Failure Model:

Cardiologists would be required to report on use of beta blockers and ACE inhibitors, as well as blood pressure. There would also be a patient reported outcome measure for functional status.

Low Back Pain Model:

Quality measures would include spinal MRI, use of high-risk meds in the elderly, depression screening, BMI, and a patient reported outcome measure.

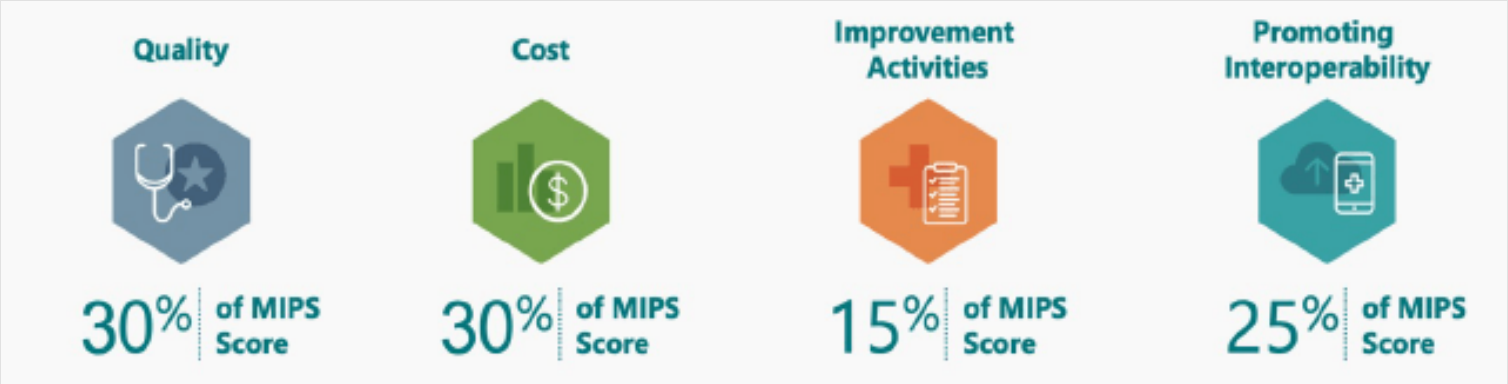


Proposed Changes to QPP/MIPS

CY2026 Physician Fee Schedule Proposed Rule

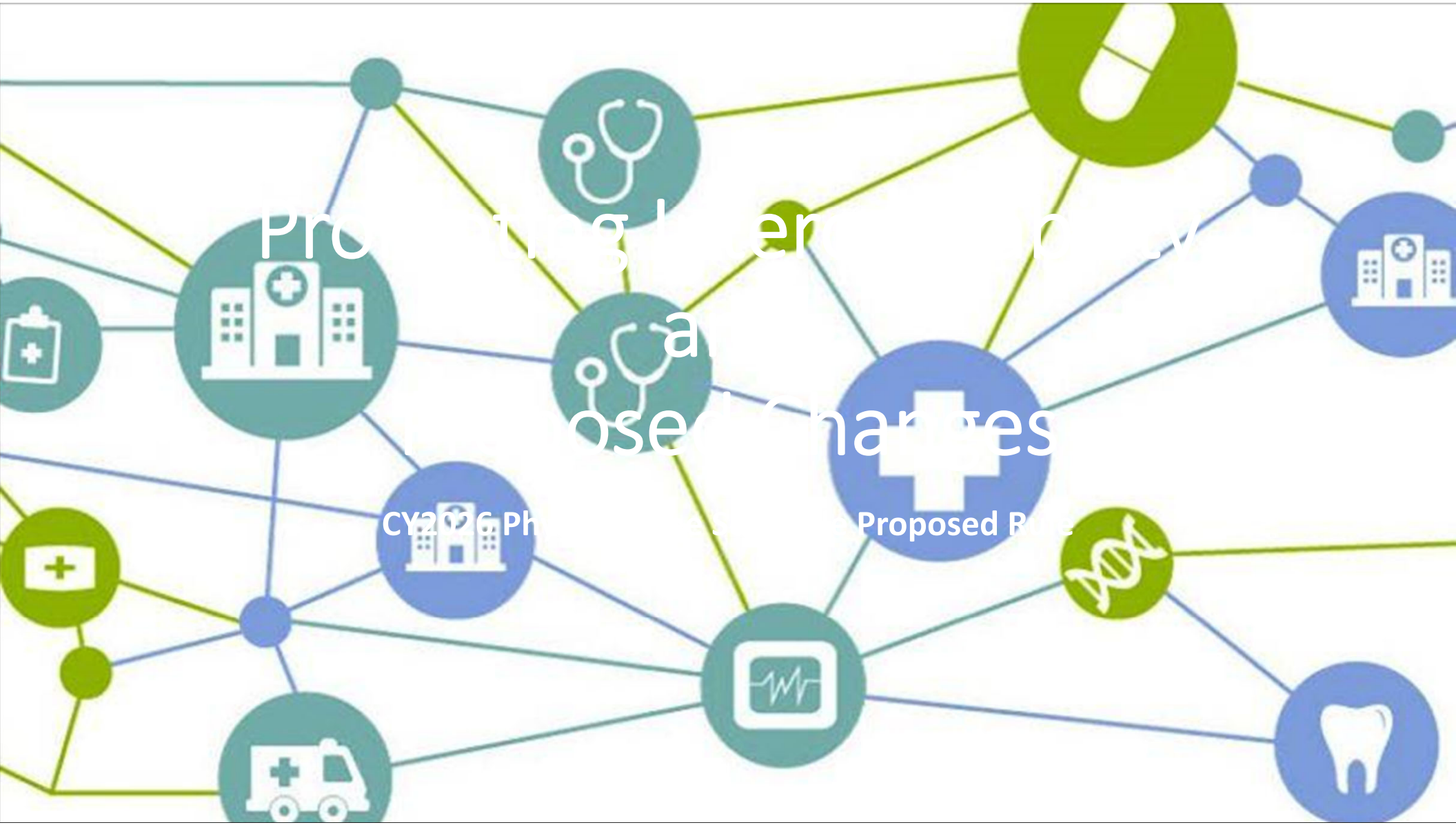
Scoring, Thresholds & Weights

- Reporting category weighting remains unchanged:



- Minimum score to avoid penalty remains at **75 points** through the CY2028.

- **No date for transition** to required participation in **MVP reporting**.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CY2025 Promoting Interoperability

OBJECTIVE	MEASURE	POINTS
Protect Patient Health Information	Conduct or review a security risk analysis	**0 points**
	Conduct an annual self-assessment using the 2016 High Priority Safer Guide	**0 points**
Electronic Prescribing	E-Prescribing	**Up to 10 points**
	Query of PDMP	**10 points**
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information, **AND;**	**Up to 15 points**
	Support of Electronic Referral Loops by Receiving & Reconciling Health information	**Up to 15 points**
	Health Information Exchange Bi-Directional Exchange, **OR;**	**30 Points**
	Enabling Exchange under TEFCA	
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	**Up to 25 Points**
Public Health and Clinical Data Exchange	Report 2 registries: Immunizations, Electronic Case Reporting *(suppressed)*	**25 points**
	(BONUS) Report one of following: Public Health Registry, Clinical Data Registry, Public Health Reporting Using TEFCA	**+5 points (Bonus)**

General Proposed Changes to Promoting Interoperability

CMS is suppressing the Electronic Case Reporting Public Health measure

- Will be excluded from scoring in CY2025

Proposed Changes to Security Risk Analysis

- The HIPAA Act of 1996 required, among other things, that covered entities conduct an accurate and thorough assessment of potential risks and vulnerabilities to the confidentiality, integrity and availability of ePHI.
- Integrated into the MIPS Promoting Interoperability program as the Security Risk Analysis measure.
  - Attesting “Yes” to having conducted or reviewed a Security Risk Analysis.
- Proposal to modify the measure requiring the **implementation of policies and procedures to support analyzing and managing the security risks to ePHI associated with the implementation and use of EHRs** as Required by the HIPAA security rule.

