February 12, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Recommendations for the Calendar Year (CY) 2027 Medicare Physician Fee Schedule (MPFS)

Dear Dr. Oz:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 128,000 family physicians and medical students across the country, I write to share recommendations for consideration as the Centers for Medicare and Medicaid Services (CMS) begins work on the calendar year (CY) 2027 Medicare Physician Fee Schedule (MPFS) proposed rule.

We appreciate CMS' responsiveness to our past input and the many ways in which CMS continues to update its policies to reflect its clearly stated belief in primary care as foundational to a high-performing health system, including the addition of the advanced primary care management codes, implementation of the efficiency adjustment, and practice expense methodologies. On behalf of family physicians who deliver the majority of primary care in the US, these policies are essential to the stabilization and future security of this much needed workforce, and they reflect an important shift toward a health system that prioritizes prevention, continuity, and whole person care rather than reactive treatment. We are grateful to CMS for these changes and for its continued efforts to strengthen the nation's primary care infrastructure at a moment when it is most needed to address chronic disease and improve long-term health outcomes rather than reactive, treatment-term health outcomes.

In sum, we are asking CMS to prioritize the following policies in the CY 2027 MPFS proposed rule:

- Modernize the primary care exception and resident supervision standards so that future physicians are trained first and foremost to prevent disease, manage chronic conditions, and keep Americans healthy,
- Remove barriers to utilization of Advanced Primary Care Management (APCM) codes including waiving patient co-pays and eliminating mandatory MIPS Value Pathway (MVP) reporting requirements, and
- Ensure payment reflects the increased demands of immunization counseling by making immunization counseling codes payable under Medicare.

Primary Care Exception

The AAFP appreciates CMS' request for information on primary care exception (PCE) reform in the CY 2025 MPFS proposed rule. The AAFP and many other stakeholders submitted

extensive comments in support of expanding the list of services included in the PCE. We are encouraged by this administration's focus on prevention and management of chronic disease and strongly urge you to implement these long-called-for reforms. **We believe that modernizing these resident supervision requirements will meaningfully improve Medicare beneficiaries' access to relationship-based, high-quality primary care services and help address the family physician workforce shortage that threatens the foundation of our health system.**

Specifically, we recommend CMS add the following services to the PCE list:

- level 4 and 5 office/outpatient evaluation and management (E/M) visits,
- evidence-based preventive services, and
- patient continuity and whole-person integration of care codes.

Background

Existing rules concerning the services of teaching physicians were created in large part by the CY 1996 MPFS in which the agency created a general requirement that teaching physicians be present during the key portion of the visit, otherwise the visit would not be eligible for payment.[i] However, the agency also recognized that applying this policy to payment in family medicine residency programs raised special concerns about the financial viability of these programs.[ii] Family medicine residents are assigned a panel of patients for whom they provide care throughout their training, and the agency noted that requirements for a teaching physicians' physical presence during all visits would undermine a resident's ability to develop patient-physician relationships that are essential for effective prevention and chronic disease management.[iii] The agency also noted that physical presence requirements for Part B payment would "unfairly deny reimbursement for the activities of teaching physicians in these programs and endanger the financial viability of these programs."[iv] Accordingly, the agency created an exception, which ultimately applied to all primary care rather than family medicine alone.

Currently, the PCE is limited to certain evaluation and management services of "lower and mid-level complexity" (as specified by CMS in program instructions).[v] Lower and mid-level complexity codes that can be furnished under the PCE are specified in Section 100 of Chapter 12 of the Medicare Claims Processing Manual, which limits the PCE to level 1-3 E/M codes and annual wellness visit codes for new and established patients despite the increasing prevalence and complexity of chronic disease in the Medicare population.

