AAFP

AMERICAN ACADEMY of FAMILY PHYSICIANS

Summary of the CY 2026 Medicare Physician Fee Schedule Final Rule

The CY 2026 Medicare Physician Fee Schedule and Quality Payment Program final rule was released on October 31, 2025. CMS released accompanying fact sheets on the for the MPFS and Medicare Shared Savings Program. The provisions in the final rule will take effect on January 1, 2026, except where otherwise specified. The AAFP provided comprehensive comments on the proposed regulation.

Policy	Summary	Impact	AAFP Recommendations
Conversion Factor	As statutorily required, in 2026 the MPFS will feature two conversion factors: one for qualifying alternative payment model participants (the qualifying APM CF) and one for all other clinicians (the non-qualifying APM CF). The CY 2026 qualifying APM CF of $33.57 represents a projected increase of $1.22 (+3.77%) from the current CF of $32.35. The CY 2026 non-qualifying APM CF of $33.40 represents a projected increase of $1.05 (+3.26%) from the current conversion factor of $32.35. The increase to both conversion factors is due to three factors: • The 2.5% increase to both CFs attributable to H.R. 1; • The statutorily required update of 0.75% for the APM CF and 0.25% to the non-APM CF; • An additional 0.49% increase is necessary to account for proposed changes in RVUs for some services (i.e., a positive budget-neutrality adjustment).	Positive	AAFP supported the increase to the conversion factor as well as the individual policies that contributed to the increase. We will continue to advocate for additional reforms, like an annual inflationary adjustment.
Total Allowed Charges by Family Physicians	CMS estimates that the impact on total allowed charges by family physicians will be a positive 3% total in 2026. However, this represents a positive 6% for non-facility FPs and a negative 9% for facility-based FPs largely due to updates to the practice expense methodology (discussed later). • Note: of the $5.4 billion in estimated allowed charges for services billed by FPs in 2026, $4.3 billion is expected to be billed by non-facility FPs, meaning	Positive	N/A

	most services billed by FPs will benefit from the change in the practice expense methodology in 2026. • Note: these estimates do not include the 2.5% increase to the CFs attributable to H.R. 1.		
Practice Expense (PE) RVU methodology	CMS will not implement the PE/hour data or cost shares from the AMA's recent Physician Practice Information and Clinician Practice Information Survey data for 2026 rate setting due to several limitations with the data as described in the proposed rule. Instead, CMS will continue to rely primarily on the AMA's Physician Practice Information (PPI) Survey data from 2008 and maintain current PE/hour data and cost shares for 2026 rate setting. Specifically, CMS's concerns focused on small sample sizes and sampling variation, low response rates and representativeness, potential measurement error, and incomplete data submission.	Positive	The AAFP was disappointed that CMS did not find the more recent AMA data satisfactory. However, the AAFP is heartened that CMS remains interested in further information that could help inform updates to the PE/HR data or cost shares through future rulemaking, and the AAFP continues to encourage CMS to work with the AMA, the AAFP, and others to identify and collect the necessary data in time for rate setting in 2027.
	However, CMS is implementing significant updates to its PE methodology to better reflect current clinical practice. Specifically, CMS will recognize greater indirect costs for services when provided in office-based (i.e., non-facility) settings compared to facility settings. CMS will exclude maternity care services from this policy. This is the policy driving the disparate impact to facility versus non-facility settings	Positive	In general, the AAFP was supportive of CMS's proposal and recommended CMS exclude maternity care services, which it did. The AAFP also recommended CMS to exclude rural physicians, but CMS chose not to do so.
	CMS also plans to use hospital data (i.e., from the Medicare Outpatient Prospective Payment System (OPPS)) to set relative rates and inform its costs assumptions for some technical services paid under PFS, such as radiation treatment services and some remote monitoring services.	Positive	The AAFP supported CMS's proposal to use OPPS cost data in valuing some of the codes for remote monitoring services, pending further RUC review of the codes in January 2028.
Efficiency Adjustments	CMS will begin applying an efficiency adjustment to codes except time-based codes, including E/M visits. Over time, this would improve the valuation of services for most FPs, as the conversion factor would increase (as procedural codes are	Positive	The AAFP supported CMS's proposal to apply a 2.5% efficiency adjustment to the intra-service time and physician work of most codes as a directionally appropriate