What does the Security Risk Assessment change really mean?

- Just performing the Security Risk Assessment will no longer meet the measure requirements.

- Must take steps to reduce risks and vulnerabilities to ePHI and provide transparency regarding efforts that are already in place to manage risks.

- "Conduct or review a security risk analysis ***and conduct security risk management activities***, in accordance with the requirements under 45 CFR 164.308(a)(1)(ii)(A) and (B), including addressing the security of data created or maintained by CEHRT (***to include encryption***), in accordance with 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), implement security updates as necessary, and correct identified security deficiencies as part of the ***eligible hospital's or CAH's*** risk management process. Actions included in the security risk analysis measure may occur any time during the calendar year in which the EHR reporting period occurs."

Safer Guide Proposed Change

- Safer Guides were first released in 2014 then updated in 2016.
- Completion of the High Priority Safer Guide (2016 version) adopted by MIPS beginning with CY2022.
- Proposing that ***starting in CY2026***, clinicians will be required to use the 2025 version of the High Priority Safer Guide starting with CY2026
- ***During CY2025 reporting period, clinicians should continue to use the 2016 version of the High Priority Safer Guide***

Query of PDMP RFI

- The Query of PDMP measure was finalized in the CY2019 Physician PFS final rule.
  - Under the e-Prescribing objective
  - Aimed at improving the treatment of opioid and substance use disorders
- *"For at least one Schedule II opioid or Schedule III or IV drug electronically prescribed using CEHRT during the EHR reporting period, the eligible clinician uses data from CEHRT to conduct a query of their PDMP for prescription drug history"*

CMS seeking comment on following policy considerations:

1. Convert from yes/no to performance-based measure?
2. Expanding types of drugs for which a PDMP query would be required?

Proposed Addition of Optional Public Health Agency Objective

+5 bonus points

- CMS proposing to add an optional bonus measure under the Public Health and Clinical Data Exchange objective for data exchange with a Public Health Agency that occurs using TEFCA.

CY2026 Promoting Interoperability

OBJECTIVE	MEASURE	POINTS
Protect Patient Health Information	Conduct or review a security risk analysis and conduct security risk management activities.	**0 points**
	Conduct an annual self-assessment using the 2025 High Priority Safer Guide	**0 points**
Electronic Prescribing	E-Prescribing	**Up to 10 points**
	Query of PDMP	**10 points**
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information, **AND;**	**Up to 15 points**
	Support of Electronic Referral Loops by Receiving & Reconciling Health information	**Up to 15 points**
	Health Information Exchange Bi-Directional Exchange, **OR;**	**30 Points**
	Enabling Exchange under TEFCA	
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	**Up to 25 Points**
Public Health and Clinical Data Exchange	Report 2 registries: Immunizations, electronic Case Reporting	**25 points**
	(BONUS) Report one of following: Public Health Registry, Clinical Data Registry, Public Health Reporting Using TEFCA	**+5 points (Bonus)**

Quality Category Proposed Changes

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General Proposed Changes to Quality

- 5 new quality measures proposed (3 high priority, 1 PRO)
- 10 quality measures proposed for removal
- 30 measures with substantive changes proposed
  - *Rule states that 42 have changes but only 30 quality measures included in tables*

- 187 quality measures available in traditional MIPS
- 190 quality measures available in MVPs

- Health equity related measures removed from the High Priority Measure set & from the MIPS program.

Topped-Out Quality Measure Proposal

- **Topped out measures** – where performance is considered so high and unvarying that meaningful distinctions and improvements in performance can no longer be made.

- Scoring cap of 7 measure achievement points.

- If a measure has been identified as topped out for 3 consecutive years, it may then be proposed for removal through notice-and-comment rulemaking.
  - Haven't removed some topped-out measures due to concern that it would leave some clinicians with fewer than 6 applicable measures to report.