Since its creation, the PCE has provided invaluable experience for applicable medical residents, expanded patient access to primary care, and improved relational continuity of the patient and primary care physician in teaching centers. In the 2025 MPFS proposed rule, CMS stated the PCE "broadens opportunities for teaching physicians to involve residents in furnishing services … and promote safe, high-quality patient care."[vi] We agree: the PCE is an integral element that allows teaching physicians to provide the experiences necessary for residents to become independent, prevention-focused family physicians who provide safe, comprehensive, quality care. Practice patterns imprinted during residency training persist

beyond graduate training and shape how physicians approach prevention, chronic illness, and patient trust throughout their careers.[vii]

Need for Reform

Historically, our members have reported that the absence of many high-value services on the PCE list discourages their integration into residency training, which has a negative impact on physician training, patient access, and longer-term outcomes. We also note below that the current PCE list unnecessarily limits teaching physicians, residents, and residency programs but does not meaningfully enhance patient safety. Expanding the list of services allowed under the PCE will also improve utilization of several under-utilized but high-value, prevention-focused services, which directly complements this administration's past and continued work to "move our country from a sick-care system to a true health care system."[viii]

1. The current PCE list perpetuates an arbitrary standard that is out of step with competency-based residency program training and inconsistent with billing standards for non-physicians with less clinical education and training.

The AAFP appreciates CMS' desire to protect Medicare beneficiaries by ensuring residents are not performing services that are beyond their capabilities. Historically, limiting the services that may be performed without the physical presence of the teaching physician was a reasonable method to achieve this goal. However, there are several reasons these limitations are no longer necessary or ineffectual:

- Residency programs are best suited to determine the appropriate level of supervision,
- Teaching physicians should be given the flexibility to supervise the resident with the greatest need, and
- Non-physicians with less training have lower supervision standards than residents under current PCE limitations.

Residency Programs are Best Suited to Determine the Appropriate Level of Supervision

Residency programs regularly evaluate resident physicians to determine the level of supervision required by teaching physicians using continuous, competency-based clinical judgment rather than one-size-fits-all regulatory thresholds. In 2023, the Accreditation Council for Graduate Medical Education (ACGME) updated core residency program requirements to ensure every residency curriculum includes "competency-based goals and objectives for each educational experience designed to promote progress on a trajectory toward autonomous practice."[ix] The emphasis on competency-based assessments enables residency programs to responsibly individualize supervision in a manner that protects patients while supporting professional development.

ACGME core requirements state, "The trajectory to autonomous practice is documented by Milestones evaluations…" Residents must demonstrate their competency against a set of requisite goals and objectives to decrease their level of supervision as they gain clinical

judgment, confidence, and experience managing real-world patient needs. Residency programs, through their ACGME-required Clinical Competency Committee process, must assess and determine when and under what circumstances (considering level of complexity, acuity, urgency, etc.) each resident has the appropriate competency to provide care without direct supervision. **This requirement ensures residency programs have proper guardrails in place to ensure patient safety, while allowing for the autonomous experience necessary to form the trusted patient-physician relationships essential to effective, preventive, and longitudinal care which more effectively prepares residents to practice independently once their training is complete**.

In addition to the core program requirements, the AGCME program requirements for family medicine note, "The program must demonstrate that the appropriate level of supervision in place for all residents is based on **each resident's level of training and ability, as well as patient complexity and acuity**." The requirements further state, "Appropriate supervision is essential for patient safety and high-quality teaching. Supervision is also contextual. The level of supervision for each resident is commensurate with that resident's level of independence in practice; this level of supervision may be enhanced based on factors such as patient complexity, acuity, urgency, risk of serious safety events, or other pertinent variables."[x] Accordingly, residency programs are currently well-equipped and accountable to make individualized decisions about a resident's competency to deliver care.

Teaching Physicians Should be Given Flexibility to Supervise the Resident with the Greatest Need

Currently, regardless of the resident's personal ability and competency, teaching physicians must be physically present during the delivery of services not included on the PCE list based solely on billing classifications rather than clinical risk. This means that the teaching physician is not available to supervise any other resident during this time. Some residents even after six months may require or desire assistance during lower-level E/M services but may be forced to choose between attempting the service without supervision or waiting for the teaching physician to conclude their supervision of another more experienced resident performing a higher complexity service. Accordingly, expanding the PCE list would allow teaching physicians the flexibility to spend their time with the resident who needs the most guidance at any given time, regardless of the services being performed.

