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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 410, 414, 424, 425, 427, 428, 495, and 512

[CMS–1832–F2]

RIN 0938–AV50

Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program; Correction

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Correcting amendments.

SUMMARY: This document corrects typographical and technical errors in the final rule that appeared in the November 5, 2025 **Federal Register** titled ''Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program'' (hereinafter referred to as the CY 2026 PFS final rule), specifying finalized changes to the Medicare physician fee schedule (PFS) that is applicable for calendar year (CY) 2026, and other changes to Medicare Part B payment policies.

DATES: Effective March 12, 2026.

Applicability date: This document is applicable to January 1, 2026.

FOR FURTHER INFORMATION CONTACT:

MedicarePhysicianFeeSchedule@cms.hhs.gov, for any issues not identified below. Please indicate the specific issue in the subject line of the email. For all questions related to reporting a service on a claim, please contact your Medicare Administrative Contractor.

Michael Soracoe, Morgan Kitzmiller, or *MedicarePhysicianFeeSchedule@cms.hhs.gov,* for issues related to practice expense, work RVUs, conversion factor, and PFS specialty-specific impacts.

Hannah Ahn, or *MedicarePhysicianFeeSchedule@cms.hhs.gov,* for issues related to potentially misvalued services under the PFS.

Julie Rauch, or *MedicarePhysicianFeeSchedule@cms.hhs.gov,* for issues related to Malpractice RVUs.

Morgan Kitzmiller, Terry Simananda, or MedicarePhysicianFeeSchedule@cms.hhs.gov for issues related to Geographic Practice Cost Indices.

Mikayla Murphy, or *MedicarePhysicianFeeSchedule@cms.hhs.gov,* for issues related to direct supervision using two-way audio/video communication technology, telehealth, and other services involving communications technology.

Erick Carrera, or *MedicarePhysicianFeeSchedule@cms.hhs.gov,* for issues related to office/outpatient evaluation and management visit inherent complexity add-on and Digital Mental Health Treatment services.

Maya Peterson, Terry Simananda, or *MedicarePhysicianFeeSchedule@cms.hhs.gov,* for issues related to payment for advanced primary care management services.

Sarah Leipnik, or *MedicarePhysicianFeeSchedule@cms.hhs.gov,* for issues related to global surgery payment accuracy.

Pamela West, or *MedicarePhysicianFeeSchedule@cms.hhs.gov,* for issues related to outpatient therapy services and KX modifier thresholds.

Zehra Hussain, or *MedicarePhysicianFeeSchedule@cms.hhs.gov,* for issues related to payment of skin substitutes.

Rebecca Ray, or *sec303aspdata@cms.hhs.gov,* for issues related to ASP reasonable assumptions.

Allison Cipro, (667) 414–0758, for issues related to Medicare Diabetes Prevention Program.

Sabrina Ahmed, (410) 786–7499, or *SharedSavingsProgram@cms.hhs.gov,* for issues related to the Medicare Shared Savings Program (Shared Savings Program) quality performance standard and other quality reporting requirements.

Janae James, (410) 786–0801, or *SharedSavingsProgram@cms.hhs.gov,* for issues related to Shared Savings Program beneficiary assignment and benchmarking methodology and shared losses mitigation.

Kari Vandegrift, (410) 786–4008, or *SharedSavingsProgram@cms.hhs.gov,* for issues related to Shared Savings Program participation options, and ACO participant and SNF affiliate change of ownership requirements.

Elisabeth Daniel, (667) 290–8793, for issues related to the Medicare Prescription Drug Inflation Rebate Program.

Benjamin Picillo or Genevieve Kehoe, *AmbulatorySpecialtyModel@cms.hhs.gov,* or 1–844–711–2664 (Option 4) for issues related to the Ambulatory Specialty Model.

Kati Moore, (410) 786–5471, for inquiries related to the Merit-based Incentive Payment System (MIPS) track of the Quality Payment Program (QPP).

Trevey Davis, (410) 786–6600, for inquiries related to the Advanced Alternative Payment Models (APMs) track of QPP.

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 2025–19787 of November 5, 2025 (90 FR 49266), the final rule entitled ''Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program'' (hereinafter referred to as the CY 2026 PFS final rule), there were typographical and technical errors that are identified in this correcting document.

The provisions of this correcting amendment are effective January 1, 2026.

II. Summary of Errors

A. Summary of Errors in the Preamble

On pages 49306, 49347, and 49385, we inadvertently made typographical and technical errors.

On page 49540, we inadvertently made technical errors.

On pages 49563 and 49564, we inadvertently made errors in describing a finalized provision.

On page 49567, we inadvertently made typographical errors and omitted a summary of a finalized provision.

On page 49569, we inadvertently omitted text.

On page 49571, we inadvertently made a typographical error.

On page 49572, we inadvertently used incorrect wording in describing participation.

On page 49575, we inadvertently excluded a definition.

On page 49576, we inadvertently excluded a reference and made two typographical errors.

On page 49578, we inadvertently included duplicative language, included

incorrect terminology, and made a grammatical error.

On page 49579, we inadvertently made a typographical error and omitted clarifying language.

On page 49580, we inadvertently included duplicative language and made typographical errors.

On page 49581, we inadvertently included duplicative language, omitted clarifying language, and made typographical and technical errors.

On page 49582, we inadvertently omitted clarifying language.

On page 49584, we inadvertently included duplicative text and made a typographical error.

On pages 49585 through 49589, we made inadvertent typographical and technical errors.

On page 49592, we inadvertently made an error in a section reference.

On pages 49598 through 49600, we made inadvertent typographical and technical errors.

On pages 49601, 49605, 49608, and 49613, we inadvertently omitted language and made technical errors.

On pages 49616, 49619, and 49620, we made inadvertent errors in section references.

On pages 49625 and 49629, we inadvertently omitted language.

On pages 49633, 49640, 49642, 49645, 49665, 49667, and 49669, we made inadvertent typographical errors.

On page 49671, we inadvertently omitted clarifying language and made typographical errors.

On pages 49672, 49675, 49679, 49680, 49683, 49684, and 49685, we made inadvertent typographical and technical errors.

On page 49687, we inadvertently omitted language and made a typographical error.

On page 49690, we made inadvertent errors in section references.

On page 49691, we inadvertently omitted language.

On page 49694, we made an inadvertent error in a section reference.

On page 49695, 49696, 49697, and 49699, we inadvertently made an error in describing a finalized provision.

On page 49716, 49717, and 49719, we made inadvertent typographical errors.

On page 49738, we inadvertently made a typographical error in a reference.

On page 49744, we inadvertently made a technical error to a footnote citation link.

On pages 49781, 49786, 49811, 49813, 49814, and 50002, we inadvertently made typographical errors relating to the Shared Savings Program.

On page 49841, we inadvertently omitted references to the QP patient count threshold and QP payment amount threshold definitional terms.

On pages 49851, 49852, 49853, and 49854 we inadvertently included a former measure title for Quality #: 001.

On page 49927, we inadvertently omitted a cross reference.

On page 49928, we inadvertently omitted several regulatory references related to QP determinations reflecting the finalized policy.

On pages 49931, 49970, and 49971, we made inadvertent errors in section references.

On page 49973, we made an inadvertent typographical error.

On pages 49994 and 50002, we made inadvertent errors in section references and typographical errors.

On page 50004, we inadvertently made typographical errors in table references.

B. Summary of Errors in the Appendices

On pages 50379, 50437, and 50445, we made typographical errors in three tables in the appendices.

C. Summary and Correction of Errors in the Addenda on the CMS Website

At the time of publication of the CY 2026 PFS final rule, we utilized the proposed Ambulatory Payment Classifications (APC) payment amounts and Geometric Mean Costs (GMCs) from the Medicare Program; Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Rating; Hospital Price Transparency; and Notice of Closure of a Teaching Hospital and Opportunity To Apply for Available Slots proposed rule (90 FR 53448) (hereinafter referred to as the CY 2026 OPPS final rule) for our PE RVU calculations of CPT codes 77402, 77407, 77412, 77436, 77437, 77438, 99445, 99454, 98977 and 98985 because that was the most recent information available. With the publication of the CY 2026 OPPS final rule, we are updating the PE RVUs for 77402, 77407, 77412, 77436, 77437, 77438, 99445, 99454, 98977, and 98985 based on the final OPPS APC payment rates and GMCs with this correction notice, as displayed in Addendum B. We are also updating the Proxy Inputs for Radiation Services public use file available under the Downloads posted with this correction notice to reflect these changes. As a result of the PE RVU changes for CPT codes77402, 77407, 77412, 77436, 77437, 77438, 99445, 99454, 98977 and 98985, all PFS PE RVUs were recalculated, and some codes on the PFS will receive slightly different PE RVUs as a result of PE RVU budget neutrality. These changes are reflected in the updated Addendum B file.