	adjusted downward) while the E/M RVU values would not decrease.		correction to observed distortions in the Medicare physician fee schedule. The AAFP also supported CMS's intent to exclude E/M services from this adjustment.
Valuation	CMS will continue to consider alternatives to AMA survey data when valuing codes due to the low-response rate to surveys, noting that studies show CMS overvalues non-time-based services. CMS is seeking information on alternative sources that could be used to more accurately value services and help address some of "these historic distortions."	Positive	The AAFP agrees CMS should continue to seek and use empiric, accurate time data sources to better inform its valuation of physician services under the Medicare physician fee schedule.
Primary Care Exception	CMS did not propose any expansion of the codes included under the Primary Care Exception. Accordingly, no changes will be implemented for 2026.	Concerning	The AAFP urged the agency to revisit this policy and the responses to its 2024 request for information. The AAFP will continue to press for this change in the 2027 proposed rule.
Telehealth	CMS will permanently adopt a definition of direct supervision that allows "immediate availability" of the supervising practitioner to include using audio/video real-time communications technology — though not audio-only — for an expanded set of services.	Positive	The AAFP supported this policy.
	CMS will permanently adopt the current policy that allows teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings.	Positive	CMS did not propose extending this policy in the proposed rule, but in response to comments, including those submitted by the AAFP, the agency has reversed course and will make this flexibility permanent.
G2211	CMS will allow G2211 to be billed as an add-on code with home or residence evaluation and management services.	Positive	The AAFP supported this policy.
APCM	CMS will implement optional add-on codes for APCM services that facilitate providing complementary behavioral health integration (BHI) services by removing the time requirements of the existing BHI and collaborative care management services (CoCM).	Positive	The AAFP supported this policy.
	In the proposed rule, CMS issued an RFI on how they should consider cost-sharing for APCM services, particularly if they	Positive	AAFP submitted extensive comments in support of removing all cost-sharing from

	were to include preventive services within the APCM bundles. CMS indicates that it will consider the feedback it has received for future rulemaking.		APCM and remains hopeful the agency will act in future rulemaking.
Chronic Disease Management	CMS will retain HCPCS code G0136 which covers Social Determinants of Health (SDOH) risk assessments, following public comments opposing its proposed deletion. The code will remain on the Medicare Telehealth Services list and continue to be included in Annual Wellness Visit definitions. However, CMS will revise the code descriptor to specify its use for administering a standardized, evidence-based assessment of physical activity and nutrition, lasting 5–15 minutes and limited to once every six months.	Positive	The AAFP submitted comments urging CMS to retain HCPCS code G0136, While CMS's decision to revise the code descriptor to focus on physical activity and nutrition marks a shift from the scope of SDOH, we appreciate the retention of G0136 and will continue to advocate for comprehensive approaches to SDOH in future policy development.
	CMS will also expand Digital Mental Health Treatment (DMHT) payment to include FDA-authorized digital therapy for ADHD payable under G0552. All existing conditions of payment for G0552 still apply.	Positive	AAFP supported CMS's proposal to expand payment for FDA-authorized DMHT devices for ADHD, but warned that its effectiveness depends on addressing access, integration, and provider support challenges.
	In the proposed rule, CMS issued an RFI seeking input on how Medicare can better support services that address chronic disease management, social isolation, physical activity, and nutrition. The agency is seeking feedback on new codes for services like 'intensive lifestyle interventions', medically tailored meals, and FDA-authorized digital therapeutics to manage chronic disease. CMS is also seeking feedback on solutions to improve the uptake of the AWV and is requesting feedback on creating standalone codes for motivational interviewing and health coaches under physician supervision (if health coaches are classified as clinical staff).	Positive	AAFP submitted responses to CMS's RFIs on chronic disease management and Software as a Service, emphasizing the priorities and needs of family physicians throughout. CMS will consider public comments for possible future rulemaking.
Skin Substitutes	CMS will introduce a fixed-price reimbursement model for skin substitutes. This will replace the Average Sales Price (ASP) methodology with a standard rate of $125.38 per square	Positive	AAFP supported this policy.