Including additional services under the PCE would not impede the teaching physician's ability to remain available for up to four residents and direct care. If a resident reviews the patient's visit with the teaching physician before, during, or after a visit, it does not reduce the availability of the teaching physician or impose additional time burdens. Without the requirement to be physically present during a visit, the teaching physician has more time available to other residents. This allows teaching physicians the flexibility to focus on whichever resident needs guidance the most at any given time, rather than which resident is performing a specific service without consideration of their ability to do so.

In particular, we urge CMS to expand the PCE list to give teaching physicians the ability to virtually supervise a resident during a house call visit. Our members who practice in home-

based settings have expressed frustration that currently, teaching physicians are effectively required to shadow their residents on house calls, which is a poor use of the physician's time and undermines the resident's expertise. If a physician can virtually supervise a nurse in a home-based setting and bill for the visit, they should be able to do the same for a resident physician. A virtual presence does not preclude a teaching physician from providing a greater degree of involvement in services furnished by the resident. The teaching physician would still have discretion to determine the appropriateness of a virtual presence rather than in-person, depending on the services furnished and the resident's experience. We encourage CMS to allow a teaching physician to virtually supervise a resident in a home-based care setting.

Non-physician Clinicians have Lower Supervision Standards than Residents under the PCE

Many of the services we propose for inclusion under the PCE are often furnished by non-physician clinicians with less training and clinical experience than residents with six months of residency training. Although the physician's physical presence in the exam room is not required for "incident to" billing of these services, the physician remains sufficiently involved as to merit MPFS payment. **If this level of supervision is safe for non-physician clinicians and sufficient for payment by CMS, we believe residents who meet the relevant competency requirements could also provide additional services without a teaching physician being physically present in the exam room when the service is provided to the patient.**

While we make the comparison to non-physician clinicians to emphasize the potential inconsistency in the approach to payment for supervision of physician residents, it is important to recognize that residents' education and training is significantly more rigorous and better prepares physician residents to work under general supervision without the physical presence of the teaching physician than nurse practitioners. Residents have completed a four-year education program compared to the two-year education most nurse practitioners complete. Residents also have more clinical training than the minimum 500 hours required for nurse practitioners to seek certification.[xi] There are no standardized residency training or post-graduate requirements for nurse practitioners.[xii] However, residents who furnish services under the PCE must also have at least six months of clinical program training experience. Even though licensed nurse practitioners have less education than family medicine residents, they may furnish more complex E/M services and bill either under their own provider number or incident to physicians without the physical presence of the teaching physician.

2. The current PCE list disadvantages residency programs' ability to adequately bill for their services which contribute to the primary care workforce shortage.

With a shortage of family and other primary care physicians, ensuring the sustainability of existing residency programs is crucial to maintaining primary care access and reversing the chronic underinvestment that has weakened the nation's primary care foundation. Many residency programs have expenses that exceed allocated resources and funding, and residency program directors are often pressured by their sponsoring organization to

demonstrate a financial benefit (or at minimum, a break-even) to continue the program. An analysis of financial data from family medicine residency programs found increases in average expenses per resident outpaced growth in graduate medical education (GME) funding, forcing programs to rely on other sources of funding, including clinical revenue, to remain solvent.[xiii] Family medicine residency clinics must also remain financially viable to cover the salary and benefits of a sufficient number of trained teaching physicians.

Because of the tight financial margins in most family medicine residency programs, accurate coding and billing patterns are critical to program sustainability. Research suggests residency clinics may be using lower-complexity codes when a higher-level code is more accurate.[xiv,xv] This coding pattern results in decreased resources for family medicine programs at a time when CMS is otherwise investing more in primary care (e.g., by implementing and expanding code G2211). Over time, the potential revenue loss from under-coding may reduce access by reducing the number of primary care residency training programs, which ultimately reduces the number of new family medicine physicians. Under-coding also risks misrepresenting the patient's clinical needs and the true acuity of their condition, which can lead to gaps in care coordination, inaccurate quality measurement, and poorer outcomes for patients.