Additionally, we note that at the time of the CY 2026 PFS final rule, the Addendum B listed the incorrect payment for the following skin substitute codes: HCPCS codes A2025, A2029, A2031, A2032, A2034, A2036, A2038, A2039, and A4100. These skin substitute codes were changed to receive active pricing (Procedure Status ''A'') with a Non-Facility PE RVU and Total Non-Facility RVU of 3.81 to align with our policy and that change is listed in the updated Addendum B file displayed online. Additionally, skin substitute codes Q4106 and Q4226 were both removed from Addendum B. We also note that HCPCS codes Q4398–Q4420, Q4431, Q4432, and Q4433 were omitted from Addendum B due to their incorrect Procedure Status ''E.'' The HCPCS codes' Procedure Status has been updated to Procedure Status ''C'' and the global periods for skin substitute HCPCS codes Q4431, Q4432, and Q4433 will be corrected to ZZZ in the updated Addendum B file. Additionally, HCPCS codes Q4224 was omitted from Addendum B due to its incorrect Procedure Status ''E.'' The HCPCS code's Procedure Status has been updated to Procedure Status ''A'' with a Non-Facility PE RVU and Total Non-Facility RVU of 3.81. We have made these updates to Addendum B file to align with the correct classification of skin substitute codes displayed online in the public use files. These changes include updating the Addendum B file to reflect that skin substitute HCPCS codes Q4398 through Q4420 receive active pricing. We also updated the Addendum B file to reflect HCPCS codes Q4431, Q4432, and Q4433 to receive contractor pricing.

D. Summary of Errors in the Amendatory Instructions

On pages 50007, 50008, 50009, 50010, 50014, 50021 we inadvertently made typographical errors in the amendatory instructions for §§ 410.15, 410.62, 410.79, 414.84, 414.1305, and 424.205.

E. Summary of Errors in the Regulations Text

On page 50006, we made typographical errors in the regulation text for § 405.2463 by noting ''On or after October 1, 2025'' instead of ''Not before October 1, 2025''.

On page 50007, we inadvertently made technical errors in the regulation text for § 410.26, by failing to remove the references to paragraphs (a)(2)(i) and (ii).

On pages 50007, 50008, and 50009, we inadvertently made typographical errors in the amendatory instructions for §§ 410.79 and 414.84, which caused regulation text to be removed.

On page 50009, in § 414.1305, we made technical errors in the definitions of: ''Attribution-eligible beneficiary'', ''Covered professional service attribution-eligible beneficiary'' introductory text, and ''E/M attribution-eligible beneficiary''. We also inadvertently omitted amendatory instructions to revise the definitions of ''QP patient count threshold'' and ''QP payment amount threshold''.

On pages 50010 and 50011 in § 414.1380, there were technical errors in the implementation of the revisions in the Code of Federal Regulations (CFR) for paragraphs (b)(2)(iii) and (vi). Specifically, the finalized changes to paragraphs (b)(2)(iii) and (vi) were inadvertently made in the CFR to paragraphs (b)(1)(iii) and (vi).

On pages 50013 and 50014 in § 414.1435, we made technical errors in the structuring of paragraphs and inadvertently omitted finalized language for § 414.1435(h).

On page 50016 in § 425.512, there were technical errors in the implementation of the finalized revisions to paragraphs (c)(3)(ii) through (iv) in the CFR. Specifically, revisions to remove the phrase ''health equity adjusted quality performance score'' and add the phrase ''quality score'' to paragraphs (c)(3)(ii) through (iv) were incorrectly implemented in the CFR.

On page 50021, we inadvertently indicated that revisions were being made to regulatory language at § 427.502(c)(1)(ii), which in fact were made to § 427.502(c)(2)(ii). In addition, there were technical errors in the revised language adopted at §§ 427.502(c)(1)(ii) and (c)(2)(ii) and 428.402(c)(1)(ii) and (c)(2)(ii). When revising the language in § 428.402(c)(2)(ii), we inadvertently failed to correct a typographical error in a reference in language adopted in the final rule that appeared in the December 9, 2024 **Federal Register** titled ''Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments''. Section 428.402(c)(2)(ii), as amended in the CY 2026 PFS final rule, referred erroneously to a Rebate Report ''specified in paragraph (b)(2),'' which paragraph does not exist, rather than such a Report ''specified in paragraph (c)(2),'' as intended. The corrected text amends the reference to ensure the regulatory text accurately reflects the policy as proposed and adopted in the CY 2026 PFS final rule.

On pages 50022 through 50035, we inadvertently omitted undesignated headings in part 512, subpart G.

On page 50022 in § 512.705, we inadvertently omitted language in the definition of ''ASM payment year''.

On page 50025 in § 512.710(f)(1), we inadvertently made a typographical error in a reference.

On page 50026 in § 512.710(g)(1)(ii), we inadvertently made a typographical error.

On page 50027 in § 512.725(b)(1), we inadvertently omitted language text in detailing the MIPS Q492 measure.

On page 50028, we inadvertently made a typographical error in the regulations text at § 512.730(e)(1).

On page 50031 in §§ 512.745(a)(3)(i) and (a)(4)(i) and 512.750(c)(1)(i), we inadvertently made typographical and technical errors.

On page 50032 in § 512.750(f)(2), we inadvertently made a technical error.

On page 50035 in § 512.775, we inadvertently made referencing errors.

III. Waiver of Proposed Rulemaking and Delay in Effective Date

Section 1871(b)(1) of the Social Security Act (the Act) requires the Secretary to provide for notice of a proposed rule in the **Federal Register** and provide a period of not less than 60 days for public comment. In addition, section 1871(e)(1)(B)(i) of the Act mandates a 30-day delay in effective date after issuance or publication of substantive changes as specified. Section 1871(b)(2)(C) of the Act provides an exception from the notice and 60-day comment period and delay in effective date requirements of the Act, under the standards set forth in 5 U.S.C. 553(b). Section 1871(e)(1)(B)(ii) of the Act provides an exception from the delay in effective date requirements of the Act as well. Section 553(b)(B) authorizes an agency to dispense with normal notice and comment rulemaking procedures for good cause if the agency makes a finding that the notice and comment process is impracticable, unnecessary, or contrary to the public interest, and includes a statement of the finding and the reasons for it in the rule. Similarly, section 1871(e)(1)(B)(ii) of the Act allows an exception to the effective date where the Secretary finds that waiver is necessary to comply with statutory requirements, or that the delay is contrary to the public interest and the agency includes in the rule a statement of the finding and the reasons for it.

In our view, this correcting document does not constitute a rulemaking that would be subject to these requirements. This document corrects technical errors in the CY 2026 PFS final rule. The corrections contained in this document are consistent with, and do not make substantive changes to, the policies and payment methodologies that were proposed, subject to notice and comment procedures, and adopted in the CY 2026 PFS final rule. As a result, the corrections made through this correcting document are intended to resolve inadvertent errors so that the rule accurately reflects the policies adopted in the final rule. Even if the notice and comment and delayed effective date requirements applied, we find that there is good cause to waive such requirements. Undertaking further notice and comment procedures to incorporate the corrections in this document into the CY 2026 PFS final rule or delaying the effective date of the corrections would be contrary to the public interest because it is in the public interest to ensure that the rule accurately reflects our policies as of the date they take effect. Further, such procedures would be unnecessary because we are not making any substantive revisions to the final rule, but rather, we are simply correcting the **Federal Register** document to reflect the policies that we previously proposed, received public comment on, and subsequently finalized in the final rule. For these reasons, we find good cause to waive notice and comment and not delay the effective date, in the event they are deemed required.

IV. Correction of Errors

In FR Doc. 2025–19787 of November 5, 2025 (90 FR 49266), make the following corrections:

A. Correction of Errors in the Preamble

1. On page 49306, first column, first partial paragraph, line 1, the phrase ''CPT codes 96920, 92921, and 96922'' is corrected to read ''CPT codes 96920, 96921, and 96922''.

2. On page 49347, second column, first partial paragraph, line 48, the reference, ''77X09'' is corrected to read ''77439''.

3. On page 49385, second column, fifth paragraph, line 25, the figure ''55 percent'' is corrected to read ''60 percent''.

4. On page 49540, first column, third full paragraph, lines 6 through 8, the phrase ''assumptions, and if any concerns are identified, we will reach out to the manufacturer.'' is corrected to

read ''assumptions, and if any concerns are identified, we may reach out to the manufacturer.''.