- In the CY2025 final rule, topped out measures frequently used by certain specialties reporting specialty measures would not be subject to the 7-point scoring cap.

Quality Measures with Proposed Substantive Changes

CY2026 Physician Fee Schedule Proposed Rule

Quality Measures with Substantive Changes

CMS	QPP	Title
143v14	012	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
N/A	048	Advance Care Plan
131v14	117	Diabetes: Eye Exam
68v15	130	Documentation of Current Medications in the Medical Record
2v15	134	Preventive Care and Screening: Screening for Depression and Follow-Up Plan
N/A	141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 20% OR Documentation of a Plan of Care
157v14	143	Oncology: Medical and Radiation – Pain Intensity Quantified
N/A	144	Oncology: Medical and Radiation - Plan of Care for Pain
N/A	176	Tuberculosis Screening Prior to First Course of Biologic and/or Immune Response Modifier Therapy
133v14	191	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
149v14	281	Dementia: Cognitive Assessment

Quality Measures with Substantive Changes

CMS	QPP	Title
N/A	357	Surgical Site Infection (SSI)
50v14	374	Closing the Referral Loop: Receipt of Specialist Report
56v14	376	Functional Status Assessment for Total Hip Replacement
N/A	389	Cataract Surgery: Difference Between Planned and Final Refraction
N/A	394	Immunizations for Adolescents
N/A	418	Osteoporosis Management in Women Who Had a Fracture
N/A	420	Varicose Vein Treatment with Saphenous Ablation: Outcome Survey
N/A	441	Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)
N/A	450	Appropriate Treatment for Patients with Stage I (T1c) - III HER2 Positive Breast Cancer
N/A	451	RAS (KRAS and NRAS) Gene Mutation Testing Performed for Patients with Metastatic Colorectal Cancer who Receive Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibody Therapy

Quality Measures with Substantive Changes

CMS	QPP	Title
N/A	453	Percentage of Patients Who Died from Cancer Receiving Systemic Cancer-Directed Therapy in the Last 14 Days of Life
N/A	457	Percentage of Patients Who Died from Cancer Admitted to Hospice for Less than 3 days
N/A	480	Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS) (claims-based measure)
N/A	484	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (MCC) (claims-based measure)
951v4	488	Kidney Health Evaluation
N/A	493	Adult Immunization Status
N/A	500	Acute Posterior Vitreous Detachment Appropriate Examination and Follow-up
N/A	501	Acute Posterior Vitreous Detachment and Acute Vitreous Hemorrhage Appropriate Examination and Follow-up
N/A	503	Gains in Patient Activation Measure (PAM ®) Scores at 12 Months

Improvement Activities Category Proposed Changes

CY2[illegible] Physician Fee Schedule Proposed Rule

Proposed Changes to Improvement Activities

- 3 new activities proposed
- 8 activities proposed for removal
- 7 activity with substantive changes

- Adding a new “Advancing Health and Wellness” subcategory

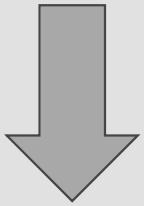
- Removing “Achieving Health Equity” subcategory and several measures within that subcategory.