Coding is difficult in residency clinics because while it may be clear that a visit will meet the medical decision-making (MDM) criteria for a level 4 or 5 visit, it cannot be billed as such unless the teaching physician is present at the time of the visit. As a result, some experienced residents may furnish a visit that meets the MDM criteria of a level 4 or 5 E/M visit, but unless they stop the visit to call in the teaching physician, they are unable to report the visit based on the actual MDM level involved. These visits do not surpass the resident's skill or ability but require a teaching physician's presence solely for regulatory compliance because the PCE policy does not encompass higher-complexity codes.

This assertion is supported by studies seeking to understand the effects of the temporary expansion of the PCE during the COVID-19 PHE. During the PHE, CMS allowed office/outpatient E/M visits at any level to be furnished under the PCE.[xvi] A recent analysis of billing data from one residency program during the COVID-19 PHE found that the use of higher-complexity visit codes increased for patients seen by residents, while coding patterns generally remained the same for attending physicians (patients seen without the presence of a resident).[xxvi] This suggests the overall frequency of higher-complexity visits did not change, and lifting the restriction for residents allowed for more accurate coding based on MDM.

When the temporary PCE expansion expired, it restored limitations on the types of visits residents can furnish. Now, even those residents determined by faculty to have the necessary clinical competencies for this level of care are required to have personal supervision for level 4 and 5 visits, which adds administrative barriers that ultimately reduce access. As described above, the exclusion of more complex E/M codes may also prevent the clinic from being paid for services furnished under the direction of the teaching physician. Over time, this weakens clinic finances, in addition to making recruiting and retaining teaching physicians challenging. Allowing higher-level E/M codes under the PCE would therefore improve patient access and strengthen family medicine residency programs—a critical pipeline for

primary care physicians and a core lever for shifting the health system toward prevention rather than late-stage intervention.

Accordingly, we urge CMS to expand the list of services available under the PCE to include (1) all levels of office/outpatient E/M services, (2) additional preventive services and codes related to patient continuity and integration of care.

(1) Higher-level Office/Outpatient E/M Services to Allow under the PCE

We recommend CMS allow all levels of office/outpatient E/M visits (99202-99205, 99212-99215) and home or residence E/M services (99341-99345, 99347-99350) under the PCE to provide residency programs with the resources needed to support workforce development and improve access and patient continuity of care—all without compromising patient safety or impeding the teaching physician's overall management of care. At a minimum, CMS should add level 4 E/M codes to the PCE list.

The PCE was established nearly 30 years ago when the Medicare population did not represent the same degree of multi-chronic complexity, and level 4 E/M codes were less common. Today, the share of Medicare beneficiaries with three or more chronic conditions is predicted to jump sharply by 2030, increasing from 26 percent to 40 percent compared to 2010.[xvii] **Accordingly, this level of care has become more common and higher level E/M codes have not only become more prevalent, but they are becoming the norm. This is true not just for initial visits with new patients, but also follow-up visits with established patients.** Encounters with multi-chronic patients require a level of time and decision-making consistent with a level 4 code for management of multiple chronic conditions, but these encounters do not involve a level of diagnostic complexity that is beyond the resident physician's ability to provide quality care with general supervision. Resident physicians must be given the opportunity to provide these services with less supervision, so long as their residency program has determined they are competent to do so.