5. On page 49563,

a. Second column, first full paragraph, lines 5 through 11, the phrase ''By evaluating clinicians individually, ASM removes the unequal reporting and scoring benefits that have been previously afforded to consolidated health systems and group practices. This form of mandatory participation'' is corrected to ''ASM removes the unequal reporting and scoring benefits that have been previously afforded to consolidated health systems and group practices while allowing reporting flexibilities for ASM participants in small practices to mitigate reporting burden. Mandatory participation of individual clinicians''.

b. Third column, last partial paragraph, lines 6 through 10, and continuing on page 49564, first partial paragraph, lines 1 through 5, the phrase ''ASM aims to assess the quality and cost performance of ASM participants providing care for Medicare beneficiaries with the targeted chronic conditions at the individual clinician level (TIN/NPI) while measuring practice transformation and interoperability strengthening at the group level. Specifically, ASM will test'' is corrected to read ''ASM aims to assess the quality performance of the majority of ASM participants at the individual clinician level (TIN/NPI), the cost performance of all ASM participants at the individual clinician (TIN/NPI level), and practice transformation and interoperability strengthening at the group (TIN) level. We note that we will allow ASM participants to report quality measures at the group (TIN) level to mitigate reporting burden as discussed in section III.C.2.d.(1).(b). of this final rule. ASM will test''.

6. On page 49567,

a. Second column, fourth full paragraph, line 3, the word ''ASMs'' is corrected to ''ASM''.

b. Third column, second full paragraph, lines 10 through 25, the phrase ''For these reasons, ASM will include specific positive scoring adjustments for ASM participants who we determine have a high degree of medically or socially complex patients, as well as scoring adjustments for participants in small practices or who are solo practitioners. We note that eligibility for these scoring adjustments will be evaluated separately, so ASM participants can qualify for both the complex patient scoring adjustment and small practice scoring adjustment. We refer readers to sections III.C.2.e.(3) and III.C.2.e.(4) of this final rule for further discussion on these provisions.'' is corrected to read ''For these reasons, ASM will include specific positive scoring adjustments for ASM participants who we determine have a high degree of medically or socially complex patients. Further, ASM participants who are solo practitioners or in a small practice will receive positive scoring adjustments on their final score and may submit quality measure data at the group (TIN) level to reduce burden. We note that eligibility for these scoring adjustments will be evaluated separately, so ASM participants can qualify for both the complex patient scoring adjustment and small practice scoring adjustment. We refer readers to sections III.C.2.d.(1).(b)., III.C.2.e.(3). and III.C.2.e.(4). of this final rule for further discussion on these provisions.''.

7. On page 49569, second column, second full paragraph, line 17, the phrase ''Part B payments'' is corrected to ''Part B payments for covered professional services''.

8. On page 49571, third column, first full paragraph, line 8, the phrase ''they would subject'' is corrected to read ''they would be subject''.

9. On page 49572, first column, first partial paragraph, last line, the phrase ''participating in'' is corrected to ''reporting under''.

10. On page 49575,

a. First column, third full paragraph,

(1) Lines 2 and 3, the phrase ''proposed 'ASM participant' definition'' is corrected to read ''proposed 'ASM participant' and 'ASM low back pain participant' definitions''.

(2) Line 11, the phrase ''the 'ASM participant' definition'' is corrected to read ''the definitions''.

11. On page 49576,

a. First column, first full paragraph, line 21, the phrase ''comment rulemaking.'' is corrected to read ''comment rulemaking. We note that we have finalized a provision for ASM participants in small practices to report quality measure data at the group (TIN) level, which we discuss in section III.C.2.d.(1).(b). of this final rule.''.

b. Third column,

(1) Fourth full paragraph, line 34, the phrase ''CMS to reconsider'' is corrected to read ''CMS reconsider''.

(2) Fifth full paragraph, line 7, the phrase ''comparing to'' is corrected to read ''comparing''.

12. On page 49578, second column,

a. Second full paragraph, lines 2 through 4, ''proposed ASM low back pain participant and ASM low back pain cohort definitions.'' is corrected to read ''proposed 'ASM low back pain cohort' definition.''.

b. Third full paragraph, line 3, ''participant'' is corrected to read ''cohort''.

13. On page 49579,

a. First column,

(1) First full paragraph, lines 2 and 3, the phrase ''define ASM low back pain participant and the ASM low'' is corrected to read ''define the ASM low''.

(2) Second full paragraph, lines 2 and 3, the phrase ''define ASM low back pain participant and ASM low'' is corrected to read ''define the ASM low''.

b. Second column, first full paragraph,

(1) Line 3, the phrase ''low back pain cohort.'' is corrected to read ''low back pain cohort, including those who oversee non-procedural interventions.''.

(2) Line 36, the phrase ''suggested CMS to'' is corrected to read ''suggested that CMS''.

14. On page 49580, first column,

a. First full paragraph,

(1) Line 15, the word ''anesthesiologists'' is corrected to read ''anesthesiology''.

(2) Line 25, the word ''provided'' is corrected to read ''providing''.

b. Second full paragraph, line 7, the word ''patient's'' is deleted.

c. Fourth full paragraph, lines 2 through 4, ''finalizing the 'ASM low back pain participant' and 'ASM low back pain cohort' definitions'' is corrected to read ''finalizing the 'ASM low back pain cohort' definition''.

15. On page 49581,

a. First column,

(1) First full paragraph, line 4, the phrase ''response We did not'' is corrected to read ''response. We did not''.

(2) Last paragraph, line 11, the phrase ''identifiable by their unique NPI. We'' is corrected to read ''identifiable by their unique NPI.''.

b. Second column,

(1) First partial paragraph, lines 1 through 9, the phrase ''stated that when TIN and NPI are used together, CMS is able to identify and evaluate individual providers. NPI-level participation also aligns with the Innovation Center's goal of creating a level playing field for all clinicians and removing unequal benefits afforded to consolidated group practices and health systems.'' is corrected by removing the phrase.

(2) Second full paragraph, lines 23 through 28, the phrase ''This approach would maintain consistency between participant identification and performance assessment within ASM and mirrors the methodology used in the Quality Payment Program.'' is corrected by removing the phrase.

(3) Third full paragraph, lines 5 through 9, the phrase ''Identifying ASM

participants at the TIN/NPI level will allow for like-to-like performance assessment of clinicians who meet ASM participant eligibility criteria.'' is corrected to read ''The ASM participation identification approach supports the goals of increasing clinician-level accountability for quality and cost performance. While we will allow ASM participants in small practices to report required quality measures at the group (TIN) level to address concerns of reporting burden for this type of ASM participant, TIN/NPI-level quality assessment for all other ASM participants and TIN/NPI-level cost performance assessment for all participants will allow for more like-to-like comparison of clinicians who meet ASM participant eligibility criteria.''

16. On page 49582, first column, second full paragraph, line 10, the phrase ''participation in ASM.'' is corrected to read ''participation in ASM. We also note that we did not consider allowing a clinician to choose under which TIN/NPI they would be an ASM participant. Rather, we considered selecting the TIN/NPI combination with the most EBCM-triggered episodes in the case that a clinician meets ASM participant eligibility criteria under more than one TIN/NPI combination.''.

17. On page 49584,

a. First column, second full paragraph, lines 18 through 23, the phrase ''eligibility criteria. Because using the majority would require that a single specialty code be applied to more than half of all Medicare Part B claims, a clinician changing their specialty midyear may not meet this threshold. Using'' is corrected to read ''eligibility criteria. Using''.

b. Third column, first full paragraph, line 4, the phrase the ''participant.; the commenters believed'' is corrected to read ''participant; the commenters believed''.

18. On page 49585, first column, first full paragraph, line 2, the phrase ''CMS to consider supplementing'' is corrected to read ''CMS consider supplementing''.

19. On page 49586, third column,

a. Second full paragraph, line 8, the phrase ''use low back pain EBCM'' is corrected to read ''use the low back pain EBCM''.

b. Third full paragraph, line 5, the phrase ''promotes consistency between MIPS'' is corrected to read ''promotes consistency with MIPS''.

20. On page 49587, second column, last full paragraph, line 3 and 4, the phrase ''episodes for EBCM to'' is corrected to read ''episodes to''.

21. On page 49588, third column, first full paragraph, line 6, the word ''conditions'' is corrected to read ''condition''.

22. On page 49589, second column, second full paragraph, line 4, the phrase ''we proposed that IP Codes'' is corrected to read ''we proposed that ZIP codes''.

23. On page 49592, second column, second full paragraph, line 23, the reference ''section VII'' is corrected to read ''section VI''.