Newly Proposed Improvement Activities

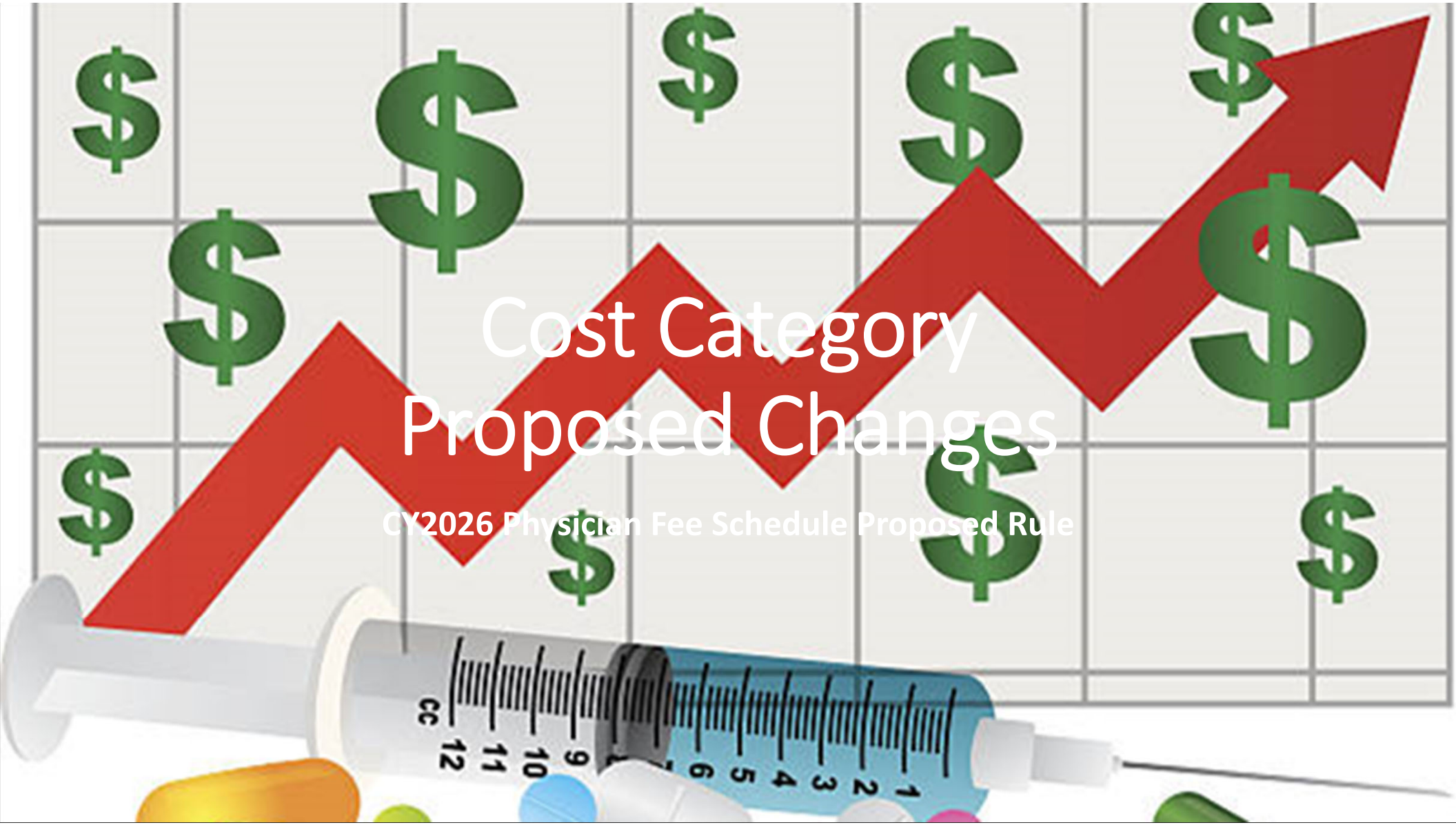
Act ID	Category	Name
IA_PM_XX	Population Management	Improving Detection of Cognitive Impairment in Primary Care
IA_PM_XX	Population Management	Integrating Oral Health Care in Primary Care
IA_PSPA_XX	Patient Safety and Practice Assessment	Patient Safety in Use of Artificial Intelligence (AI)

Improvement Activities with Proposed Changes

Act ID	Category	Name
IA_BMH_1	Behavioral and Mental Health	Diabetes screening



Act ID	Category	Name
IA_BMH_1	Behavioral and Mental Health	Antipsychotic-Medication-Associated Physical Health Condition Assessment and Monitoring



