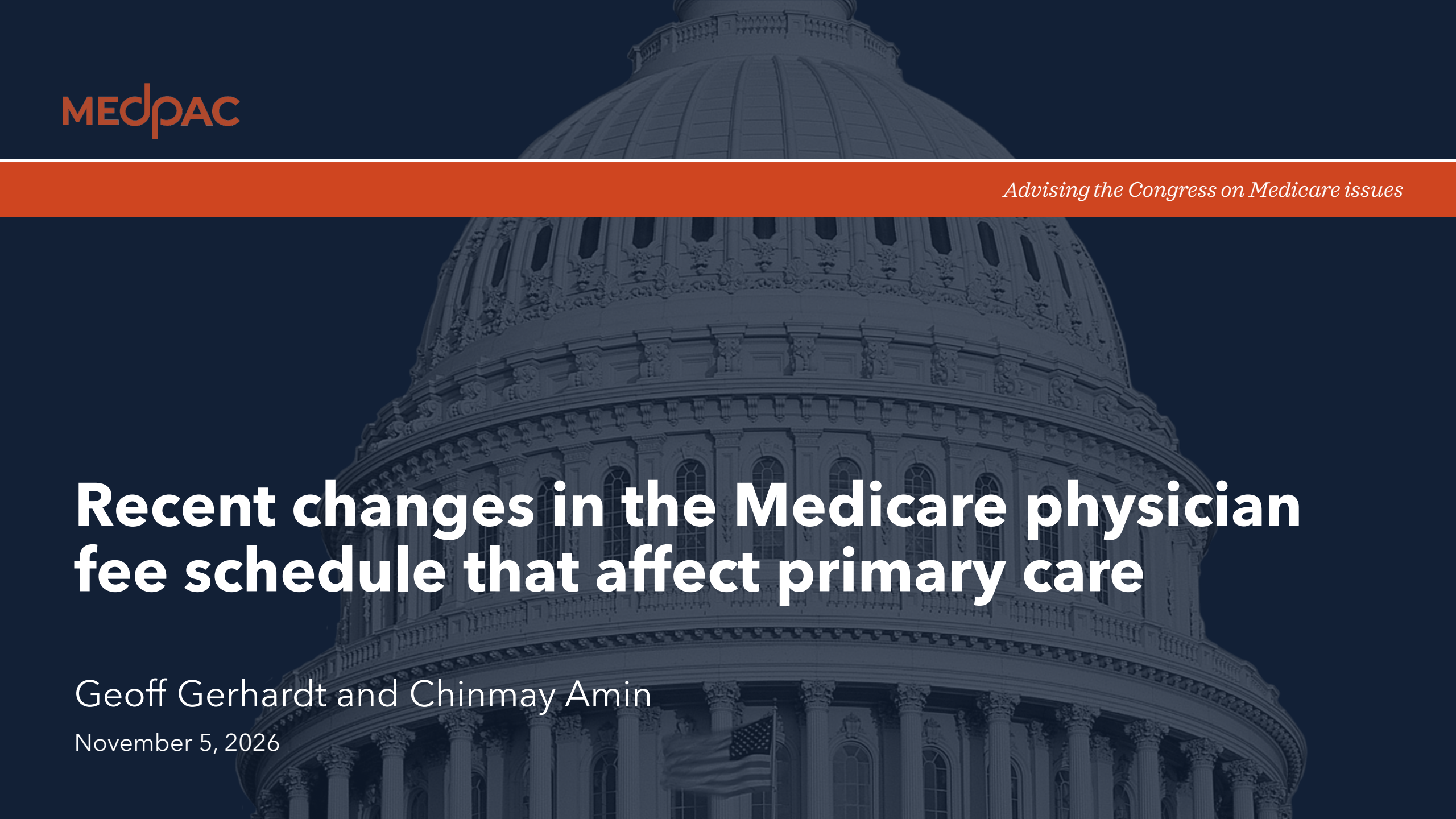
MEDPAC

Advising the Congress on Medicare issues



Recent changes in the Medicare physician fee schedule that affect primary care

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November 5, 2026

Background on primary care in the physician fee schedule

Concerns about primary care

- Robust primary care infrastructure has been linked to healthier populations, better access to care, and lower costs
- Data show that the number of primary care physicians has been declining
- When seeking a new provider, Medicare beneficiaries report having more difficulty finding primary care provider than specialist
- Historically, primary care has been undervalued in the PFS relative to specialty care
- Total average compensation for specialist physicians is much higher than for primary care physicians

Note: PFS (physician fee schedule).
Source: Basu, S., S. A. Berkowitz, R. L. Phillips, et al. 2019. Association of primary care physician supply with population mortality in the United States, 2005-2015. *JAMA Internal Medicine* 179, no. 4: 506-514; MedPAC, June 2026 report to Congress: Medicare and the Health Care Delivery System.

MedPAC has made recommendations to support primary care

- Budget-neutral payment adjustment for primary care services when furnished by clinicians focused on primary care
- Per-beneficiary per-month payment for primary care clinicians
- Medical home pilot that would make per-beneficiary per-month payments to practices that are focused on primary care
- Add-on payment of 15% to primary care providers for care furnished to low-income beneficiaries

Source: MedPAC, June 2008 report to Congress: Medicare and the Health Care Delivery System; MedPAC, March 2009 report to the Congress: Medicare Payment Policy; MedPAC, March 2015 report to the Congress: Medicare Payment Policy; March 2023 report to the Congress: Medicare Payment Policy.

CMS has recently taken steps to support primary care in the PFS

- Added new billing codes for care management and other primary care-oriented activities
- Increased payment rates for commonly performed E&M office/outpatient visit codes

- *These actions may have secondary effects on other Medicare payment systems and other payers*

Note: PFS (physician fee schedule), Evaluation and management (E&M).

What we did to assess changes in E&M payment policies

- Analyzed spending and utilization of new care management and other primary care-oriented billing codes
  - Segmented data by provider specially and type of practice
- Analyzed the impact of increasing payment rates of E&M visit codes
  - Estimated what share of current fee schedule revenue can be attributed to 2021 increase in RVUs for office/outpatient visit codes
  - Segmented data by provider specialty

Note: E&M (evaluation and management), RVUs (relative value units).