24. On page 49598,

a. First column, first partial paragraph, line 6, the phrase ''ASM's performance'' is corrected to read ''ASM participant's performance''.

b. Second column, first partial paragraph, line 9, the phrase ''ASM's performance'' is corrected to read ''ASM participant's performance''.

25. On page 49599, second column, first full paragraph, line 7, the phrase ''specialty'' is corrected to read ''specialists''.

26. On page 49600, first column,

a. First full paragraph, lines 23 through 28, the sentence ''We have determined that allowing multiple reporting configurations would undermine ASM's design objective of creating clear peer-to-peer performance comparisons for determining payment adjustments.'' is corrected to read ''We have determined that allowing multiple reporting configurations could undermine ASM's design objective of creating clear peer-to-peer performance comparisons for determining payment adjustments.''.

b. Second full paragraph, line 10, the phrase ''believe that it is'' is corrected to read ''believed that it was''.

27. On page 49601,

a. First column, first full paragraph, line 33, the phrase ''the TIN-level.'' is corrected to read ''the TIN-level. We believe this flexibility is appropriate because in a small practice each clinicians' relative contribution to an individual quality measure's performance is larger, meaning there is increased accountability on each clinician for their performance even though the quality measure reflects a group's performance.''

b. Second column, fifth full paragraph, lines 7 through 11, the sentence ''Based on the data submission provisions we are finalizing in this final rule, we note that ASM participants will not have the flexibility to report both as an individual and as a group.'' is corrected to read ''Based on the data submission provisions we are finalizing in this final rule, we note that ASM participants must report quality measure data at the individual clinician (TIN/NPI) level unless they are in a small practice; ASM participants in small practices may report quality measure data at the group (TIN) level. All ASM participants must report improvement activities and Promoting Interoperability at the group (TIN) level.''.

28. On page 49605, third column, first partial paragraph,

a. Line 37, the word ''incentivizing'' is corrected to read ''incentivizes''.

b. Lines 38 and 39, the phrase ''experience could drive improvements'' is corrected to ''experience, which could drive improvements''.

29. On page 49608, second column, first full paragraph, line 6 and 7, the phrase ''measure in the heart failure quality measure set'' is corrected to read ''measure, with minor modification, in the heart failure quality measure set''.

30. On page 49613, second column, second full paragraph, lines 1 and 2, the sentence ''We also received broad feedback on the heart failure quality measure set.'' is corrected to read ''After reviewing public comments, we are finalizing the inclusion of Functional Status Assessments for Heart Failure (MIPS Q377) as proposed at § 512.725(b)(5). We intend to consider re-specification of this measure into a PRO–PM through future notice-and-comment rulemaking. We also received broad feedback on the heart failure quality measure set.''.

31. On page 49616, first column, first partial paragraph, lines 24 through 32, the sentences ''After reviewing public comments, we are finalizing the inclusion of Functional Status Assessments for Heart Failure (MIPS Q377) as proposed at § 512.725(b)(5). We intend to consider re-specification of this measure into a PRO–PM through future notice-and-comment rulemaking.'' is corrected to read ''After reviewing public comments, we are finalizing the quality measure set for the heart failure cohort as proposed at § 512.725(b).''.

32. On page 49619, second column, first full paragraph, line 10, the citation ''(90 FR 32589 through 32594)'' is corrected to read ''(90 FR 32581)''.

33. On page 49620, first column, second full paragraph, lines 8 and 9, the citation ''(90 FR 32589 through 32594)'' is corrected to read ''(90 FR 32581)''.

34. On page 49625, first column, third full paragraph, lines 2 through 7, the phrase ''we are finalizing the inclusion of the (MIPS Q220) Functional Status Change for Patients with Low Back Impairments in the low back pain quality measure set as proposed at § 512.725(c)(4).'' is corrected to read ''we are finalizing the quality measure set for the ASM low back pain cohort, with modification, at § 512.725(c).''.

35. On page 49629, second column, third full paragraph, lines 10 through 11, the phrase ''incorporated into the quality measure sets accordingly'' is corrected to read ''incorporated into the quality measure sets accordingly, except as noted for MIPS Q492, with modification.''

36. On page 49633, third column, first full paragraph, line 34, the phrase ''case minimum of this proposed rule'' is corrected to read ''case minimum of this final rule''.

37. On page 49640, first column, first full paragraph,

a. Line 26, the phrase ''opportunities for findings savings'' is corrected to ''opportunities for finding savings''.

b. Line 28, the phrase ''extensive with interested parties input, including specialty societies'' is corrected to read ''extensive review including with specialty societies''.

38. On page 49642,

a. First column, first partial paragraph, line 16, the phrase ''extensive interested parties'' is corrected to read ''extensive review from interested parties''.

b. Second column,

(1) First partial paragraph, line 3, the phrase ''relationship that'' is corrected to read ''relationship exists''.

(2) Second full paragraph,

(a) Line 7, the phrase ''triggered. And'' is corrected to read ''triggered, and''.

(b) Line 8, the phrase ''attributable to a TIN or TIN/NPI The'' is corrected to read ''attributable to a TIN or TIN/NPI. The''.

(3) Fourth paragraph, line 10, the phrase ''20-episodethreshold'' is corrected to read ''20-episode threshold''.

39. On page 49645,

a. First column, first partial paragraph, line 2, word ''believe'' is corrected to read ''believed''.

b. Second column, second full paragraph, line 21, the phrase ''include'' is corrected to read ''while including''.

40. On page 49665, lower three-fourths of the page, third column, first partial paragraph, line 31, the phrase ''of this proposed rule'' is corrected to ''of this final rule''.

41. On page 49667, second column, second full paragraph, line 11, the word ''incentive'' is corrected to read ''incentivize''.

42. On page 49669, third column, first partial paragraph, line 6, the word ''reweighing'' is corrected to read ''reweighting''.

43. On page 49671, first column, last partial paragraph, lines 1 through 3, through the second column, first paragraph, lines 1 through 10, the phrase ''We considered, but did not propose, adopting an approach in which quality performance is risk adjusted for complex patients. We believe that providers have substantial control over the health care encounter and the outcomes assessed after the encounter. Thus, we decided that adjustments made at the quality measure or quality ASM performance category level would undermine our core aim to promote direct accountability and high-quality outcomes for all beneficiaries.'' is corrected to read ''We considered, but did not propose, adopting an approach in which the quality ASM performance category is risk adjusted for complex patients. We believe that providers have substantial control over the health care encounter and the outcomes assessed after the encounter. Thus, we decided that adjustments made at quality ASM performance category level would undermine our core aim to promote direct accountability and high-quality outcomes for all beneficiaries. We note that we will maintain any risk adjustment in required quality measures whose specifications include risk adjustment.''.

44. On page 49672, first column, first partial paragraph, line 5, the phrase ''using data from data from the'' is corrected to read ''using data from the''.

45. On page 49675, first column, third full paragraph, line 15, the phrase ''of this proposed rule'' is corrected to read ''of this final rule''.

46. On page 49679,

a. Second column, second full paragraph,

(1) Line 12, the phrase ''ASM payment year.'' is corrected to read ''ASM payment year (90 FR 32605).''

(2) Line 22, the phrase ''an ASM payment year.'' is corrected to read ''an ASM payment year (90 FR 32605).''

b. Third column,

(1) First partial paragraph, line 11, the phrase ''of this proposed rule'' is corrected to read ''of this final rule''.

(2) First full paragraph, line 2, the phrase ''2026 PFS proposed rule'' is corrected to read ''2026 PFS proposed rule (90 FR 32605)''.

(3) Second full paragraph, lines 1 and 2, the phrase ''The proposed payment methodology is'' is corrected to read ''In the CY2026 PFS proposed rule (90 FR 32605), we proposed a payment methodology''.

47. On page 49680,

a. First column, last partial paragraph, line 2, the word ''differs'' is corrected to read ''differed''.

b. Second column, first partial paragraph, lines 10 and 11, the phrase ''As discussed earlier and later in this section'' is corrected to read ''As discussed in section III.C.2.f.(2).''.

48. On page 49683, second column, second full paragraph, line 6, the phrase ''of this proposed rule'' is corrected to read ''of this final rule''.

49. On page 49684, first column, second full paragraph, lines 19 through 21, the phrase ''same set of requirements reported at the same TIN/NPI level (that is, the level at which an ASM participant is identified)'' is corrected to read ''same set of requirements''.

50. On page 49685, first column, first partial paragraph, lines 21 thorough 25, the phrase ''We do not believe that allow this subset of ASM participants to report data at the TIN level would not undermine our performance comparison approach.'' is corrected to read ''We do not believe that allowing this subset of ASM participants to report quality measure data at the TIN level would undermine our performance comparison approach.''.

