Regulatory Affairs Office Hour
CY 2026 Medicare Physician Fee Schedule

December 15, 2025

Read the final rule here.
Read the fact sheet here.

NATIONAL ASSOCIATION OF Community Health Centers®

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- Today's webinar is being recorded. The recording and additional resources will be made available to all registrants.
- A copy of the slides and recording will be sent from regulatoryaffairs@nachc.org after the event.
- Please be sure to put all questions in the Q&A box. Questions put in the chat are less likely to be answered!

Housekeeping

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Today's Speakers

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Agenda

1. Updates to Primary Care
2. RHCs and FQHCs
3. Behavioral Health
4. Medicare Programs
5. Q&A
6. Relevant upcoming calls/events

Primary Care

Conversion Factor Update

For the first time in six years, CMS finalized an increase to physician payments. The CY 2026 PFS CF is $33.5675 for clinicians who meet certain participation thresholds in Advanced Alternative Payment Models (APMs) and $33.4009 for other clinicians.

These amounts represent increases of 3.77% and 3.26%, respectively, from the CY 2025 CF of $32.3465.

Efficiency Adjustment

To better reflect the resources involved in furnishing services paid under the PFS, CMS has finalized a 2.5% reduction to both work RVUs and the physician intra-service time for non-time-based services.

The efficiency adjustment will apply to around 7,700 codes, excluding time-based codes, services on the CMS telehealth list, and including evaluation and management, care management, and behavioral health services.

Practice Expense Methodology

CMS modified the indirect PE allocation methodology for services furnished in the facility setting beginning in CY 2026 by reducing the portion of indirect PE allocated per work RVU to 50% of the amount allocated for non-facility services.

Remote Patient Monitoring Codes

CMS finalized two new RPM codes that give providers more billing options for shorter monitoring durations and management times. Four foundational RPM codes received updates reimbursement rates for CY 2026.

CPT	Description	2026 Rate
99445	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial device(s) supply with daily recording(s) or programmed alert(s) transmission, 2-15 days in a 30-day period.	$47
99470	Remote physiologic monitoring treatment services, clinical staff/physician/other qualified health care professional time in a calendar month requiring 1 real-time interactive communication with the patient/caregiver during the calendar month; first 10 minutes.	$26
99453	Initial set-up and patient education on use of RPM equipment of psychological parameters.	$22
99454	Initial device(s) supply with daily recording(s) or programmed alert(s) transmission, 16-30 days in a 30-day period.	$47
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time; first 20 minutes	$52
99458	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time; each additional 20 minutes	$41

Telehealth

- **Streamlined the process for adding services to the Medicare telehealth services list.** CMS removing the distinction between provisional and permanent services and limiting their review on whether the service can be furnished using an interactive, 2-way audio-video telecommunications system.
- **Beginning January 1, 2026, CMS is continuing to allow teaching physicians to have a virtual presence in all teaching settings, but only for services furnished as a Medicare telehealth service.** This will continue to permit teaching physicians to have a virtual presence during the key portion of the Medicare telehealth service for which payment is sought, through audio/video real-time communications technology, for all residency training locations.
- **Permanently adopted 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) for services we require to be performed under the direct supervision of a physician or other supervising practitioner.

Evaluation and Management (E/M) Complexity Add-on

- CMS finalized G2211 to be billed as an add-on code with the home or residence evaluation and management visits code family.
- This code was not extended to FQHCs in this final rule.

RHCs and FQHCs

CY2026 PPS Rates

For CY 2026:

- The FQHC market basket is 2.5%
- The FQHC PPS base payment rate is $207.72, which is a 2.5% increase from 2025.

Telehealth (FQHC specific)

- Finalized permanently including **remote supervision in the definition of supervision**
- CMS has finalized that CHCs may continue to furnish and receive payment for distant site **non-behavioral health telehealth services** - billable via G2025- through **December 31, 2026**.

- **Does not revise** the definition of medical visit to include interactive, real-time, audio/video telecommunication technology – we still bill for G2025
- **Does not extend** delay of mental health services in-person requirements
- ***Congress could change this***

Additional telehealth resources:
NACHC Government Shutdown FAQ
CMS FAQ

Aligning with the PFS for Care Coordination

- Reminder: G0511 is no longer reportable.
- CMS finalized it proposal to adopt services that are **established and paid under the PFS and designated as care management services be instead designated as care coordination services for purposes of separate payment for FQHCs.**
- See the CY2026 Designated Care Management Services Assigned General Supervision table.