Utilization and spending on care management and related codes

Medicare now pays for a variety of new primary care-oriented billing codes

- Most new codes pay for care management activities that occur between face-to-face visits
  - Clinicians have flexibility in how they use payments to coordinate care, including investing in care management technologies or hiring additional support staff
- Advanced primary care management (APCM) codes make monthly per-beneficiary payments for care management activities not paid under other codes or in lieu of other codes
- Add-on code for ongoing care of patients with complex conditions
- Most of the new codes can be billed by clinician of any specialty who is focal point of patient's care

Note: With certain exceptions, these codes require 20 percent cost-sharing payment from beneficiaries.

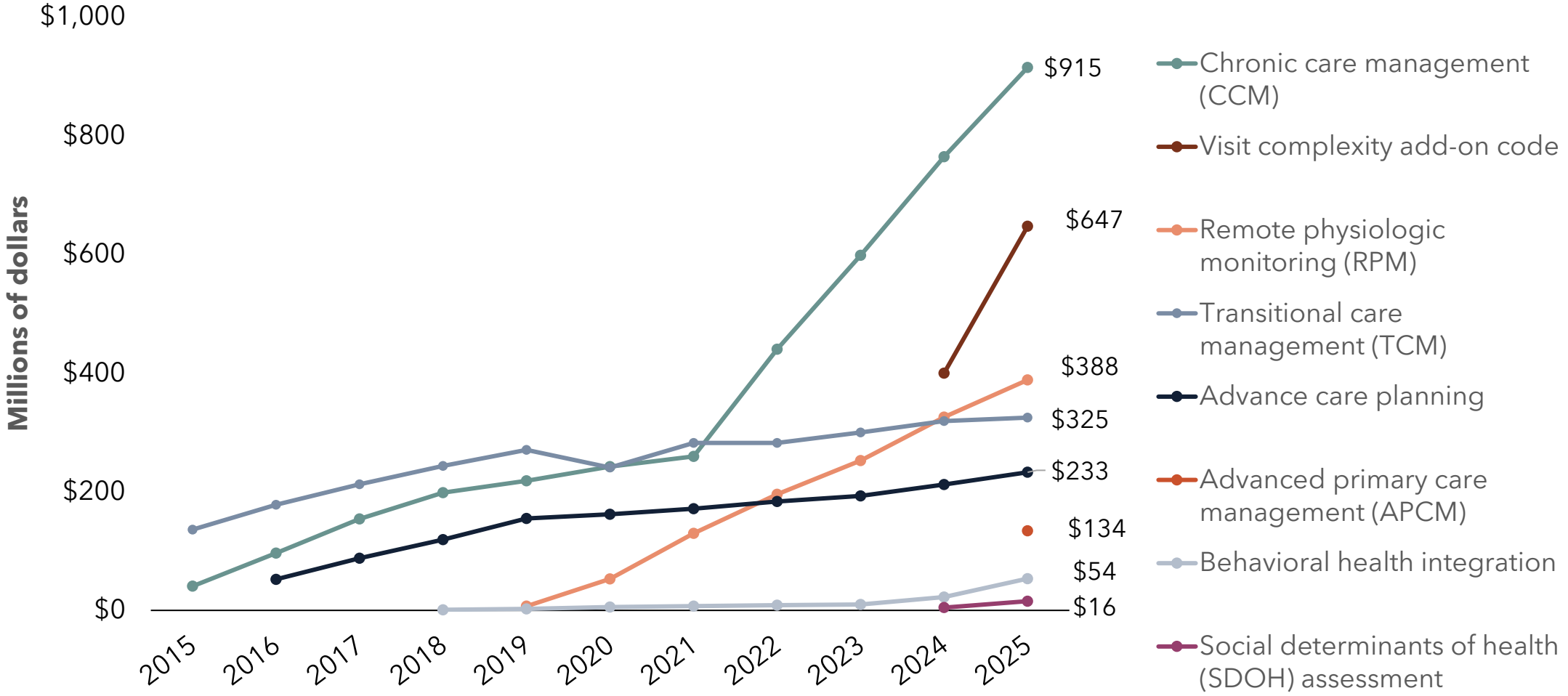
Care management codes in the physician fee schedule

Type of services	Years introduced	Number of payment codes	Payment rate range, 2026
Chronic care management (CCM)	2015-2021	5	$50 - $144
Transitional care management (TCM)	2013	2	$220 - $299
Advanced primary care management (APCM) (*can use instead of above codes*)	2025	3	$54 - $117
Behavioral health integration	2018	1	$57
Social determinates of health assessment	2024	3	$20 - $86
Remote physiologic monitoring (RPM)	2019-2026	5	$22 - $52
Advanced care planning	2016	2	$78 - $87
Visit complexity add-on code (G2211)	2024	1	$17

Note: "Payment rate range in 2026" reflects national payment amounts for a nonfacility setting (e.g., office), actual payment amounts vary based on geography and other factors. Some codes that are infrequently used are not shown (e.g., for e-visits, virtual check-ins)