51. On page 49687,

a. First column, first full paragraph, line 36, the phrase ''ASM we would'' is corrected to read ''we would''.

b. Third column, fourth full paragraph, line 13, the phrase ''statistical variation'' is corrected to read ''undesirable statistical variation''.

52. On page 49690,

a. Second column, first partial paragraph, line 23, the phrase ''section VII'' is corrected to read ''section VI.''.

b. Third column, first full paragraph, line 2, the phrase ''section VII'' is corrected to read ''section VI.''.

53. On page 49691, first column, first full paragraph, line 29 and 30, the phrase ''Part B adjustments'' is corrected to read ''Part B payment adjustments''.

54. On page 49694, lower two-thirds of the page, first column, first full paragraph, line 14, the reference ''section VII'' is corrected to read ''section VI.''.

55. On page 49695, second column, second paragraph, line 45, the phrase ''advantage'' is corrected to read ''advantageous''.

56. On page 49696, second column, third full paragraph, lines 1 and 2, the phrase ''During an ASM payment year, we proposed at § 512.750(f)(1) that'' is corrected to read ''In the CY 2026 PFS proposed rule (90 FR 32614), we proposed at § 512.750(f)(1) that during an ASM payment year''.

57. On page 49697, top of page, second column, partial paragraph, lines 1 and 2, the phrase ''on ASM payment adjustment multiplier.'' is corrected to read ''one ASM payment multiplier.''.

58. On page 49699, first column, second full paragraph, lines 14 through 24, the phrase ''We note that we are not allowing ASM participants choice in how they report data (that is, as an

individual and as a group) for a given ASM performance year, so there is no need to develop rules for resolving such reporting conflicts. Our finalized policies related to data submission at § 512.720 also describe how we will manage multiple data submissions from an individual ASM participant.'' is corrected to read ''Beyond allowing ASM participants in small practices to report group-level quality measures discussed in section III.C.2.d.(1).(b) of this final rule, we are not allowing most ASM participants choice in the level at which they report quality, improvement activities, or Promoting Interoperability data (that is, as an individual or as a group) for a given ASM performance year. We intend to revisit these data submission provisions in the CY 2027 rulemaking cycle to clarify how allowing ASM participants in small practices to report group-level quality measures data may influence data submission procedures, determination of ASM performance category scores, and calculation of final scores.''

59. On page 49716, third column, second full paragraph, line 6, the phrase ''eligibility criteria'' is corrected to read ''ASM participant eligibility criteria''.

60. On page 49717, first column, second partial paragraph, line 4, the phrase ''we would not preclude'' is corrected to read ''we will not preclude''.

61. On page 49719,

a. Second column, second full paragraph, line 9, the word ''models'' is corrected to read ''model''.

b. Third column, second full paragraph, line 1, the phrase ''We would also'' is corrected to ''We will also''.

62. On page 49738, first column, last partial paragraph, line 13, the phrase ''As stated on page 98578 of the CY 2025 PFS final rule).'' is corrected to read ''As stated in the CY 2025 PFS final rule (89 FR 98264).''.

63. On page 49744, third column, first footnote paragraph (footnote 362), lines 6 and 7, the hyperlink ''*https://edit.cms.gov/files/document/ipay-2028-final-guidance.pdf*''is corrected to read ''*https://www.cms.gov/files/document/ipay-2028-final-guidance.pdf*''.

64. On page 49781, second column, first full paragraph, line 8, the phrase ''precent'' is corrected to read ''percent''.

65. On page 49786, first column, first full paragraph, lines 4 and 5, the phrase, ''that they have fewer than 5,000 beneficiaries'' is corrected to read ''that have fewer than 5,000 beneficiaries''.

66. On page 49811, third column, third full paragraph, lines 1 and 2, the reference ''section III.F.8.(2)'' is corrected to read ''section III.F.8.b.(2).''.

67. On page 49813, third column, last partial paragraph, line 4, the phrase ''downside risks'' is corrected to read ''downside risk''.

68. On page 49814, first column, first partial paragraph, line 1, the reference ''section III.F.2.(2)'' is corrected to read ''section III.F.2.''.

69. On page 49841, second column, sixth and seventh bulleted paragraphs, the bulleted paragraphs are corrected to read as follows:

''• MVP Participant
• QP patient count threshold
• QP payment amount threshold
• Single specialty group''.

70. On page, 49851, in the table titled Table C–BC1: APM Performance Pathway Quality Measure Set Beginning with the CY 2026 Performance Period/2028 MIPS Payment Year, second column, second row, the measure title ''Diabetes: Hemoglobin A1c (HbA1c) Poor Control'' is corrected to read, ''Diabetes: Glycemic Status Assessment Greater Than 9%''.

71. On page 49852, in the table titled Table C–BC2: App Plus Quality Measure Set for the CY 2026 Performance Period/2028 MIPS Payment Year, second column, second row, the measure title ''Diabetes: Hemoglobin A1c (HbA1c) Poor Control'' is corrected to read, ''Diabetes: Glycemic Status Assessment Greater Than 9%''.

72. On page 49853, in the table titled Table C–BC3: App Plus Quality Measure Set for the CY 2027 Performance Period/2029 MIPS Payment Year, second column, second row, the measure title ''Diabetes: Hemoglobin A1c (HbA1c) Poor Control'' is corrected to read, ''Diabetes: Glycemic Status Assessment Greater Than 9%''.

73. On page 49854, lower three-fourths of the page, in the table titled Table C–BC4: App Plus Quality Measure Set Beginning with the CY 2028 Performance Period/2030 MIPS and Subsequent Performance Periods/MIPS Payment Years, second column, second row, the measure title ''Diabetes: Hemoglobin A1c (HbA1c) Poor Control'' is corrected to read, ''Diabetes: Glycemic Status Assessment Greater Than 9%''.

74. On page 49927, second column, first partial paragraph, line 20, the placeholder reference ''XX.XX.x.(2).'' is corrected to read ''IV.5.b.(2).''.

75. On page 49928,

a. Second column, first partial paragraph, lines 58 through 68 and continuing to the first partial sentence of the third column, beginning with the phrase ''We further are finalizing'' and ending with the phrase ''amendments to § 414.1435'' is corrected to read ''We further are finalizing amendments at § 414.1305 to support and clearly delineate these separate calculations by: (1) revising the definition of ''attribution-eligible beneficiary'' to sunset with the 2025 QP Performance Period; (2) adding new definitions for ''Covered professional service attribution-eligible beneficiary'' and ''E/M attribution-eligible beneficiary'' effective with the 2026 QP Performance Period; and (3) making conforming revisions to the definitions of ''QP payment amount method'' and ''QP patient count method''.

b. Third column, first partial paragraph, lines 11 and 12, the phrase ''(payment and patient count).'' is corrected to read ''(payment and patient count). Because the policy we are finalizing results in the use of two sets of payment amount and patient count calculations—one using E/M and another using Covered Professional Services—these amendments are needed to fully effectuate the final policy. We note that these changes were not necessary under the proposed policy because that policy maintained the use of a single set of payment amount and patient count calculations. Additionally, we are finalizing revisions to § 414.1435(a) and (b) to sunset the original payment amount and patient count methodologies after the 2025 QP Performance Period, and we are redesignating § 414.1435(c) and (d) to (g) and (h), respectively. Together, these amendments serve to effectuate the use of both E/M-based calculations as well as Covered Professional Services-based calculations for all eligible clinicians in Advanced APMs.

Finally, we are finalizing conforming revisions to the use of methods regulation at the redesignated § 414.1435(h) to provide that through 2025, both the payment amount and patient count methods described in paragraphs (a) and (b) are used to determine QP status, and that, starting with 2026, all of the methods described in paragraphs (c) through (f) will be used to determine QP status for each QP Performance Period. These revisions will maintain our existing practice of using the highest score in assigning a status of QP, Partial QP, or neither.''

76. On page 49931, first column, first full paragraph, line 23, the reference ''section VII.I.5.'' is corrected to read ''section VI.F.4.''.

77. On page 49970, third column, first partial paragraph, line 4, the reference ''section VI.E.7.b.(1).'' is corrected to read ''section VI.F.4.b''.

78. On page 49971,

a. Second column, fourth full paragraph, line 1, the reference ''section

VI.H'' is corrected to read ''section VI.B.''.

b. Third column, second full paragraph, line 1, the reference ''section VI.E.b.(1).'' is corrected to read ''section VI.F.4.b.''.

79. On page 49973, third column, first partial paragraph, line 6, the phrase ''which will would range'' is corrected to read ''which will range''.