Payment for CTBS and Remote Evaluation Services

- G0071 is no longer reportable beginning January 1, 2026. CHCs must report the following individual codes that make up Communications Technology-Based Services (CTBS) and Remote Evaluation Services:
  - **G2010:** Remote image submitted by patient
  - **G2250:** Remote image submitted by patient (non-E/M)
  - **98016:** Brief communication-technology-based service
- CMS finalized the Advanced Primary Care Model (APCM) in the CY2025 PFS, which previously bundled some CTBS services into the established rate.

Behavioral Health

Integrating Behavioral Health into APCM

- Finalized separate coding and payment for Advanced Primary Care Management (APCM) services (HCPCS codes G0556, G0557, and G0558)

G0556	G0557	G0558
For beneficiaries with one chronic condition or fewer	For beneficiaries with multiple (2+) chronic conditions	For beneficiaries who are a Qualified Medicare Beneficiaries with multiple (2+) chronic conditions

CMS finalized three new optional add-on codes for APCM services that would provide complimentary BHI or CoCM service.

HCPCS code G0568:	HCPCS code G0569:	HCPCS code G0570:
Initial psychiatric collaborative care management, in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified professional	Subsequent psychiatric collaborative care management, in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified professional	Care management services for behavioral health conditions, directed by a physician or other qualified health care professional, per calendar month

Community Health Integration & Principal Illness Navigation for BH

- Clarified that MFT, MHCs, and CSWs, can serve as auxiliary personnel under the general supervision of the billing physician/QHP in performing these services.
- Finalized that CPT 90791 (psychiatric diagnostic evaluation) and Health Behavior Assessment and intervention (HBAI) services can serve as initiating visits for CHI
- Replaced the term "social determinants of health (SDOH) with "upstream driver(s)"

NACHC was supportive of these changes and advocated for HBAI codes to be added as a FQHC qualifying visit to ensure alignment for all Medicare beneficiaries, however CMS did not agree.

NACHC's Response to BH RFIs

- NACHC urged CMS **not to include the Annual Wellness Visit (AWV), depression screening, or other preventive services in the APCM bundle**.
- NACHC supports allowing CHCs and RHCs to **bill APCM alongside behavioral health services** but strongly recommends **against behavioral health add-on codes within APCM**.
- NACHC asked CMS to clarify how any APCM-related behavioral health add-ons would be **valued** and whether they could result in **lower total reimbursement** than billing APCM and BHI/CoCM separately. We also requested CMS differentiate between CoCM and General BHI in CHCs.
- NACHC recommended **eliminating cost-sharing for APCM and behavioral health services** by classifying them as preventive.
- NACHC recommended CMS broaden the definition of a **qualifying behavioral health visits** for CHCs. We also urged CMS to revisit and update mental health visit definitions and HCPCS code lists to reflect modern, team-based CHC care.

Social Determinants of Health Risk Assessment - G0136

- CMS opted **not** to remove this code, but updated the definition for services provided on or after 1/1/2026:
  - *"Administration of a standardized, evidence-based assessment of physical activity and nutrition, 5-15 minutes, not more often than every 6 months."*
  - G0136 may be performed in an FQHC but will not result in additional reimbursement when performed on the same day as another service. It is not considered a qualifying visit in an FQHC, so if it is the only service performed on that date of service, there is no reimbursement for it.

Medicare Programs

Medicare Prescription Drug Inflation Rebate Program – Quick IRA refresher

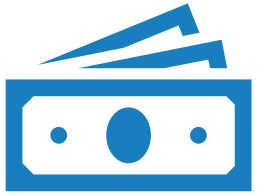
Provision	Effective	Applies To
Inflationary Rebates	2023	Part B & D drugs
$35 Insulin Co-Pay Cap	2023	Medicare
Vaccine Cost-Sharing Elimination	2023	Medicare Part D
$2,000 Out-of-Pocket Cap	2025	Medicare Part D
Medicare Drug Price Negotiation	**2026**	**Part B & D drugs, High-cost drugs**

- Inflation Reduction Act was signed into law August 16, 2022
  - Included provisions to address rising drug prices
- Medicare Drug Price Negotiation
  - Jan 1, 2026: initial 10 MFPs negotiated take effect
  - Applies to Medicare Part D only for first 2 years (2026-2027)
  - Medicare Part B is added in 2028

Refresher: Inflation Reduction Act

Manufacturers whose prices increased faster than inflation must pay rebates to Medicare