Cost Category Proposed Changes

CY2026 Physician Fee Schedule Proposed Rule

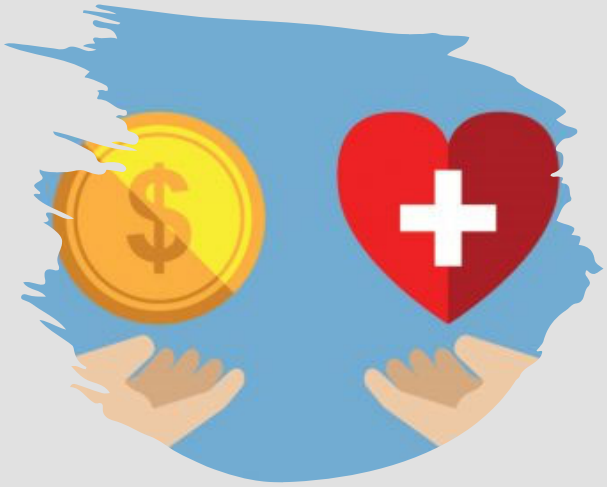
Proposed Changes to the Cost Category

- 35 measures within the Cost category:
  - 33 episode-based measures
  - 2 population-based measures

- **No new Cost measures** proposed for CY2026.

- Total Per Capita Cost (TPCC) modified.

- Proposing to adopt a 2-year informational-only feedback period for newly implemented MIPS Cost measures going forward.
  - New cost measures would not impact scoring or be shared publicly



Proposed Changes to MVPs

CY2026 Physician Fee Schedule Proposed Rule

General Changes to MIPS Value Pathways

- **Modifications proposed to all 21** previously finalized MVPs

- **Six (6) new MVPs being proposed:**
  - Diagnostic Radiology
  - Interventional Radiology
  - Neuropsychology
  - Pathology
  - Podiatry
  - Vascular Surgery

- Registries and QCDRs must support all Quality measures within an MVP.

Proposed Subgroup Reporting Policies

- Beginning with CY2026, multispecialty groups will no longer be able to report MVP as a single group.
  - Must divide into and report as subgroup or report as an individual to report an MVP
  - Multispecialty groups can continue to participate in traditional MIPS

- A single specialty group is defined as consisting of one specialty type.
- A multispecialty group is defined as consisting of two or more specialty types.

- Specialty group types determined by CMS via claims.

Proposed Subgroup Reporting Policies (cont)

- Multispecialty groups that meet the requirements of a **small practice** (15 or fewer providers) will be permitted to report via an MVP as a single group.
  - Small practices have shared that reporting via different MVPs would serve as a barrier to reporting.

- Groups/subgroups must register as an MVP participant between April 1 and November 30.

MIPS Value Pathways RFIs

CMS is seeking feedback via three (3) RFIs related to MVPs:

- Development of a subset of key quality measures within each MVP, referred to as “Core Elements,” from which an MVP Participant would be required to report one Core Element.
- Identifying Medicare Part B procedural billing codes that align with each MVP to encourage specialists to report the relevant MVP based on their use of the procedural billing codes.
- Well-being and nutrition tools and measures that assess overall health, happiness, and satisfaction in life.

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CliniSync*PLUS* provides customized technical assistance and consulting services for providers and organizations that include support for:

- MIPS, Hospital Promoting Interoperability (PI) & Quality reporting programs
- QPP, QualityNet and other attestation support
- Audit response and mock audits of past years' information
- Detailed feedback and program report overview presentations
- Chronic Care Management (CCM), Transitional Care Management (TCM), APM, ACO, CPC and support for other value-based payment models.
- Educational webinars, monthly meetings/calls and unlimited email/phone support

We also provide:

- Ohio-specific information on Public Health Reporting from the Ohio Department of Health and payment model updates from the Ohio Department of Medicaid.
- Resources to assist provider and hospital quality reporting.
- Customized educational programs
- Health Information Exchange (HIE) services through CliniSync HIE

Let our experienced staff assist you in understanding the various payment reform programs so you can get back to what you do best – caring for your patients!

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