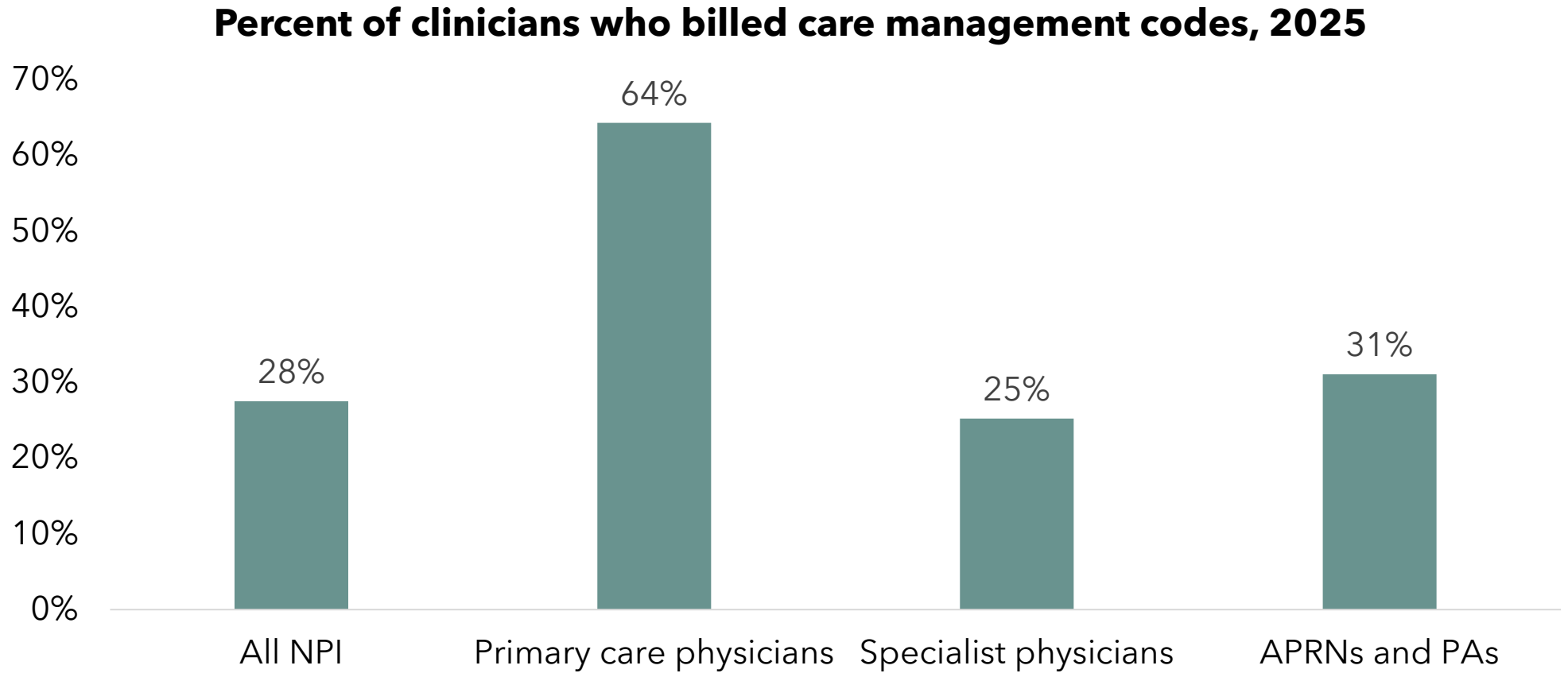
Source: American Medical Association RBRVS Data Manager.

Allowed charges for care management codes have grown substantially since 2015



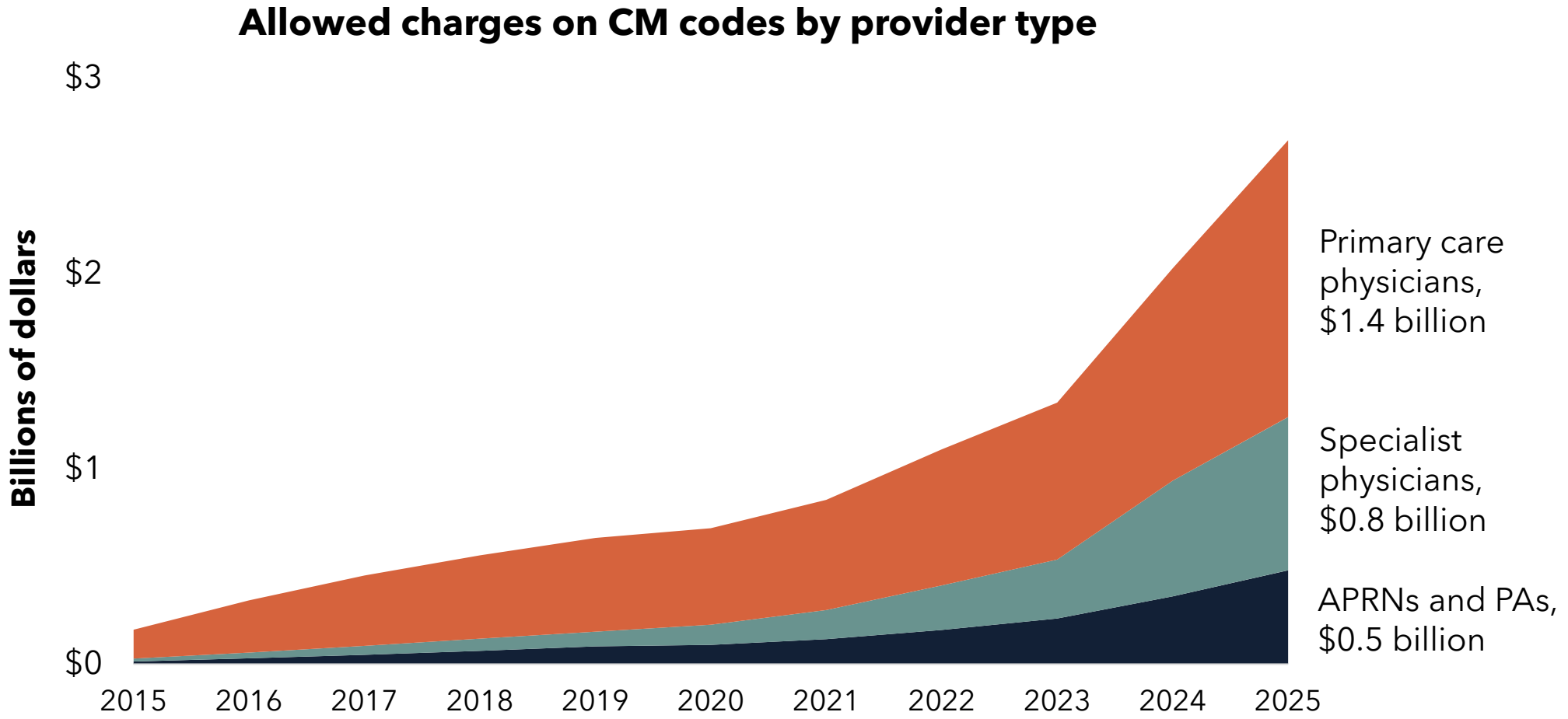
Source: MedPAC analysis of Physician/Supplier Procedure Summary Dataset.