Manufacturers that do not comply must pay civil monetary penalties of 125% of the rebate amount



Drugs discounted under the 340B Program are excluded from the inflation rebates

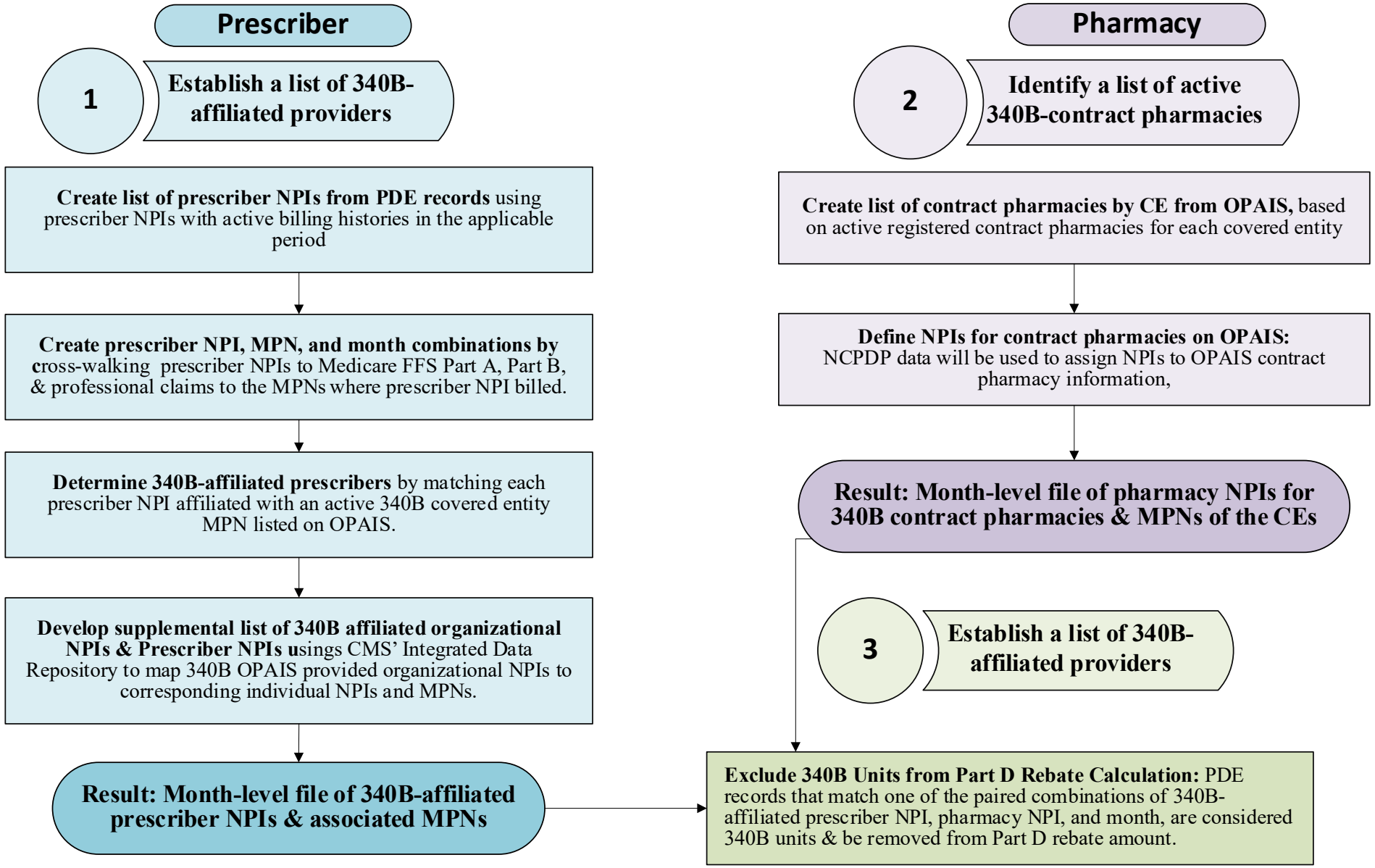
Original Estimation Methodology to Remove 340B Units

- Statutory Requirement Compliance
  - Removal of 340B units from rebate calculations starting January 1, 2026.
- Proposed Policy for Unit Removal
  - Based on a calculated percentage reflecting 340B purchases relative to total sales.
- Estimation 340B Percentage
  - Total 340B units purchased by covered entities divided by total units sold.
  - Proposes using 340B PVP data to estimate total 340B units purchased by CEs.