80. On page 49994, first column, fourth full paragraph,

a. Line 1, the reference ''section III.D.'' is corrected to read ''section III.C.''.

b. Line 11, the reference ''section III.D.'' is corrected to ''section III.C.''.

81. On page 50002,

a. First column, last partial paragraph

(1) Line 1, the reference ''section III.D.'' is corrected to read ''section III.C.''.

(2) Line 3, the phrase ''ASM. As proposed, we would test'' is corrected to read ''ASM. We will test''.

b. Third column, first full paragraph, line 23, the phrase ''patients'' is corrected to read ''patient''.

82. On page 50004, lower half of the page, third column, last full paragraph, lines 3 and 4, the references ''Tables 113 through 115'' are corrected to read ''Tables D–B28 through D–B30''.

B. Correction of Errors in the Appendices

83. On page 50379, top of the page, in the table titled ''Table A.1 Diagnostic Radiology MVP Clinical Groupings'', third row (Q494: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Clinician Level) (Collection Type: eCQM)),

a. Third column (Outcome), the entry ''No'' is corrected to read ''Yes''.

b. Fourth column (High Priority), the entry ''No'' is corrected to read ''Yes''.

84. On page 50437, middle of the page, in the table titled ''Table B.11 Optimal Care for Kidney Health MVP Clinical Groupings'', sixth row (Q511: Percentage of Prevalent Patients Waitlisted (PPPW) and Percentage of Prevalent Patients Waitlisted in Active Status (APPPW), third column (Outcome), the entry ''Yes'' is corrected to read ''No''.

85. On page 50445, lower third of the page, in the table titled ''Table B.14 Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV MVP Clinical Groupings'', third row (Q340: HIV Medical Visit Frequency), second column (Measure), the parenthetical phrase ''(Collection Type: MIPS CQM)'' is corrected to read ''(Collection Type: eCQM, MIPS CQM)''.

C. Correction of Errors to the Amendatory Instructions

86. On page 50007,

a. First column, amendatory instruction 8 for § 410.15, lines 1 through 7, the instruction ''Section 410.15 is amended by revising paragraph (a), the definition for ''First annual wellness visit providing personalized prevention plan services'' and ''Subsequent annual wellness visit providing personalized prevention plan services'' is corrected to read ''Section 410.15 is amended in paragraph (a), in the definitions for ''First annual wellness visit providing personalized prevention plan services'' and ''Subsequent annual wellness visit providing personalized prevention plan services'' by revising paragraphs (xiii) and (xi), respectively.''.

b. Second column,

(1) Amendatory instruction 11 for § 410.62, lines 1 and 2, the instruction ''Section 410.62 is amended by revising paragraph (a) to read as follows:'' is corrected to read ''Section 410.62 is amended by revising paragraph (a) introductory text to read as follows:''.

(2) Amendatory instruction 12 for § 410.79, lines 10 and 11 (12.b.), the instruction ''Revising paragraphs (c)(1)(ii) and (e)(3)(iii)(c);'' is corrected to read ''Revising paragraphs (c)(1)(ii), (d) introductory text, and (e)(3)(iii)(c);''.

87. On page 50008, second column, amendatory instruction 14 for § 414.84, lines 8 and 9 (14.d.), the instruction ''Revising newly redesignated paragraph (c)(4)(ii)'' is corrected to read ''Revising newly redesignated paragraphs (c)(4)(ii) and (c)(5)''.

88. On page 50009, beginning at the bottom of the third column and continuing to the second column on page 50010, second amendatory instruction 19 for § 414.1305 and its associated regulations text is removed.

89. On page 50014, second column, amendatory instruction 31 for § 424.205, the instruction ''Section 424.205 amended by revising paragraphs (c)(10), (f)(2)(i), and (f)(5) to read as follows:'' is corrected to read ''Section 424.205 is amended by revising paragraphs (c)(10), (f)(1)(ii), (f)(2)(i), and (f)(5) to read as follows:''.

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Diseases, Health facilities, Health professions, Medical devices, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 410

Diseases, Health facilities, Health professions, Laboratories, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 414

Administrative practice and procedure, Biologics, Diseases, Drugs, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 425

Administrative practice and procedure, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 427

Administrative practice and procedure, Biologics, Medicare, Prescription drugs.

42 CFR Part 428

Administrative practice and procedure, Biologics, Medicare, Prescription drugs.

42 CFR Part 512

Administrative practice and procedure, Health care, Health facilities, Health insurance, Intergovernmental relations, Medicare, Penalties, Privacy, Reporting and recordkeeping requirements.

Accordingly, 42 CFR chapter IV is corrected by making the following correcting amendments to parts 405, 410, 414, 425, 427, 428, and 512:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

■ 1. The authority citation for part 405 continues to read as follows:

Authority: 42 U.S.C. 263a, 405(a), 1302, 1320b–12, 1395x, 1395y(a), 1395ff, 1395hh, 1395kk, 1395rr, and 1395ww(k).

■ 2. Section 405.2463 is amended by revising paragraph (b)(3) introductory text to read as follows:

§ 405.2463 What constitutes a visit.

* * * * *

(b) * * *

(3) *Visit-Mental health.* A mental health visit is a face-to-face encounter or an encounter furnished using interactive, real-time, audio and video telecommunications technology or audio-only interactions in cases where the patient is not capable of, or does not consent to, the use of video technology for the purposes of diagnosis, evaluation or treatment of a mental health disorder. Not before October 1, 2025, in the case of mental health visits furnished via

interactive, real-time, audio and video telecommunications technology or audio-only interactions, within 6 months prior to the furnishing of the telecommunications service and that an in-person mental health service (without the use of telecommunications technology) must be provided at least every 12 months while the beneficiary is receiving services furnished via telecommunications technology for diagnosis, evaluation, or treatment of mental health disorders, unless, for a particular 12-month period, the physician or practitioner and patient agree that the risks and burdens outweigh the benefits associated with furnishing the in-person item or service, and the practitioner documents the reasons for this decision in the patient's medical record, between an RHC or FQHC patient and one of the following:

* * * * *

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

■ 3. The authority citation for part 410 continues to read as follows:

Authority: 42 U.S.C. 1302, 1395m, 1395hh, 1395rr, and 1395ddd.

■ 4. Section 410.26 is amended by revising paragraph (a)(2) to read as follows:

§ 410.26 Services and supplies incident to a physician's professional services: Conditions.

(a) * * *

(2) *Direct supervision* means the level of supervision by the physician (or other practitioner) of auxiliary personnel as defined in § 410.32(b)(3)(ii). The presence of the physician (or other practitioner) required for direct supervision may include virtual presence through audio/video real-time communications technology (excluding audio-only) for services without a 010 or 090 global surgery indicator.

* * * * *

■ 5. Section 410.79 is amended by adding paragraph (d)(1)(i) to read as follows:

§ 410.79 Medicare Diabetes Prevention Program expanded model: Conditions of coverage.

* * * * *

(d) * * *

(1) * * *

(i) The curriculum furnished during the make-up session must address the same CDC-approved DPP curriculum topic as the regularly scheduled session that the beneficiary missed;

* * * * *

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

■ 6. The authority citation for part 414 continues to read as follows:

Authority: 42 U.S.C. 1302, 1395hh, and 1395rr(b)(l).

■ 7. Section 414.84 is amended by revising paragraph (c)(5) to read as follows:

§ 414.84 Payment for MDPP services.

* * * * *

(c) * * *

(5) Current Procedural Terminology (CPT) Modifier 76 (repeat services by same physician) must be appended to any claim for G9886, G9887, or G9871 to identify a MDPP make-up session that was held on the same day as a regularly scheduled MDPP session.

* * * * *

■ 8. Section 414.1305 is amended by—

■ a. Revising the introductory text for the definitions of ''Attribution-eligible beneficiary'', ''Covered professional service attribution-eligible beneficiary'', and ''E/M attribution-eligible beneficiary''.

■ b. Revising the definitions of ''QP patient count threshold'' and ''QP payment amount threshold''.

The revisions read as follows:

§ 414.1305 Definitions.

* * * * *

Attribution-eligible beneficiary means, effective through the 2025 QP Performance Period, a beneficiary who, during the QP Performance Period:

* * * * *

Covered professional service attribution-eligible beneficiary means, effective starting with the 2026 QP Performance Period, a beneficiary who, during the QP Performance Period:

* * * * *

E/M attribution-eligible beneficiary means, effective starting with the 2026 QP Performance Period, a beneficiary who, during the QP Performance Period:

* * * * *

QP patient count threshold means the minimum threshold score specified in § 414.1430(a)(3) and (b)(3) that an eligible clinician must attain through a patient count methodology described in §§ 414.1435(b), (d), or (f) and 414.1440(c) to become a QP for a year.

