



2026 Medicare Physician Fee Schedule Final Rule Includes Health IT Changes

The Centers for Medicare & Medicaid Services (CMS) posted the calendar year 2026 Medicare Physician Fee Schedule (PFS) final rule for public inspection in the [Federal Register](#). Policy changes to Medicare payments under the PFS, and other Medicare Part B issues become effective on or after January 1, 2026. In addition to payment policies, the final rule includes the following health information technology (IT) related provisions.

Telehealth Services

- A streamlined process for adding services to the Medicare Telehealth Services List has been finalized. The distinction between provisional and permanent services is being removed and the focus of reviews will be on whether the service can be furnished using an interactive, two-way audio-video telecommunications system.
- The frequency limitations for follow up inpatient visits, follow up nursing facility visits, and critical care consultations are permanently removed.
- A definition of direct supervision that allows the supervising practitioner to provide such supervision through real-time audio and visual interactive telecommunications is permanently adopted, except for certain global surgery services.
- An allowance for teaching physicians to have a virtual presence in all teaching settings, only in clinical instances when the service was furnished virtually, is made permanent.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

- The same definition of direct supervision for telehealth services has been adopted for RHC and FQHC services requiring direct supervision.
- The allowance for non-behavioral health visits furnished via telecommunication technology for RHC and FQHC services furnished using telecommunication technology, including services furnished using audio-only communications technology, have been extended through December 31, 2026.

Additional details on the Medicare PFS final rule are available [here](#).

Medicare Shared Savings Program Changes

- The current maximum of seven performance years is being decreased to five years for Accountable Care Organizations (ACOs) identified as inexperienced with performance-based risk Medicare ACO initiatives participating in the Shared Savings Program under a one-sided model's first agreement period in the BASIC track's glide path. ACOs inexperienced with performance-based risk Medicare ACO initiatives will be required to progress more rapidly to higher levels of risk and potential reward under a two-sided model by their second or subsequent agreement period.
- Beginning on or after January 1, 2027, ACOs must have at least 5,000 assigned beneficiaries in benchmark year 3 (BY3) but may have fewer than 5,000 assigned beneficiaries in BY1, BY2, or both.
- The health equity adjustment applied to an ACO's quality score beginning in performance year 2026 is being removed to deduplicate scoring factors and further simplify the quality scoring methodology.
- The quality measure sets for the Alternative Payment Model Performance Pathway (APP) Plus have been updated for the Shared Savings Program ACOs to promote alignment with CMS' quality reporting programs. More information on the Quality Payment Program is available at the [QPP Resource Library](#).
- Cyberattack, including ransomware and malware, is being added to the quality and finance extreme and uncontrollable circumstance policies under the Shared Savings Program starting for performance year 2025 and beyond.
- The definition of "primary care services" used for purposes of beneficiary assignment under the Shared Savings Program is being revised to align with payment changes under the Medicare PFS starting on January 1, 2026, and beyond. The expanded definition will include new behavioral health integration and psychiatric collaborative care management services.
- The "health equity benchmark adjustment" is renamed the "population adjustment" for the Shared Savings Program for performance year 2025 and beyond to reflect the adjustment more accurately.
- The Shared Savings Program quality reporting monitoring requirements are being revised for performance years beginning on or after January 1, 2026, and ACOs will be monitored for their adherence to the alternative quality performance standard.

Additional details on the Medicare Share Saving Programs changes in the Medicare PFS final rule are available [here](#).