As noted, existing ACGME requirements set resident supervision levels based on individual assessments of a resident's competencies. These requirements ensure residency programs have proper guardrails in place to ensure patient safety, while allowing the resident to gain the autonomous experience necessary to practice independently once the program is complete. In updating the PCE, **CMS should affirm that the residency program is the only authority which can make the assessment of competency to ensure that these guardrails are respected and that a change in policy is not misinterpreted as deeming all residents competent to furnish level 4 or 5 E/M codes under the exception.**

We also note that teaching physicians would remain sufficiently involved in directing these services to warrant MPFS payment for directing and managing additional E/M services furnished by qualified residents—activities that the teaching physician regularly performs when not physically present during the delivery of a specific service, just as they do with non-physician practitioners. Currently, non-physician practitioners (such as nurse practitioners) may furnish level 4 and 5 visits and bill "incident to" a supervising physician without the physician being present during the service. Expanding the PCE to include all levels of E/M

service is therefore compatible with existing CMS policy because it is the same amount of physician involvement (not the physician's physical presence during the service) which justifies payment for non-physician clinicians. Resident physicians would still review patient care with the teaching physician just as non-physician clinicians do when billing a service "incident to" a supervising physician.

Finally, including these services under the PCE would not impede the teaching physician's ability to remain available for up to four residents and direct care. If a resident reviews the patient's visit with the teaching physician before, during, or after a visit, it does not reduce the availability of the teaching physician or impose additional time burdens. Without the blanket requirement to be physically present during all level 4 or 5 visits, the teaching physician has more time available to residents who might need greater levels of guidance. This level of involvement, coupled with the ACGME requirements tying the degree of physician supervision to the resident's level of competency, allows teaching physicians to focus their time supervising more complex visits with residents who continue to require physical supervision, assuring appropriate care for Medicare beneficiaries.

(2) Additional Preventive Services and Patient Continuity and Integration of Care Codes to Allow under the PCE

We request CMS include the following services under the PCE:

- G0442 – Alcohol misuse screening
- G0443 – Brief face-to-face behavioral counseling for alcohol misuse
- G0444 – Annual depression screening
- G0446 – Annual, face-to-face intensive behavioral therapy for cardiovascular disease
- G0447 – Face-to-face behavioral counseling for obesity
- 99406 – Smoking and tobacco use cessation counseling visit; intermediate
- 99407 – Smoking and tobacco use cessation counseling visit; intensive
- 99421-99423 – Online digital E/M service for an established patient
- 99495 – Transitional care management
- 99497 – Advance Care Planning, including explanation and discussion of advance directives
- 99498 – Add-on code for CPT 99497 (Advance Care Planning, each additional 30 minutes)
- 99490 – Chronic Care Management services, first 20 minutes of clinical staff time directed by a physician or other qualified health care professional
- 99439 – Add-on code for CPT 99490 for each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional

We recommend CMS expand the PCE to include this list of services, which will encourage the integration of high-value services in resident training and support a prevention-first primary care workforce capable of addressing the root causes of chronic disease. CMS has previously recognized the need to expand the PCE to include additional

preventive services to further integrate them into residency training. For example, the PCE allows teaching physicians to bill for Medicare wellness visits (G0402, G0438, G0439) furnished by a resident without a teaching physician present during the service. Additional opportunities for teaching physicians to integrate these services into training are needed to ensure residents include these services in their day-to-day practice after program completion and carry these habits into careers focused on keeping patients healthy rather than managing downstream illness.

Alcohol screening and behavioral counseling services are underutilized.[xviii] Research suggests residents' insufficient training and lack of confidence in their ability to furnish services are primary barriers to incorporating alcohol misuse screening and intervention into regular practice.[xix] Additionally, approximately half of US adults over age 35 are not screened for depression.[xx] Expanding the PCE to include these services will increase utilization during residency and post-residency to promote earlier intervention for behavioral and mental health conditions that drive poor health outcomes.

Screening and interventions for tobacco use have increased over time, yet there is still an opportunity to increase the use of screening and interventions in the primary care setting.[xxi] Research indicates physicians who use best practices for tobacco use screening and cessation with patients during residency training are twice as likely to continue to furnish tobacco-related screening and interventions upon program completion, compared to physicians who only received training but did not have the opportunity to apply their learnings with patients during residency.[xxii] We believe allowing these services to be furnished by residents under the PCE would allow teaching physicians to increase opportunities for residents to practice these services during residency and help establish lifelong clinical habits that reduce preventable chronic disease.