QP payment amount threshold means the minimum threshold score specified in § 414.1430(a)(1) and (b)(1) that an eligible clinician must attain through the payment amount methodology described in §§ 414.1435(a), (c), or (e) and 414.1440(b) to become a QP for a year.

* * * * *

■ 9. Section 414.1380 is amended by:

■ a. Revising paragraphs (b)(1)(iii) and (vi) and (b)(2)(iii) introductory text; and

■ b. Adding paragraph (b)(2)(vi).

The revisions and addition read as follows:

§ 414.1380 Scoring.

* * * * *

(b) * * *

(1) * * *

(iii) *Minimum case requirements.* Except as otherwise specified in the MIPS final list of quality measures described in § 414.1330(a)(1), the minimum case requirement is 20 cases.

* * * * *

(vi) *Improvement scoring.* Improvement scoring is available to MIPS eligible clinicians that demonstrate improvement in performance in the current MIPS performance period compared to performance in the performance period immediately prior to the current MIPS performance period based on measure achievement points.

(A) Improvement scoring is available when the data sufficiency standard is met, which means when data are available and a MIPS eligible clinician has a quality performance category achievement percent score for the previous performance period and the current performance period.

(*1*) Data must be comparable to meet the requirement of data sufficiency which means that the quality performance category achievement percent score is available for the current performance period and the previous performance period and quality performance category achievement percent scores can be compared.

(*2*) Quality performance category achievement percent scores are comparable when submissions are received from the same identifier for two consecutive performance periods.

(*3*) If the identifier is not the same for two consecutive performance periods, then for individual submissions, the comparable quality performance category achievement percent score is the highest available quality performance category achievement percent score associated with the final score from the prior performance period that will be used for payment for the individual. For group, virtual group, and APM Entity submissions, the comparable quality performance category achievement percent score is the average of the quality performance category achievement percent score

associated with the final score from the prior performance period that will be used for payment for each of the individuals in the group.

(*4*) Improvement scoring is not available for clinicians who were scored under facility-based measurement in the performance period immediately prior to the current MIPS performance period.

(B) The improvement percent score may not total more than 10 percentage points.

(C) The improvement percent score is assessed at the performance category level for the quality performance category and included in the calculation of the quality performance category score as described in paragraph (b)(1)(vii) of this section.

(*1*) The improvement percent score is awarded based on the rate of increase in the quality performance category achievement percent score of MIPS eligible clinicians from the previous performance period to the current performance period.

(*2*) An improvement percent score is calculated by dividing the increase in the quality performance category achievement percent score from the prior performance period to the current performance period by the prior performance period quality performance category achievement percent score multiplied by 10 percent.

(*3*) An improvement percent score cannot be lower than zero percentage points.

(*4*) Beginning with the CY 2018 performance period/2020 MIPS payment year, we will assume a quality performance category achievement percent score of 30 percent if a MIPS eligible clinician earned a quality performance category score less than or equal to 30 percent in the previous year.

(*5*) The improvement percent score is zero if the MIPS eligible clinician did not fully participate in the quality performance category for the current performance period.

(D) For the purpose of improvement scoring methodology, the term ''quality performance category achievement percent score'' means the total measure achievement points divided by the total available measure achievement points, without consideration of measure bonus points or improvement percent score.

(E) For the purpose of improvement scoring methodology, the term ''improvement percent score'' means the score that represents improvement for the purposes of calculating the quality performance category score as described in paragraph (b)(1)(vii) of this section.

(F) For the purpose of improvement scoring methodology, the term ''fully participate'' means the MIPS eligible clinician met all requirements in §§ 414.1335 and 414.1340.

* * * * *

(2) * * *

(iii) Excluding cost measure scores calculated for informational-only purposes as provided in paragraph (b)(2)(vi) of this section, the cost performance category score is the sum of the following, not to exceed 100 percent:

* * * * *

(vi) Beginning with the 2028 MIPS payment year, CMS calculates a score for each new cost measure in accordance with the scoring policy set forth in this paragraph (b)(2) for informational-only purposes during the measure's informational-only feedback period.

(A) For the purposes of this paragraph (b)(2)(vi), the following terms have the following meanings.

(*1*) *New cost measure* means a measure that CMS has newly specified for the MIPS cost performance category for a performance period under § 414.1350 beginning with the 2028 MIPS payment year. This term excludes any cost measures that CMS has specified for the MIPS cost performance category prior to the 2028 MIPS payment year or CMS modifies at any time.

(*2*) *Informational-only feedback period* means a 2-year period beginning with the first day of the first performance period and ending with the final day of the second performance period for the two applicable MIPS payment years for which CMS initially has specified the new cost measure.

(B) During a new cost measure's informational-only feedback period, CMS does not include any scores for the new cost measure calculated for informational-only purposes under this paragraph (b)(2)(vi) in CMS's calculation of a MIPS eligible clinician's cost performance category score under paragraph (b)(2)(iii) of this section or a MIPS eligible clinician's MIPS final score under paragraph (c) of this section.

(C) During a new cost measure's informational-only feedback period, CMS confidentially provides each MIPS eligible clinician their measure score under this paragraph (b)(2)(vi) for informational-only purposes. CMS also provides performance feedback to the MIPS eligible clinician in accordance with section 1848(q)(12) of the Act.

(D) Upon completion of a new cost measure's informational-only feedback period, CMS includes its calculation of any scores for the cost measure in CMS's calculation of a MIPS eligible clinician's cost performance category score under paragraph (b)(2)(iii) of this section and a MIPS eligible clinician's MIPS final score under paragraph (c) of this section.

* * * * *

■ 10. Section 414.1435 is amended by—

■ a. Removing paragraphs (2) and (3) following paragraph (b)(4); and

■ b. Revising paragraph (h).

The revision reads as follows:

§ 414.1435 Qualifying APM participant determination: Medicare option.

* * * * *

(h) *Use of methods.* (1) CMS calculates Threshold Scores for an APM Entity or eligible clinician as provided by § 414.1425(b) under either of the following:

(i) For QP status determination through QP performance period 2025, both the payment amount and patient count methods described in paragraphs (a) and (b) of this section for each QP Performance Period.

(ii) For QP status determination starting with QP performance period 2026, all of the methods described in paragraphs (c) through (f) of this section for each QP Performance Period.

(2) CMS assigns to the eligible clinicians included in the APM Entity group or to the eligible clinician the score that results in the greater QP status. QP status is greater than Partial QP status, and Partial QP status is greater than no QP status.

PART 425—MEDICARE SHARED SAVINGS PROGRAM

■ 11. The authority citation for part 425 continues to read as follows:

Authority: 42 U.S.C. 1302, 1306, 1395hh, and 1395jjj.

■ 12. Section 425.512 is amended by revising paragraphs (c)(3)(ii) through (iv) to read as follows:

§ 425.512 Determining the ACO quality performance standard for performance years beginning on or after January 1, 2021.

* * * * *

(c) * * *

(3) * * *

(ii) For performance year 2023, if the ACO reports quality data via the APP and meets data completeness and case minimum requirements, CMS will use the higher of the ACO's quality score or the equivalent of the 30th percentile MIPS Quality performance category score across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring, for the relevant performance year.

(iii) For performance year 2024, if the ACO reports quality data via the APP

and meets the data completeness requirement at § 414.1340 of this subchapter and receives a MIPS Quality performance category score under § 414.1380(b)(1) of this subchapter, CMS will use the higher of the ACO's quality score or the equivalent of the 40th percentile MIPS Quality performance category score across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring, for the relevant performance year.

(iv) For performance year 2025 and subsequent performance years, if the ACO reports the APP Plus quality measure set and meets the data completeness requirement at § 414.1340 of this subchapter and receives a MIPS Quality performance category score under § 414.1380(b)(1) of this subchapter, CMS will use the higher of the ACO's quality score or the equivalent of the 40th percentile MIPS Quality performance category score across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring, for the relevant performance year.

* * * * *

PART 427—MEDICARE PART B DRUG INFLATION REBATE PROGRAM

■ 13. The authority citation for part 427 continues to read as follows:

Authority: 42 U.S.C. 1395w–3a(i), 1302, and 1395hh.

■ 14. Section 427.502 is amended by revising paragraphs (c)(1)(ii) and (c)(2)(ii) to read as follows:

§ 427.502 Rebate Reports for applicable calendar quarters in calendar years 2023 and 2024.

* * * * *

(c) * * *

(1) * * *

(ii) For this single Preliminary Rebate Report for the applicable calendar quarters in calendar year 2023, the Suggestion of Error period as set forth in § 427.503 will be 30 calendar days.