Majority of primary care physicians billed for care management codes in 2025



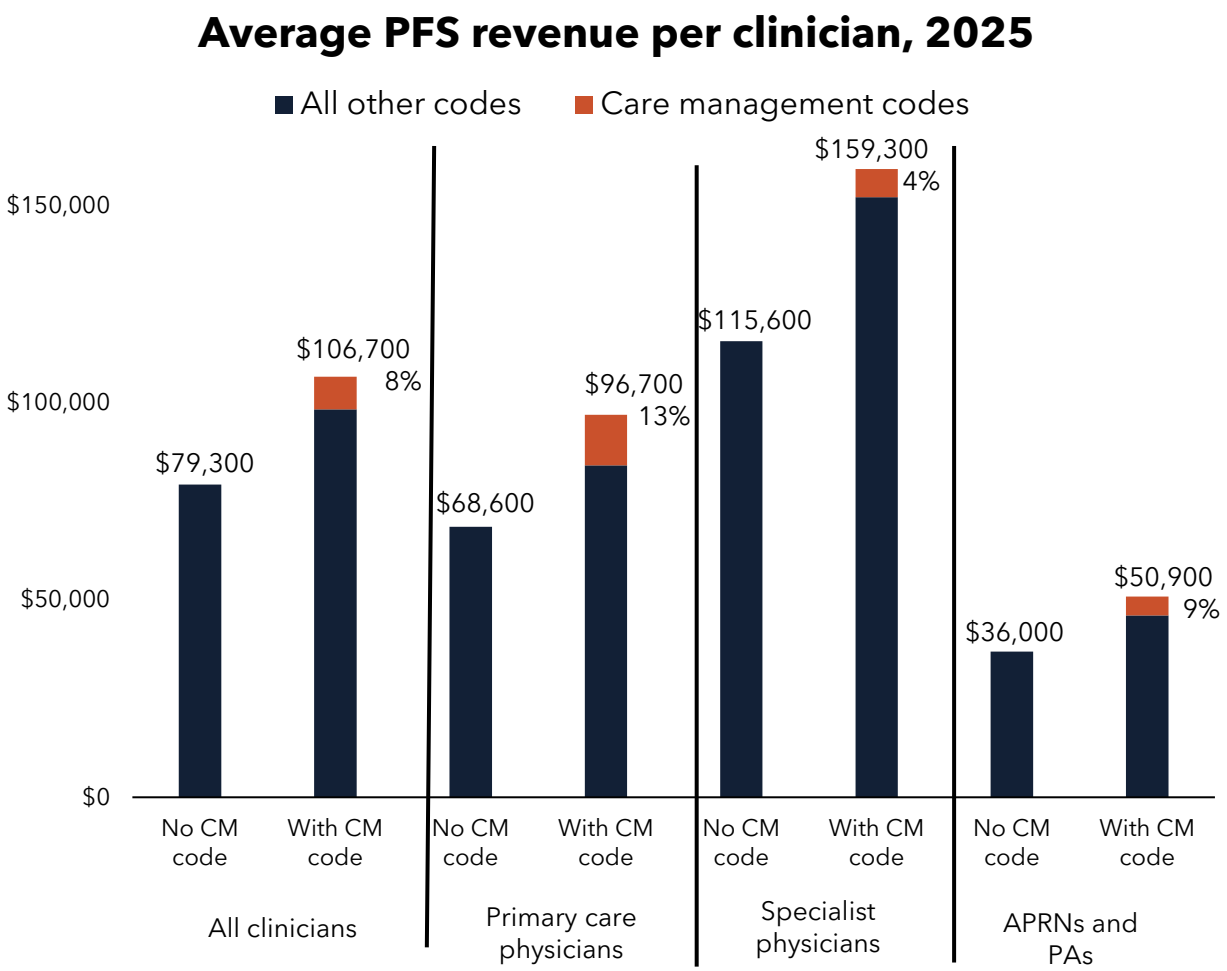
Note: NPI (national provider identifier, APRNs (advanced practice registered nurses), PAs (physician assistants).
Source: MedPAC analysis of Physician/Supplier Procedure Summary Dataset.

Most spending on care management codes went to primary care physicians, 2015-2025



Note: CM (care management), APRNs (advanced practice registered nurses), PA (physician assistants).
Source: MedPAC analysis of Physician/Supplier Procedure Summary Dataset.

Clinicians who billed for care management codes tended to have higher revenue than non-billers

