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Healthcare Alert

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CMS proposes efficiency adjustment to the valuation of physician work RVUs

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CMS proposes a 2.5% payment reduction in 2026, reflecting assumed gains in physician efficiency for non-time-based procedures.

What's the impact?

- CMS proposes to reduce the intraservice portion of physician time and the work RVU for all non-time-based services.
- Reductions to work RVUs will ripple through compensation arrangements that are tied to physician work RVUs.
- Changes to the economics of physician arrangements warrants a review of existing contracts to evaluate the impact of the efficiency adjustment and determine the need for amendments.

CMS is proposing a 2.5% reduction to the work RVUs for all non-time-based physician services in the 2026 Medicare Physician Fee Schedule, aiming to reflect increased efficiencies in procedures, radiology, and diagnostics. This change could significantly impact physician compensation models and contractual arrangements tied to work RVUs, especially for specialists whose

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productivity is measured by these metrics. Stakeholders are advised to review existing agreements and prepare for potential amendments ahead of these significant changes.

What are work RVUs?

Under the Medicare Physician Fee Schedule (PFS), every billable service is assigned three separate relative value units (RVUs): (i) a work RVU, intended to capture the physician's time, technical skill, mental effort, physical effort, and risk of patient complications that are inherent in furnishing the service; (ii) a practice expense RVU, reflecting overhead costs such as staff, supplies and equipment; and (iii) a malpractice RVU, reflecting professional liability costs. After adjustment by geographic practice cost indices and conversion to dollars through the annual conversion factor, the work RVU component typically accounts for more than 50 percent of the resulting payment rate for most professional services. Because work RVUs purport to isolate the physician's personal effort, they have become a metric of choice in calculating physician compensation in employment agreements, professional services agreements, independent contractor arrangements, and value-based enterprise models.

CMS's proposed changes to Valuation of Work RVUs

The Centers for Medicare & Medicaid Services (CMS) proposed CY 2026 PFS, includes an "efficiency adjustment" that would automatically reduce the intraservice portion of physician time and the work RVU for all non-time-based services. The efficiency adjustment would apply to procedural, imaging and diagnostic test codes, and any other code that is not time-based. Time-based codes such as Evaluation and Management (E/M) visits, care-management services, behavioral health services, telehealth services, and maternity codes with a global period are excluded.

In support of this proposal, CMS notes that it has been concerned for several years that the PFS has not accounted for the efficiencies gained in work RVUs for non-time-based services, such as codes describing procedures, radiology services, and diagnostic tests, that have become more efficient as they have become more common, professionals have gained more experience, and technology has improved.

To calculate the efficiency adjustment, CMS proposes to sum the preceding five years of the Medicare Economic Index (MEI) productivity adjustment for and apply that percentage reduction to the intraservice potion of physician time and work RVUs. For CY 2026, the five-year look-back produces the proposed efficiency adjustment of -2.5 percent.

Potential impact on physician compensation tied to work RVUs

Many physician and medical group contracts provide productivity bonuses or establish base salary floors and ceilings by reference to personally performed work RVUs. For physicians, such as radiologists and some surgical specialists, whose service mix is dominated by procedures, imaging, diagnostic tests, and other non-time-based codes, the proposed 2.5 percent reduction in the underlying work RVU values would mechanically lower measured productivity even if volume and clinical effort remain unchanged. Conversely, physicians in primary care, behavioral health, and other time-based specialties would likely experience an increase in RVUs. Where compensation formulas multiply total work RVUs by a fixed dollar amount, physician and medical group take-home pay could decline, or increase, in lockstep.

Physician arrangements governed by the federal Stark Law and Anti-Kickback Statute often rely on "commercially reasonable" and "fair market value" benchmarks (commonly MGMA or AAMC survey data) that likewise incorporate CMS work RVU values. When those benchmarks are next published, the embedded 2.5 percent downward shift may alter the percentile positioning of existing compensation rates, potentially raising compliance questions.

Recommended next steps for employment and professional services agreements

Given these significant changes, healthcare organizations and medical providers that rely on work RVU methodology for compensation arrangements should take the following steps:

- Inventory all agreements that reference "work RVUs," "wRVUs," or similar metrics, especially productivity-based employment contracts, independent contractor agreements, medical directorships, and other physician compensation arrangements.
- Model the anticipated change in measured productivity for each affected physician using historical CPT distribution data and a 2.5 percent reduction to non-time-based code work RVUs.
- Determine whether contracts contain automatic "evergreen" adoption of CMS code valuations or whether the parties must affirmatively agree to incorporate updates. Identify contracts where you or your organization could be financially disadvantaged or advantaged once new benchmarks are published.
- Evaluate whether amendments are necessary to:
  - Adjust the per-work RVU compensation rate to preserve intended economics;
  - Carve out the CMS efficiency adjustment from productivity calculations; or
  - Replace pure work RVU metrics with blended productivity/quality measures that are less sensitive to valuation changes.

- For agreements subject to Stark Law and Anti-Kickback Statute compliance, confirm that any revised compensation remains commercially reasonable and within contemporaneous fair market value ranges after accounting for the efficiency adjustment.

Stakeholders should begin impact analyses now so they can participate meaningfully in the rulemaking process and be positioned to renegotiate contracts well before the January 1, 2026, effective date.

Proposed changes to the PFS beyond the efficiency adjustment

The proposed PFS is a major proposed rule and addresses a wide range of topics related to Medicare Part B payment policies. Beyond the work RVU efficiency adjustment, we highlight the following important proposals related to Medicare's services and payments to physicians that are also included in the proposed PFS:

- Conversion factor—The conversion factor is the standardized dollar amount used to convert RVUs into payment rates. Beginning in 2026, CMS proposes that there will be two separate conversion factors: one for qualifying alternative payment model (APM) participants and one for physicians and practitioners who are not APM participants. The proposed conversion factor of $33.59 for qualifying APM participants represents a projected increase of $1.24 (+3.8%) from the current conversion factor, while the proposed conversion factor of $33.42 for those not participating in an APM represents a projected increase of $1.07 (+3.3%) from the current conversion factor.
- Telehealth services—CMS is proposing to permanently adopt a definition of "direct supervision" that allows a physician or supervising practitioner to provide supervision through real-time interactive audio and visual communications (excluding audio-only). CMS is also proposing to remove frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations.
- Behavioral health services—The proposed PFS includes a proposal to create optional add-on codes for Advanced Primary Care Management (APCM) services that would facilitate the provision of complementary behavioral health integration (BHI) or psychiatric Collaborative Care Model (CoCM) services. The services of the proposed add-on codes are meant to be directly comparable to existing CoCM and BHI codes and would be billable when the APCM base code is reported by the same practitioner in the same month.

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