* * * * *

(2) * * *

(ii) Within 9 months after issuance of the single Rebate Report, CMS will perform one regular reconciliation for the applicable calendar quarters in calendar year 2024 in order to include revisions to the information used, determined under § 427.501(b)(1), to calculate the rebate amount. Such reconciliation will be as determined under § 427.501(d) inclusive of a preliminary reconciliation and a report with the reconciled rebate amount.

* * * * *

PART 428—MEDICARE PART D DRUG INFLATION REBATE PROGRAM

■ 15. The authority citation for part 428 continues to read as follows:

Authority: 42 U.S.C. 1395w–114b, 1302, and 1395hh.

§ 428.402 Rebate Reports for applicable periods beginning October 1, 2022, and October 1, 2023.

■ 16. Section 428.402 is amended by revising paragraphs (c)(1)(ii) and (c)(2)(ii) to read as follows:

* * * * *

(c) * * *

(1) * * *

(ii) The rebate amount will be reconciled within 21 months after the Rebate Report set forth in this paragraph (c)(1) is issued to include the information set forth in § 428.401(d)(1)(i)(A) through (G).

* * * * *

(c) * * *

(2) * * *

(ii) The rebate amount will be reconciled within 9 months after the Rebate Report and within 33 months after the Rebate Report specified in this paragraph (c)(2) is issued to include the information determined under § 428.401(d)(1)(i)(A) through (G).

PART 512—STANDARD PROVISIONS FOR MANDATORY INNOVATION CENTER MODELS AND SPECIFIC PROVISIONS FOR CERTAIN MODELS

■ 17. The authority citation for part 512 continues to read as follows:

Authority: 42 U.S.C. 1302, 1315a, and 1395hh.

■ 18. Add an undesignated center heading before § 512.700 to read as follows:

General

■ 19. Section 512.705 is amended by revising the definition of ''ASM payment year'' to read as follows:

§ 512.705 Definitions.

* * * * *

ASM payment year means a calendar year in which CMS applies the ASM payment multiplier to Medicare Part B payments for covered professional services based on the final score achieved by that ASM participant for the ASM performance year 2 years prior.

* * * * *

■ 20. Section 512.710 is amended by revising paragraphs (f)(1) introductory text and paragraph (g)(1)(ii) to read as follows:

§ 512.710 Participant eligibility and selection.

* * * * *

(f) * * *

(1) *Exclusions.* CMS excludes from the selection of CBSAs and metropolitan divisions applicable areas that meet any of criteria described in paragraph (f)(1)(i) or (ii) of this section.

* * * * *

(g) * * *

(1) * * *

(ii) *Final ASM participants.* CMS identifies the final ASM participants selected for participation starting in the 2027 ASM performance year/2029 ASM payment year by confirming that the preliminarily eligible ASM participants identified under paragraph (g)(1)(i) of this section meet the ASM participant eligibility criteria using applicable data from CY 2025. The clinicians selected as ASM participants starting in the 2027 ASM performance year/2029 ASM payment year is made public in a form and manner determined by CMS.

* * * * *

■ 21. Add an undesignated center heading before § 512.715 to read as follows:

Performance Categories and Scoring

■ 22. Section 512.725 is amended by revising paragraph (b)(1) to read as follows:

§ 512.725 Quality ASM performance category.

* * * * *

(b) * * *

(1) Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure for the Merit-based Incentive Payment System (MIPS Q492) with minor modification to the measure specifications to attribute solely to ASM participants who have had one (1) or more visits with the beneficiary.

* * * * *

§ 512.730 [Amended]

■ 23. Section 512.730 is amended by redesignating the second paragraph (e)(1)(i) as paragraph (e)(1)(ii).

■ 24. Section 512.745 is amended by revising paragraphs (a)(3)(i) and (a)(4)(i) to read as follows:

§ 512.745 Final scoring.

(a) * * *

(3) * * *

(i) The complex patient scoring adjustment is limited to ASM participants with a risk indicator at or above the risk indicator calculated median for their ASM cohort. To determine the median for the respective

risk indicator (HCC and dual eligible proportion) for each ASM cohort, risk indicators associated to an ASM participant in the corresponding ASM cohort from the calendar year preceding the applicable ASM performance year, for all ASM participants within an ASM cohort who meet the data submission requirements for the quality ASM performance category at § 512.720(a)(1)(i) are used.

* * * * *

(4) * * *

(i) *Scoring adjustment for an ASM participant that is in a small practice and is not a solo practitioner.* CMS adds 10 points to the final score of an ASM participant that meets all of the following:

(A) Is in a small practice.

(B) Is not a solo practitioner.

(C) Meets the requirements to receive a final score greater than zero as described in paragraph (a)(2)(i) of this section for an applicable ASM performance year.

* * * * *

■ 25. Add an undesignated heading before § 512.750 to read as follows:

Payment and Timely Error Notice Process

■ 26. Section 512.750 is amended by—

■ a. Revising paragraphs (c)(1)(i); and

■ b. Redesignating the second paragraph (f)(2) as paragraph (f)(2)(ii).

The revision reads as follows:

§ 512.750 Payment adjustment.

* * * * *

(c) * * *

(1) * * *

(i) *ASM risk level.* CMS sets an ASM risk level that is the magnitude of the maximum downside and upside risk to which an ASM participant is subject to during an ASM payment year.

* * * * *

■ 27. Add an undesignated center heading before § 512.760 to read as follows:

Data Sharing, Waivers, Safe Harbor, and Compliance

■ 28. Section 512.775 is amended by revising paragraphs (a), (b)(2) introductory text, and (b)(3)(i) and (ii) to read as follows:

§ 512.775 Medicare program waivers.

(a) *Medicare payment waivers.* Unless otherwise specified in § 512.710(a)(2), CMS waives the requirements of section 1848(q) of the Act, and its implementing regulations, for an ASM participant for each ASM performance year that the ASM participant meets the ASM eligibility criteria set forth in § 512.710(b).

(b) * * *

(2) *Waiver of the originating site requirements.* Except for the originating site requirements for a face-to-face encounter for home health certification, CMS waives the originating site requirements under section 1834(m)(4)(C)(*ii*)(*I*) through (VIII) of the Act for episodes to permit a telehealth visit to originate in the beneficiary's home or place of residence solely for services that—

* * * * *

(3) * * *

(i) Under section 1834(m)(2)(B) of the Act so that the facility fee normally paid by Medicare to an originating site for a telehealth service is not paid if the service is originated in the beneficiary's home or place of residence.

(ii) Under section 1834(m)(2)(A) of the Act to allow the distant site payment for telehealth home visit HCPCS codes unique to ASM.

* * * * *

Liesl I. Fowler,

Executive Secretary to the Department, Department of Health and Human Services.

[FR Doc. 2026–04797 Filed 3–11–26; 8:45 am]

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DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 648

[260225–0057]

RTID 0648–XF357

Fisheries of the Northeastern United States; Atlantic Deep-Sea Red Crab Fishery; 2026 Atlantic Deep-Sea Red Crab Specifications

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Final rule.

SUMMARY: NMFS is finalizing specifications for the 2026 Atlantic deep-sea red crab fishery, including an annual catch limit and total allowable landings limit. This action is necessary to fully implement previously projected allowable red crab harvest levels that will prevent overfishing and allow harvesting of optimum yield. This action is intended to establish the allowable 2026 harvest levels, consistent with the Atlantic Deep-Sea Red Crab Fishery Management Plan.

DATES: Effective April 13, 2026, through February 28, 2027.

FOR FURTHER INFORMATION CONTACT: Allison Murphy, Fishery Policy Analyst, (978) 281–9122.

SUPPLEMENTARY INFORMATION: The Atlantic deep-sea red crab fishery is managed by the New England Fishery Management Council (Council). The Atlantic Deep-Sea Red Crab Fishery Management Plan (FMP) includes a specification process that requires the Council to recommend an acceptable biological catch (ABC), an annual catch limit (ACL), and total allowable landings (TAL) every 4 years. Collectively, these are the red crab specifications. Prior to the start of fishing year 2024, the Council recommended specifications for the 2024–2027 fishing years (table 1).

TABLE 1—COUNCIL-APPROVED 2024–2027 RED CRAB SPECIFICATIONS

	Metric tons	Millions of pounds (lb)
Acceptable Biological Catch	2,000	4.41
Annual Catch Limit	2,000	4.41
Total Allowable Landings	2,000	4.41

On February 8, 2024, NMFS published a final rule implementing the Council-recommended specifications for the 2024 fishing year, effective through February 28, 2025, and projecting the fishery's specifications for 2025 through