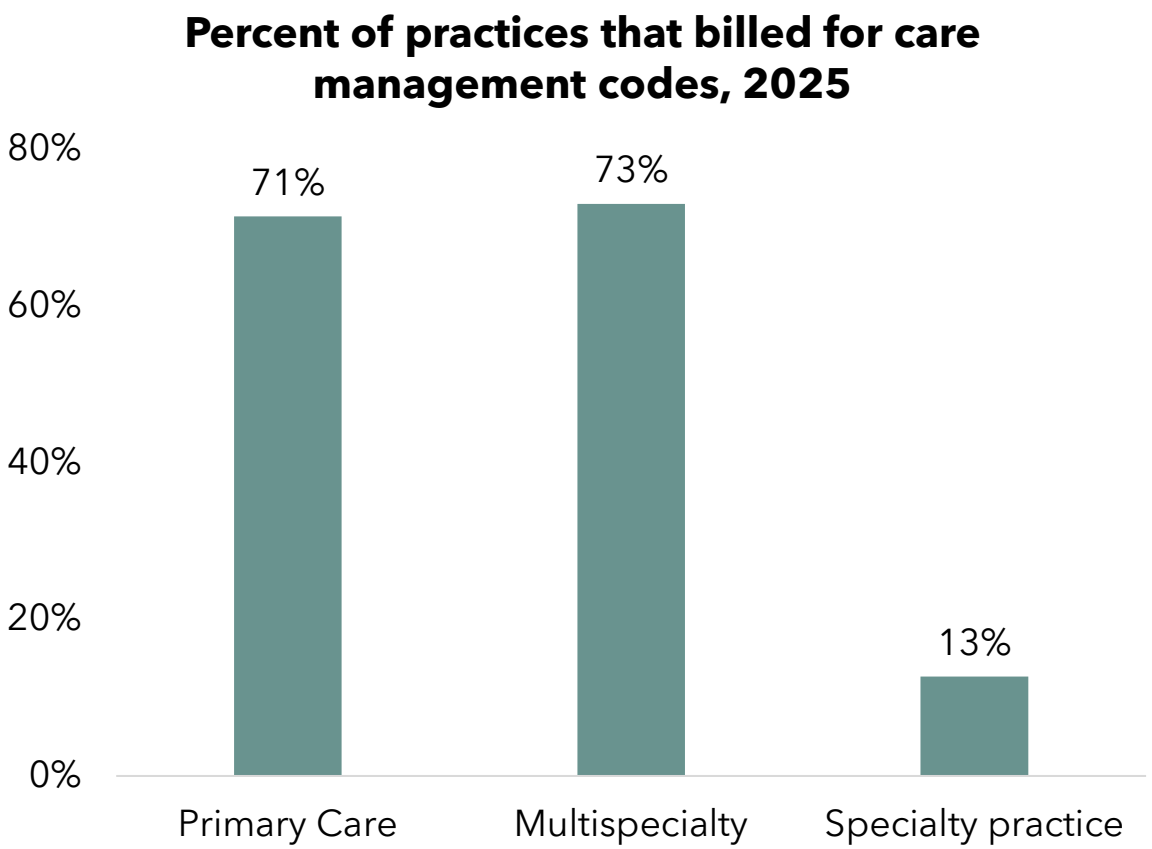


- Care management codes account for average of 8% of total PFS revenue among clinicians who bill for such codes
  - CM codes account for 13% of total PFS revenue among primary care physicians
- "Incident to" billing can affect distribution of revenue

Note: PFS (physician fee schedule), CM (care management), APRNs (advanced practice registered nurses), physician assistants (PAs)

Source: MedPAC analysis of Physician/Supplier Procedure Summary Dataset.

Most multispecialty and primary care practices billed for care management codes in 2025



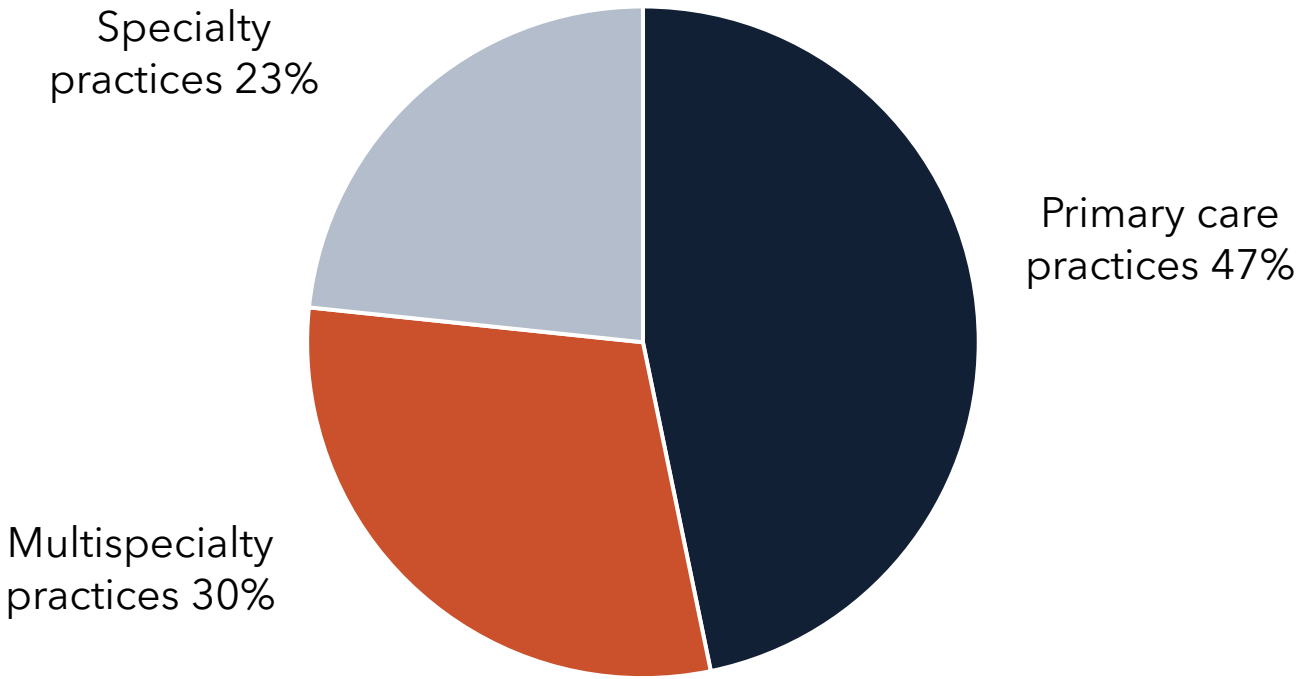
- Almost three-quarters of primary care and multispecialty practices billed care management codes in 2025
- 13% of specialty practices billed for care management

Note: Practices types are based on distribution of allowed charges by specialty for each tax identification number (TIN) used to bill for PFS service.

Source: MedPAC analysis of Physician/Supplier Procedure Summary Dataset.