	centimeter, regardless of product type or manufacturer in 2026. In future years, CMS will establish payment rates based on the three FDA categories of skin substitutes. This policy should result in significant savings as the ASP-based methodology, which allowed wide variation in payment rates—from $200 to over $3,000 per centemeter.		
RHCs/FQHCs	CMS will adopt Advanced Primary Care Management (APCM) add-on codes that will allow RHCs and FQHCs an easier billing process when providing Behavioral Health Integration (BHI) and Psychiatric Collaborative Care Model (CoCM) services.	Positive	AAFP supported this policy.
	CMS will unbundle HCPCS code G0071 and instead require RHCs and FQHCs that provide advanced primary care services through Remote Evaluation and Communication Technology-Based Services (CTBS) report the individual codes that comprise G0071.	Positive	AAFP supported this policy.
	CMS is finalizing a policy to pay for services that are established and paid under the PFS and designated as care management services as care coordination services for purposes of separate payment for RHCs and FQHCs.	Positive	AAFP supported this policy.
	For RHC and FQHC services requiring direct supervision, CMS is permanently adopting a definition of direct supervision that allows the physician or supervising practitioner to provide such supervision through real-time audio and visual interactive telecommunications (excluding audio-only).	Positive	AAFP supported this policy.
	CMS will continue to allow RHCs and FQHCs to report HCPCS code G2025 when billing for non-behavioral health visits provided via telecommunications technology (also referred to as “medical visit services”) through December 31, 2026. This would be a continuation of the payment methodology used during the COVID-19 public health emergency.	Positive	While AAFP supported an alternative payment methodology for RHCs and FQHCs, this policy change will allow RHCs and FQHCs to continue to provide non-behavioral telehealth services through 2026.

MSSP	CMS will reduce the number of years an MSSP ACO can participate in a one-sided model of the BASIC track from seven years to five years under the ACO's first agreement period. This change will be applicable for agreement periods beginning on or after January 1, 2027, and is intended to encourage participation in two-sided risk models.	Positive	AAFP supported this policy and specifically advocated for CMS to make it apply to agreements that begin in 2027 or later, rather than those that begin in 2026.
	CMS will remove the "health equity adjustment" applied to ACO's quality score beginning in 2026 instead of 2025 as proposed. CMS will also rename the "health equity benchmark adjustment" to "population adjustment."	Negative	The AAFP advocated against the removal of the health equity adjustment, noting that while there may be elements of the adjustment that seem to overlap with the eCQM/MIPS CQM reporting incentive and Complex Organization Adjustment, the health equity adjustment is unique in that it is also available to ACOs that report Medicare CQMs.
	CMS will also implement changes to the APM Payment Pathway (APP) Plus quality measure set to align with other quality measure changes proposed elsewhere in the rule, including removing the measure related to screening for SDOH.	Positive	The AAFP did not oppose removal of these measures given our concerns regarding lack of health IT capabilities and interoperability, administrative burden, and lack of capacity or availability of needed resources in many communities. However, AAFP expressed the importance of identifying and addressing health-related social needs.
Ambulatory Specialty Model	CMMI is implementing a new Ambulatory Specialty Model that will run from January 1, 2027, through December 31, 2031. It will test whether adjusting payment for specialists will result in enhanced quality of care and reduced costs through more effective upstream management of chronic conditions. It will be a mandatory model focused on care provided by select specialists to beneficiaries with heart failure and low back pain. Family medicine is not among the specialties identified as participants. Participants will be incentivized to ensure their patients have a regular source of primary care.	Neutral	The AAFP expressed its support for CMMI's commitment to expanding accountable care participation to more specialists. The AAFP encouraged CMMI and CMS to continue partnering with other agencies and stakeholders to ensure there is a sustained focus on addressing the persistent and unresolved barriers to coordination between specialists and primary care, namely interoperability of health IT systems and limited data sharing.

Merit-based Incentive Payment System (MIPS)	CMS will maintain the performance threshold at 75 points through the 2028 performance year. Physicians will receive informational-only scoring feedback for new cost measures for two years before the measure contributes to the final score.	Positive	The AAFP supported CMS' efforts to provide program stability and predictability maintaining the same performance threshold through the 2028 performance year. The AAFP supported the inclusion of new cost measures as informational only for their first two years in the MIPS program.
MIPS Value Pathway (MVP) Subgroup Reporting	CMS will allow multispecialty small practices (15 or fewer eligible clinicians) to report MVPs as a group rather than requiring them to divide into subgroups. Beginning CY2026, multispecialty practices that do not have the small practice special status must register at the subgroup, individual, or APM Entity level.	Negative	While the AAFP supported CMS' proposal to provide flexibility to small multispecialty groups, the AAFP urged CMS to expand the policy to include instances where a subgroup would include fewer than 15 eligible clinicians, regardless of whether the group is designated a small practice. The AAFP also strongly opposed mandatory subgroup reporting for MVPs and urged CMS to retract its previously finalized policy.