The AAFP believes the existing requirements related to resident training are sufficient to ensure safe and effective care for these preventive services that every Medicare beneficiary should be able to easily access. As discussed throughout this letter, the ACGME competency-based program requirements ensure all resident physicians demonstrate the competencies required to furnish a particular service without a teaching physician's physical presence.

Non-physician clinical staff often furnish these services under the direct — but not personal — supervision of the physician, with the physician receiving full MPFS payment under "incident to" billing despite the lack of their personal presence during the service. Standardized screening instruments are frequently used for alcohol misuse and depression screening, and they are often administered by nurses or other auxiliary staff under the direct supervision of a physician. Additionally, tobacco cessation counseling may be provided by non-physician clinicians with less clinical training and experience than a resident with six months of training experience. Allowing these additional preventive services under the PCE would not hinder the teaching physician from maintaining sufficient involvement to warrant payment, as the level of physician involvement required to merit billing would be the same or more when furnished under the PCE.

Including these preventive services under the PCE would not preclude a teaching physician from providing a greater degree of involvement in supervision of services furnished by a resident if the teaching physician deemed it necessary based on their assessment of the resident's level of demonstrated competency. Teaching physicians are still required to be on site for resident supervision, and residents must review all encounters with the teaching physician—even if the teaching physician does not directly see the patient. All documentation must be reviewed and countersigned by the teaching physician. Thus, teaching physicians would remain highly involved with resident delivery of these services if allowed under the PCE.

Advanced Primary Care Management Codes

The AAFP is encouraged by CMS' continued efforts to reduce the burden associated with the delivery of high quality, comprehensive primary care, including visit- and non-visit-based care management services. The recent addition of add-on codes for behavioral health integration and collaborative care management services is a welcome enhancement to the APCM codes. However, adoption of these codes continues to be low, and we believe CMS can improve utilization of APCM by making two meaningful changes to the codes: removing cost-sharing for beneficiaries and removing the MVP reporting requirement.

Cost Sharing

The AAFP appreciates that CMS requested comments on approaches to eliminating the APCM patient cost-sharing in the 2026 MPFS proposed rule. As we outlined in our comments,[xxiii] the AAFP believes there is sufficient and meaningful alignment between APCM and prevention for CMS to waive cost-sharing and recommends that CMS eliminate cost-sharing in full for APCM services starting in 2027. We do not recommend a partial reduction in cost-sharing that is likely to be impractical to implement and confusing to practices and patients.

The AAFP believes the majority of services provided by a patient's primary care physician should not be subject to cost-sharing. We agree with CMS that there is a strong degree of alignment between elements of APCM and the "personalized prevention plan services" included in the Annual Wellness Visit (AWV) and that this should qualify APCM services for waived cost-sharing. We appreciate that CMS took initial steps in the 2025 MPFS final rule to recognize this rationale by allowing the care plan developed as part of the AWV to satisfy the patient-centered comprehensive care plan element of APCM. We believe this strong link between the AWV and APCM provides strong rationale for a cost-sharing waiver.

As CMS notes, there are many aspects of the AWV and APCM that complement each other. For example, the health risk assessment of the AWV can be used as a starting point to identify which additional care management activities of APCM may be most beneficial and applicable to the patient. Moreover, APCM includes "system-based approaches to ensure receipt of preventive services." This ensures that patients actually receive the crucial preventive services that are included in the screening schedule established as part of the personalized prevention plan under 1861(hhh)(2)(E) of the Act.

The AAFP is greatly appreciative of CMS' expressed commitment and ongoing support for preventive services and effective management of chronic disease. Family physicians are the first point of contact for patients and provide comprehensive, continuous care that spans primary care prevention, early detection/secondary prevention, and long-term management/tertiary prevention of chronic conditions. **Eliminating patient cost-sharing for these services through APCM is an important step toward realizing this level of care by family physicians, and we stand ready to support our members in its implementation.**

MVP Reporting Requirement

The AAFP urges CMS to reconsider the use of the MVP as a requirement to bill APCM. Our primary concern is that making a practice's ability to bill specific services contingent on performance measurement reporting is unprecedented and could lead to an uneven playing field across practices with different data and reporting capabilities, thus hindering CMS' primary goal of strengthening primary care for all of its beneficiaries.