Most spending on care management codes went to primary care practices in 2025

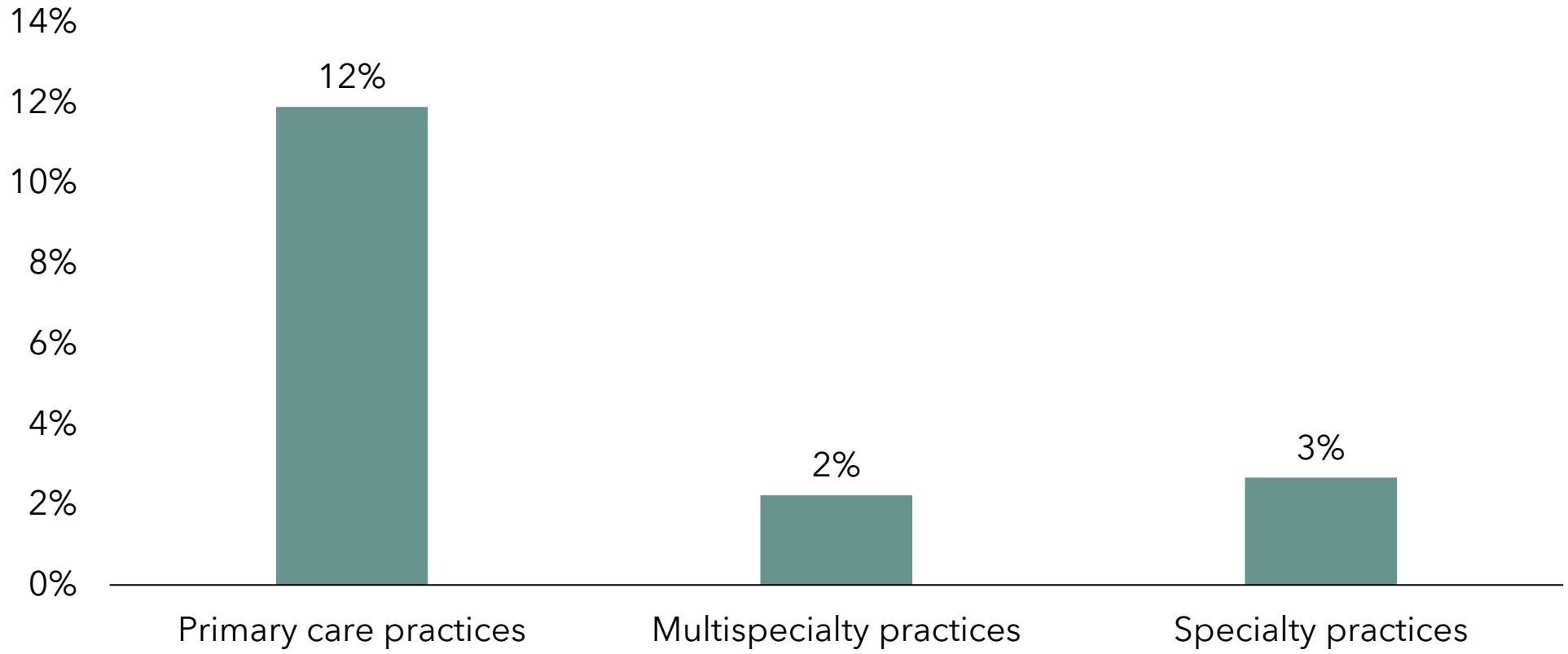
Share of total care management spending, by practice type, 2025



Source: MedPAC analysis of Physician/Supplier Procedure Summary Dataset.

Substantial share of total revenue at primary care practices was from care management codes

Share of total practice PFS revenue from care management codes, 2025



Note: PFS (physician fee schedule).
Source: MedPAC analysis of Physician/Supplier Procedure Summary Dataset.

Increased valuation of E&M outpatient/office visit codes

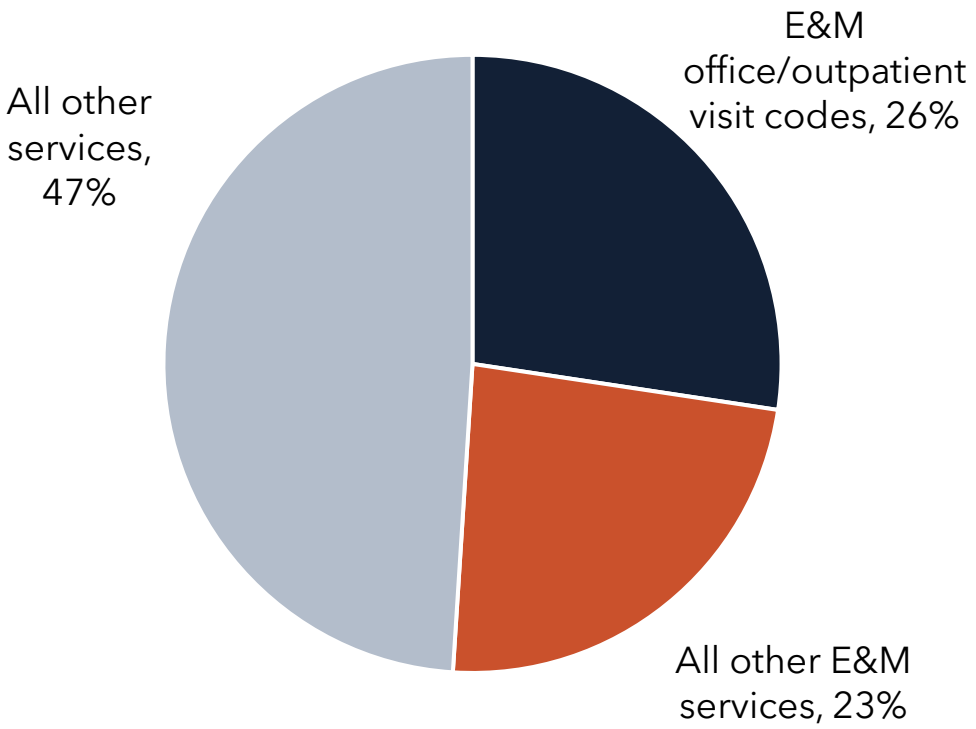
In 2021, CMS increased payment rates for E&M office/outpatient visit codes

- E&M office/outpatient visit codes pay for clinician's assessment of patient and management of their care
- In 2021, relative values for these codes increased by average of 22%
  - Driven by increase in work relative values
- Budget neutrality requirement mandates that estimated increases in spending resulting from changing RVUs must be offset by across-the-board reduction in payment rates for all codes

Note: E&M (evaluation and management), RVUs (relative value units).
Source: MedPAC analysis of Physician/Supplier Procedure Summary Dataset.

