2026 Medicare Payment and CPT Coding Update: Progress for Primary Care But Long-Term Fix Needed

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The amount Medicare pays per RVU gets its first substantial boost in years, but most of the increase will expire at the end of 2026 unless Congress acts.

The old Yogi Berra aphorism "a nickel ain't worth a dime anymore" might resonate with many physicians these days. The Medicare Physician Fee Schedule's (MPFS) budget neutrality requirements combined with a lack of any updates to account for inflation have created a Medicare payment system that hasn't kept pace with the rising costs of running a practice.

While a lasting solution remains elusive, the 2026 MPFS final rule provides some temporary relief and signals that the Centers for Medicare & Medicaid Services (CMS) is prioritizing primary care.[1] For example, the final rule includes an increase in the Medicare conversion factor, many common primary care codes exempted from an "efficiency adjustment" cut, a practice-expense calculation change that favors care provided in offices versus facilities, and expanded use of code G2211.

Key Points

- The 2026 Medicare Physician Fee Schedule includes several provisions that should boost primary care, including an increase in the conversion factor and expanded use of G2211 for home and residence visits.
- The Centers for Medicare & Medicaid Services also changed how it calculates practice expense RVUs in a way that increases payment for services provided in office settings while decreasing it for facility settings.
- CPT added new codes that expand payment opportunities for remote monitoring and immunization counseling.

Medicare Payment Update

Here are the noteworthy changes in the MPFS for primary care physicians.

Conversion factor increase. The conversion factor is the amount Medicare pays per relative value unit (RVU). The 2026 final rule includes the most meaningful increase in the conversion factor we have seen in many years. It comes from three sources:

1. **A 2.5% one-time increase** mandated by H.R. 1 (also referred to as the "One Big Beautiful Bill Act"), which expires at the end of 2026,
2. **A 0.75% increase** for Alternative Payment Model (APM) qualifying participants (QPs) and a 0.25% increase for non-QPs (implementation of two conversion factors is required by the Medicare Access and CHIP Reauthorization Act; CMS will apply the conversion factor that aligns with your participation status from two years prior),
3. A **0.49% budget-neutrality adjustment,** which is positive for just the second time in the last 10 years,[2] and is driven in large part by changes discussed below.

In total, the 2026 conversion factor will be $33.57 for QPs, an increase of 3.77% or $1.22 more than 2025. The conversion factor for non-QPs will be $33.40, an increase of 3.26% or $1.05 more than 2025. But most of that comes from H.R. 1, which is temporary. The American Academy of Family Physicians (AAFP) continues to urge Congress to pursue more sustained reform, such as a permanent inflationary adjustment.

Efficiency Adjustment

CMS has historically relied on survey data from the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC) to establish RVUs for the physician fee schedule. Over the last few years, CMS and others have expressed concerns about low survey response rates and the infrequency with which the RUC reviews codes. CMS estimates that, on average, there is at least a

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decade between when a code is introduced in the fee schedule and when the RUC reviews it. As technology and workflows improve and physicians gain more expertise, CMS believes physicians become more efficient at providing non-time-based services. Without more regular review, CMS concludes they are most likely over-valuing codes by not accounting for these efficiencies.

Thus, CMS is implementing an "efficiency adjustment" for the first time in 2026. It will start as a payment reduction of 2.5% for intraservice time (e.g., "skin-to-skin" time in procedural services) and the work RVUs of approximately 7,000 codes.

The good news is that time-based codes are exempt. This includes (but is not limited to) E/M services, care management services, behavioral health services, services on the CMS telehealth list, and maternity care codes — all of which are common in primary care. CMS also exempted new codes and time-based drug administration codes. A full list of codes subject to the efficiency adjustment is available on the CMS website (download "CY 2026 PFS Final Rule Codes Subject to Efficiency Adjustment"). CMS will recalculate the adjustment every three years. The next recalculation will be in 2029 and will reflect efficiency gains measured from 2027 through 2029.

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A Family Physician's Perspective

Dr. Christopher Hopper Responds to Medicare Fee Changes

Dr. Christopher Hopper

MAFP member **Christopher Hopper, MD, MScPH, FAIHM, FAAFP** weighed in on recent Medicare fee changes, noting that the expanded use of G2211 has improved the financial sustainability of his practice. He emphasized that prioritizing office-based care helps keep family medicine preventive, community-centered, and cost-effective. Looking long term, he said Medicare payments must keep pace with inflation and better support care coordination and patients with greater social and health needs. You can read his full interview below.

Q: *How do the changes in the 2026 Medicare Physician Fee Schedule, particularly the increase in the conversion factor and expanded use of G2211, affect your day-to-day practice?*

A: The changes in the Medicare Physician Fee Schedule including the use of the G2211 have made running the private practice I work at more financially sustainable. The reimbursements from Medicare had been essentially flat since the early 2000s, so paying my staff (who are not directly reimbursed from Medicare) from physician reimbursements has become more difficult over time. With the use of the G2211 code, I can afford to keep paying the referral coordinator my office hired to help keep patients receiving timely care when insurance denies the services and medications I prescribe and helps me to free up time to continue seeing patients in the clinic.

Q: *The new practice-expense calculation favors care delivered in office settings rather than facility settings. From your perspective as a family physician, why does that distinction matter, and how might it influence where and how care is delivered?*

A: As a family physician, the calculation favoring care delivered in office settings helps to keep preventive-minded care at the forefront of the healthcare arena. Family physicians function to help maintain the health of the entire family from womb to end of life and our position only stays successful as long as the system favors and incentivizes care in the office. Facility settings drive up the cost of care and redirect care away from community-based settings where family doctors who know their patients and understand their needs reside.

Q: *While these updates offer some relief, Medicare payments still haven't kept pace with inflation. What would a more sustainable Medicare payment system need to look like to truly support primary care long term?*

A: A sustainable Medicare payment system reimburses family doctors rather than facilities and keeps pace with inflation incentivizing doctors to live in a myriad of communities where they can provide the best care for their patients. Additionally, office visits that are reimbursed at a much higher rate when compared to procedures ensures that the complex needs of the patients are discussed and their mental and physical health is prioritized.

Health care reimbursements should also be higher in areas where patients face social disadvantage or have additional needs like nutrition, exercise, and safety needs which take more time and team-based discussions to solve long-term. Incentivizing family physicians to coordinate care with nutritionists, exercise physiologists, physical therapists, and social workers to name a few helpful professions will increase healing of the whole patient with the family physician as the head coordinator of this healing plan. Payments from enhanced coordination of team-based care would go far in this regard.