Sample Part D Inflationary Penalty 340B Exclusion Calculation	
Total Part D Units Dispensed	1,000
Estimation Percentage (340B Purchases/Total Sales)	10%
340B Units Excluded	100
Net Part D Rebatable Units	900

Proposed in CY 25 & Rescinded

Claims-Based Methodology to Remove 340B Units from Rebate Calculations: "Prescriber-Pharmacy Methodology"



https://doi.org/10.1093/haschl/qxae157

Medicare Part D: 340B Claims Repository

CMS is establishing a *voluntary* Medicare Part D claims data repository to comply with the requirement to exclude 340B from total Part D rebatable units.

Key Aspects of the Proposed Medicare Part D Claims Data Repository	
Data Submission	Covered entities to submit 340B-identified Part D claims data
Repository Function	Stores data elements, no further 340B status verification
Data Accuracy	Attestation required, methods for accuracy review sought
Rebate Calculation Impact	Data matched to PDE records; matched units excluded

Data Elements: Fill Date, Prescription Number, Fill Number, Dispensing NPI, & NDC-11

Anticipated: Fall 2026!

Medicare Shared Savings Program

- Require ACOs applying to enter a new agreement period to have at least 5,000 assigned beneficiaries in BY3, while allowing the ACO to have under 5,000 assigned beneficiaries in BY1, BY2, or both (section III.F.4.b.(2)(a) of this proposed rule).
- Safeguards apply:
  - ACOs that drop below 5,000 beneficiaries in any benchmark year must participate only in the BASIC track.
  - They face caps on savings/losses and exclusion from benefits designed for low-revenue organizations.
  - These ACOs cannot join the ENHANCED track, limiting advanced participation options.

Medicare Shared Savings Program – eligibility & financial reconciliation requirements for ACOs with ~ 5,000 ppl

- Beginning with agreement periods starting in 2027, ACOs will only need to meet the 5,000-beneficiary threshold in Benchmark Year 3.
- They may fall below this level in Benchmark Years 1 or 2; however, if their beneficiary count drops below 5,000 at any point during the agreement period, they must participate in the BASIC track and will be subject to corresponding limits on shared savings and shared losses.

Review CMS' Fact Sheet on the changes to the ACO Program

MIPS: Social Drivers of Health (SDOH) Quality Measures Removal & Health Equity Benchmark Adjustment

- Screening for SDOH measured is removed starting in 2028 in MIPS
- CMS is removing the health equity adjustment from ACO quality scores starting in the performance year 2026 (instead of performance year 2025 as proposed).
- The “health equity benchmark adjustment” is renamed as the **“population adjustment,”** accounting for the proportion of an ACO’s population with dual eligibility or low-income subsidy status.
- CMS plans to rely on other mechanisms, such as the Complex Organization Adjustment and incentives for eCQM reporting, to recognize the challenges faced by safety-net providers.

Medicare Diabetes Prevention Program (MDPP)

CMS modified some of the proposed changes to the MDPP in their final rule:

- Clarified that MDPP suppliers are not required to maintain in-person delivery capability through December 31, 2029
- Added additional coverage for on-demand (asynchronous), online delivery of MDPP through December 31, 2029
- Updating weight collection requirements, allowing beneficiaries to self-report their weight for MDPP session
- Beneficiaries will also be able to submit their weight for an MDPP session if it was collected as part of a medical record within 5 days.
- Established a new G-code for online sessions (HCPCS code G9871 - $18)

Questions?

NACHC is finalizing a fact sheet that will be ready early 2026.

Please send any additional questions to regulatoryaffairs@nachc.org.

Resources

NACHC's Medicare Reimbursement Tips for FQHCs

CMS' CY2026 PFS Webpage

CMS' FQHC Center

Upcoming Webinars

Upcoming Webinars

CY2027 MA/Part D Proposed Rule Office Hour | Register Here	Tuesday, January 6, 2026 | 4:00 PM ET
Building Blocks of Care Coordination: Starting or Contracting with a PACE Organization (Part III) | *Register Here*	Thursday, January 8, 2026 | 4:00 PM ET
2025 Regulatory Roundup | *Register Here*	Wednesday, January 14, 2026 | 2:00 PM ET
340B Office Hours: Part III on the 340B Rebate Model | *Register Here*	Wednesday, January 21, 2026 | 2:00 PM ET
340B Offices Hours | *Register Here*	Thursday, January 29, 2026 | 3:00 PM ET

Thank you!

Please send questions to regulatoryaffairs@nachc.org.