E&M office/outpatient visit codes accounted for a large share of total PFS spending in 2025

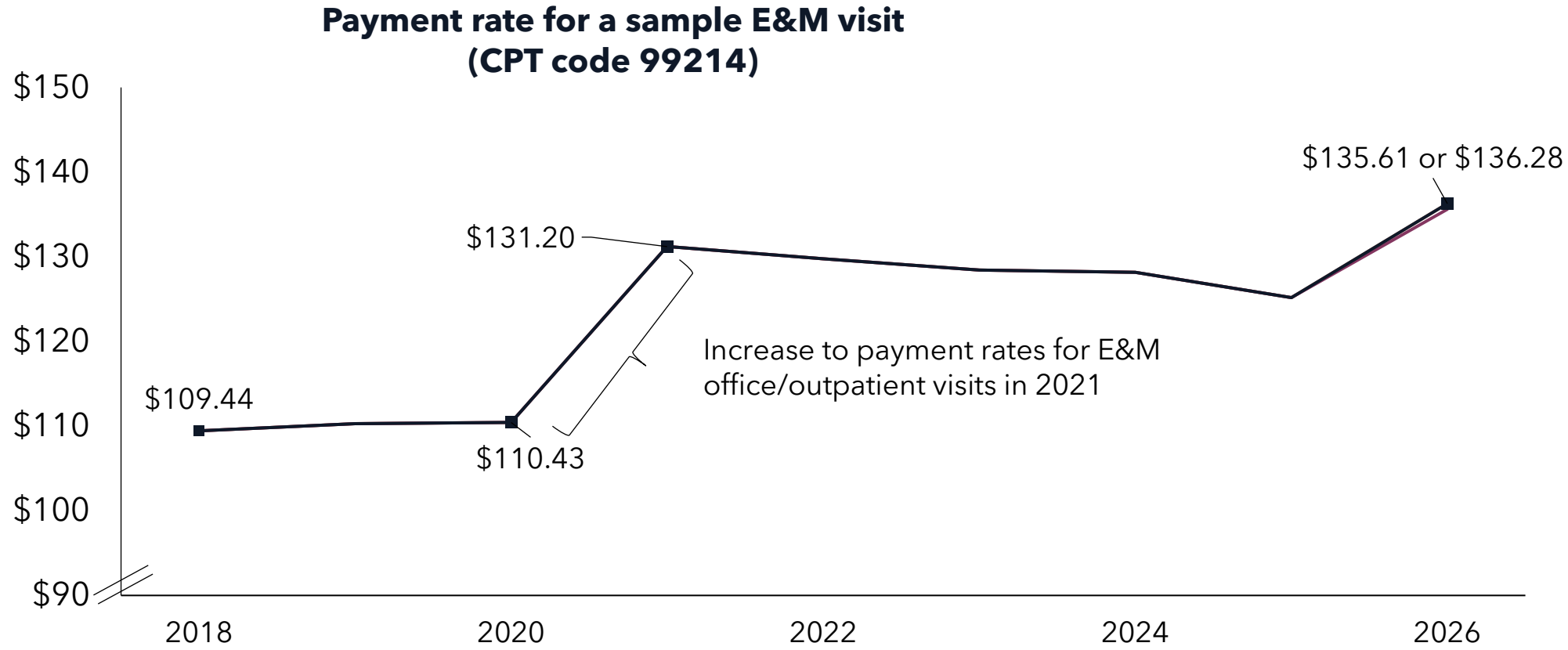
Spending on office/outpatient visit codes as share of total PFS spending, 2025



- E&M office/outpatient visit codes are the most widely used in the PFS
  - 26% of total fee schedule spending

Note: E&M (evaluation and management), PFS (physician fee schedule).
Source: MedPAC analysis of Physician/Supplier Procedure Summary Dataset.

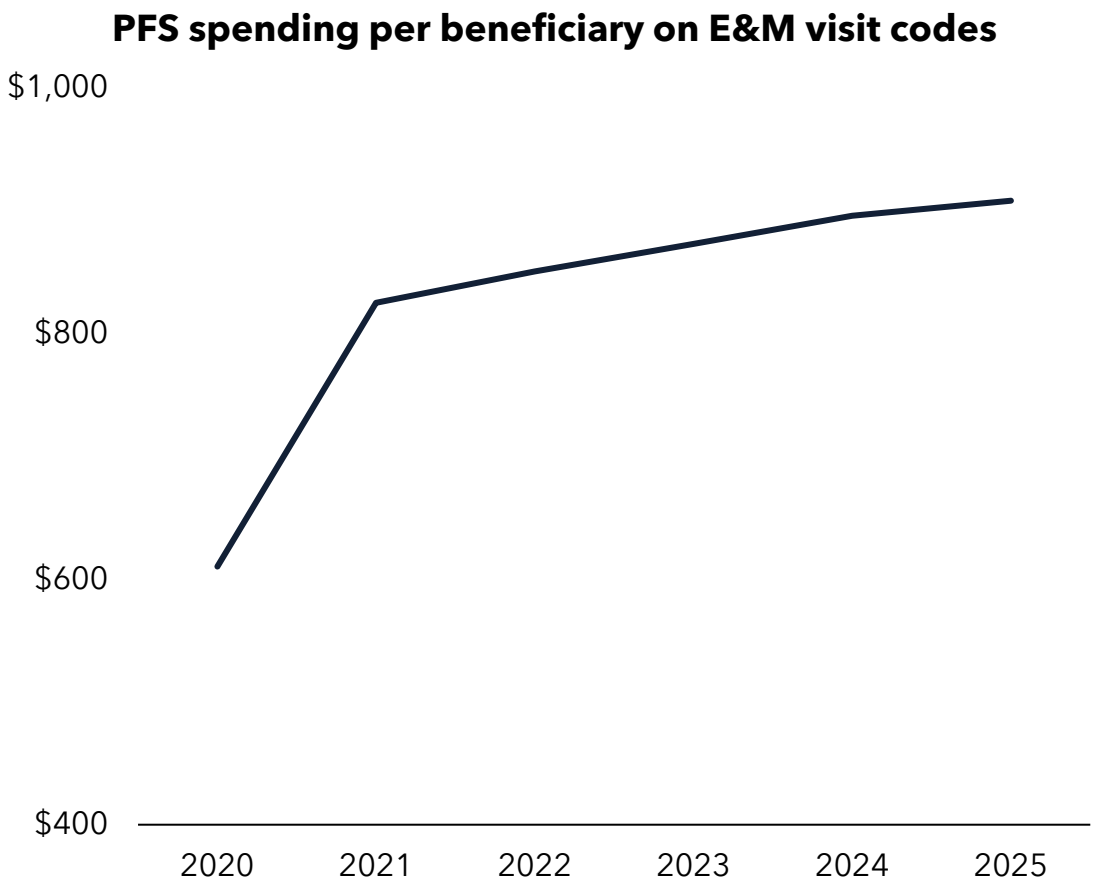
Example of increase in payment rates for E&M office/outpatient visits