We agree with CMS that the Value in Primary Care MVP aligns with the service requirements and practice capabilities outlined in the APCM codes. However, we remain concerned that several MVP measures — while conceptually aligned with primary care — are difficult to implement in practice due to persistent health data silos and interoperability challenges that remain largely outside the control of frontline clinicians. Measures like Adult Immunization Status impose ongoing administrative burden on primary care practices due to persistent data silos and systems that make reporting challenging even when physicians are delivering appropriate, evidence-based care. Tying the ability to bill APCM codes to these reporting requirements risks creating an uneven playing field between well-resourced practices able to address these challenges and smaller, resource-constrained practices, potentially undermining access to advanced primary care services in communities that rely on independent and safety-net providers the most.

As with all new HCPCS or CPT codes, implementation and uptake of APCM will increase gradually as more practices become aware of the service and patients recognize its benefits providing consent for billing. APCM is still in the early stages of adoption, and **the AAFP recommends that CMS continue gathering data and feedback on APCM from physicians and other clinicians, as well as patients.**

<u>Immunization Counseling Codes</u>

In 2022, CMS created HCPCS level II codes for stand-alone immunization counseling when a vaccine is not administered (G0310, G0311, G0312, G0313).[xxiv] From their inception, the G-codes carried a Medicare coverage indicator of "I," signaling that they were not payable under the Medicare Physician Fee Schedule. This policy remained unchanged when the AMA created permanent CPT Category I codes 90482–90484 for time-based immunization counseling when vaccines are not administered. When CMS incorporated these new CPT codes into the CY 2026 MPFS, it assigned them status indicator "I" effective January 1, 2026—the same treatment Medicare had applied to the predecessor G-codes since 2022.

The AAFP urges CMS to revisit this decision because federal vaccine policy has fundamentally shifted the clinical work Medicare expects physicians to perform. Over the past year, the

Advisory Committee on Immunization Practices (ACIP) has expanded its use of shared clinical decision-making (SCDM) for multiple vaccines, replacing simple age- or risk-based recommendations with guidance that explicitly requires individualized physician-patient discussion. By definition, SCDM requires physicians to engage patients in substantive, individualized discussions about risks, benefits, and alternatives, taking into account medical history, patient preferences, and values. When CMS adopts ACIP recommendations for Medicare coverage, it implicitly adopts the clinical obligation to counsel—yet under current policy, Medicare does not recognize or pay for that increase in work.

Many family physicians report that recent policy changes have increased the number of questions and concerns patients have in response to a vaccine recommendation. It is no longer uncommon to spend 20-30 minutes answering questions about the safety profile of a vaccine and explaining the health risks of not being immunized. Family physicians also report that a growing number of patients decline vaccination after an initial recommendation but later accept after several conversations over the course of multiple visits. We are unaware of any codes in Medicare Part B that allow a physician to report and receive payment for the standalone time spent on counseling patients about a vaccine when the patient declines vaccination.

This administration has made clear that informed consent and SCDM are foundational to its vaccine policy; accordingly, we ask CMS to change the status indicator of the immunization counseling codes to "A" or, at minimum, issue more detailed instruction to physicians on how to correctly bill for time spent counseling patients who ultimately decline vaccine administration.

Conclusion

The AAFP greatly appreciates CMS' ongoing work to support family physicians' ability to provide comprehensive, longitudinal primary care, and we appreciate this opportunity to offer our recommendations. We look forward to continued collaboration with CMS to support equitable access to high-quality, holistic, person-centered primary care. Thank you again for your consideration of our recommendations. Should you have any questions, please contact Kate W. Gilliard, Senior Manager of Federal Policy and Regulatory Affairs at kgilliard@aafp.org.

Sincerely,

Jen Brull, MD, FAAFP
American Academy of Family Physicians, Board Chair

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