NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS®

Medicare FQHC Updates: Calendar Year 2026

Medicare is an important program for Federally Qualified Health Centers (FQHCs), also known as Community Health Centers (CHCs), and the changing policy landscape plays a critical role in the services CHCs can provide to their patients. The Centers for Medicare and Medicaid Services (CMS) issues an annual rule, the Physician Fee Schedule Final Rule, which provides details on new policies for Medicare providers. Below is a summary of the latest updates for CHCs, including any specific provisions in the Calendar Year 2026 Physician Fee Schedule directly impacting CHCs.

Questions? Send them to regulatoryaffairs@nachc.org.

Medicare Population Continues to Grow at CHCs

The number of Medicare patients seeking care at CHCs is increasing rapidly, reflecting the demographic shift toward an older population. Data from the 2024 Uniform Data Set indicate that patients aged 65+ are the fastest-growing patient population, and that almost 11% of CHCs' patients are Medicare beneficiaries.

FQHC Provisions from the CY26 Medicare Physician Fee Schedule

The FQHC market basket update of 2.5% increases the **FQHC PPS base payment rate to $207.72 for 2026**, reflecting higher costs for staff, supplies, and operations. This increase helps CHCs keep up with rising costs, supports financial stability, and enables them to continue providing comprehensive care to Medicare patients.

Telehealth

- **CHCs may continue to bill G2025 for distant-site non-behavioral health telehealth services through December 31, 2026.**
- CMS did not revise the definition of a medical visit to include audio-video technology; telehealth billing rules remain unchanged for CHC visits. Congress delayed the in-person requirement for mental health services until January 1, 2028 (H.R. 7148).
- **Additional Resources:**
  - NACHC's Government FAQ
  - CMS' Telehealth FAQ
  - Specific Payment Codes for FQHC PPS

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

Additional Telehealth Updates

Teaching physicians may continue to provide **virtual supervision for Medicare telehealth services in all teaching settings** beginning January 1, 2026. 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.

- Teaching health centers and CHCs hosting residents from other programs for outpatient rotations must ensure documentation continues to show whether the teaching physician was physically or virtually present and for which portion of the service to be reimbursed.

CMS also **permanently adopted a definition of direct supervision that allows real-time audio and video supervision (excluding audio-only)**. CHCs should review supervision protocols, especially for incident-to services and services requiring direct supervision, to ensure compliance.

Aligning with the Physician Fee Schedule

CMS finalized its 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 CHCs.**

REMINDER: G0511 (care management) is no longer reportable.

- If your organization is having issues reporting the individual codes that make up G0511 to your state Medicaid agency given this change, please contact NACHC's Regulatory Affairs team for support (regulatoryaffairs@nachc.org)

Primary Care Updates

Conversion Factor & Efficiency Adjustment: CMS finalized a conversion factor increase for CY26 but also adopted a 2.5% efficiency adjustment reducing work RVUs and intra-service time for most non–time-based services, including E/M, care management, and behavioral health codes.

- Changes to the conversion factor directly impact how much Medicare pays for services, so this increase means increased reimbursement for CHCs billing for PFS services, and better reimbursement for CHCs participating in value-based care (VBC) arrangements as well.
- Additionally, the efficiency adjustment shifts value from costly procedures to time-based services (like primary care) and increases predictable funding for care coordination, making primary care more sustainable and better resourced.

Practice Expense Methodology: CMS modified the indirect practice expense (PE) allocation for facility services, reducing the indirect PE per work RVU to 50% of the non-facility amount. This change may affect reimbursement assumptions for services furnished in facility settings and should be reflected in internal financial modeling.

- This change means facility-provided (hospital) services get less PE, while non-facility (office-based) services receive more, shifting payments to favor and generally stabilize services provided in office settings

Remote Patient Monitoring (RPM): CMS finalized two new RPM codes that give providers more billing options for shorter monitoring durations and management times. Four foundational RPM codes received updated 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

Behavioral Health

CMS finalized separate coding and payment for Advanced Primary Care Management (APCM) services. Three optional add-on codes were finalized to support complementary Behavioral Health Integration (BHI) or Collaborative Care Model (CoCM) services.

- CHCs should evaluate whether to bill APCM, continue separate care management and behavioral health services, or use a combination based on patient mix and operational capacity. CMS did not classify APCM or behavioral health services as preventive, meaning cost-sharing may still apply.

APCM G-Codes		
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

BHI Optional Add-on Codes		
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 (CHI) and Principal Illness Navigation

CMS clarified that **Marriage and Family Therapists (MFTs), Mental Health Counselors (MHCs), and Clinical Social Workers (CSWs) can serve as auxiliary personnel** under the general supervision of the billing physician/qualified health professional in performing these services. They are also eligible to bill Medicare directly for Health Behavior Assessment and Intervention (HBAI) services they furnish, including when those services function as initiating visits for CHI/PIN.

- CMS finalized that **CPT 90791** (psychiatric diagnostic evaluation) and Health Behavior. Assessment and Intervention (HBAI) services, which focus on psychological factors in managing physical health conditions, can serve as initiating visits for Community Health Integration (CHI).
- The CY26 Physician Fee Schedule officially replaced the term "social determinants of health (SDOH) with "**upstream driver(s)**."

340B and Medicare Prescription Drug Inflation Rebate Program (IRA) Updates

Claims-Based Methodology: CMS finalized a new policy to comply with the statutory requirement of **excluding 340B units from Part D rebate calculations**. This involves an estimation percentage based on 340B purchases relative to total sales.

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

Voluntary Part D Claims Repository: CMS is establishing a voluntary Medicare Part D 340B claims data repository, anticipated in Fall 2026. Under the 340B data repository, 340B covered entities would **opt-in to participate in a testing period for submission of certain limited claim-level data necessary to identify (and exclude) 340B drugs for the inflation rebate calculations**.

- While the repository is currently framed as voluntary, CMS has made clear in the PFS that they **expect to move towards a mandatory claims data submission process** in the near future and that 340B covered entities should take advantage of the "voluntary" period to familiarize themselves with the process for when it becomes mandatory.
  - CHCs should prepare for potential data submission requirements, including NDC-11, dispensing NPI, fill date, and prescription identifiers.

Medicare Shared Savings Program (MSSP)

The CY26 PFS now requires ACOs applying to enter a new agreement period to have at least 5,000 assigned beneficiaries in Benchmark Year (BY) 3, while allowing the ACO to have under 5,000 assigned beneficiaries in BY1, BY2, or both. *CHCs participating in or considering MSSP should reassess financial risk exposure and consider building or strengthening risk reserves.*

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.

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

Social Determinants of Health Risk Assessment

CMS opted **not** to remove G0136, 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."*

REMINDER: G0136 may be performed in an CHCs but will not result in additional reimbursement when performed on the same day as another service. It is not considered a qualifying visit in CHCs, so if it is the only service performed on that date of service, there is no reimbursement for it. CHCs should ensure appropriate use and avoid scheduling G0136 as the sole service.

Quality Programs and Health Equity Adjustments

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.

Screening for **social drivers of health** will be removed as a Merit-based Incentive Payment System (MIPS) quality measure starting in 2028.

Medicare Diabetes Prevention Program (MDPP)

CMS extended flexibility for **virtual and asynchronous MDPP delivery through December 31, 2029**. A new HCPCS code (G9871) was established for online MDPP sessions and beneficiaries may now self-report weight, including data collected in medical records within five days. Review CMS' Fact Sheet on changes to the MDPP Program.