Note: E&M (evaluation and management), CPT (Current Procedural Terminology). CPT code 99214 refers to a visit involving a middle level of medical decision-making; if time is used for code selection, 30–39 minutes are spent on the date of the encounter. Payment rates shown for 99214 are nonfacility national payment rates. CMS increased values for E&M services in other clinical settings as well, which contributed to declines to the conversion factor. In 2026, there are two different conversion factors (and therefore payment rates), depending on whether a clinician is a qualifying participant in an advanced alternative payment model (A-APM) or not.

Source: CMS. Search the physician fee schedule (billing code–payment rate look-up website), https://www.cms.gov/medicare/physician-fee-schedule/search/overview.

Spending on E&M visit codes grew rapidly in 2021, followed by smaller increases through 2025

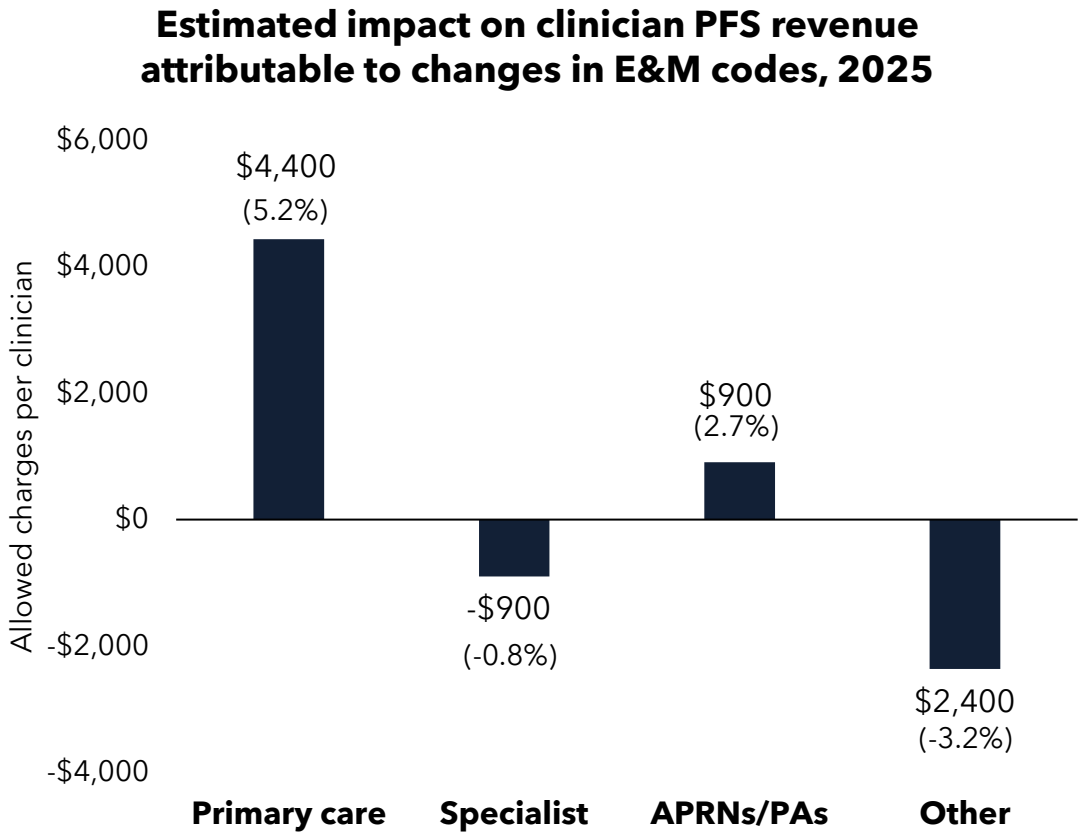


- Spending per beneficiary grew 49% from 2020 to 2025
  - Driven by RVU increases, volume growth, and adjustments to the fee schedule conversion factor
- Aggregate spending on E&M visit codes grew from $19.7 billion to $25.5

Note: E&M (evaluation and management), PFS (physician fee schedule), RVUs (relative value units).

Source: MedPAC analysis of Physician/Supplier Procedure Summary Dataset, National Physician Fee Schedule Relative Value File 2020-2025

Estimated impact of 2021 increases in office/outpatient visit RVUs on provider fee schedule revenue



- E&M payment rates increased, and budget neutrality adjustment reduced rates for other codes
- Clinicians with relatively high E&M usage saw net increase in PFS revenue
- Clinicians with relatively low E&M usage saw net decrease in PFS revenue

Note: RVU (relative value unit), E&M (evaluation and management), PFS (physician fee schedule). Dollar amounts represent the estimated average impact on per clinician PFS allowed charges attributable to 2021 increase in E&M RVUs. Percentages are share of total average allowed charges per clinician.

Source: MedPAC analysis of Physician/Supplier Procedure Summary Dataset.

Discussion

Care management codes and changes in E&M payment rates increased revenue for primary care providers

- Primary care physicians received the largest share of care management payments, but specialists and APRNs/PAs also received significant amounts
- On average, CM codes account for 13% of primary care physician revenue and 9% of APRN/PA revenue among providers who bill for those codes
- On average, increases in E&M RVUs increased net fee schedule payments to primary care physicians by 5.2% and APRNs/PAs by 2.7%.
  - Fee schedule payments to specialist physicians and other practitioners are less than they otherwise would be

Note: E&M (evaluation and management), APRNs (advanced practice registered nurses), PAs (physician assistants), CM (care management), RVUs (relative value units).
Source: MedPAC analysis of Physician/Supplier Procedure Summary Dataset.

Discussion/questions

- Questions about the analysis?
- Interest in having MedPAC do additional work on primary care?
- What should future work on primary care focus on?



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