AAFP Government Relations:

A Look into the Academy's Advocacy Priorities

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Government Relations Overview

About AAFP Government Relations

Based in Washington, DC

Advocates on behalf of AAFP and its members before Congress and the Administration

Four Division Segments
Legislative Affairs · Policy & Regulatory Affairs · Political Affairs · State Affairs & Member Advocacy

Advocacy Focus Areas

1. Recognizing the value of primary care
2. Reducing administrative burden
3. Increasing, strengthening, & sustaining the primary care workforce
4. Improving health care for all

∞ Access and Affordability ∞ Health Disparities ∞ Rural Health ∞ Team-Based Care ∞ Physician-Patient Relationship

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Value of Primary Care

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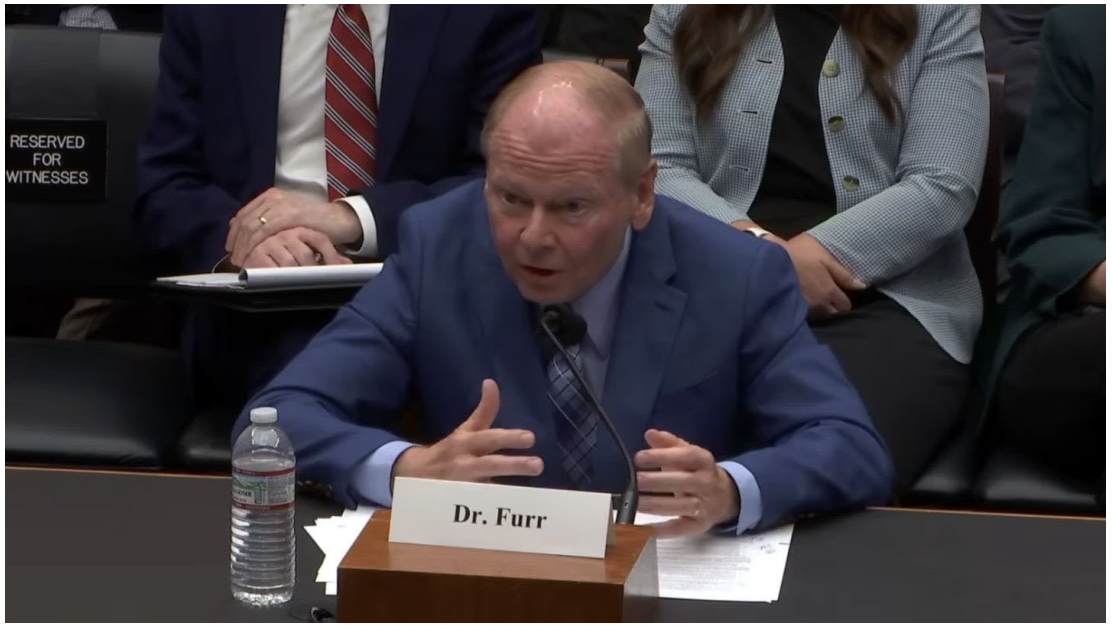
Up First: Medicare

Medicare Payment: Congress is Listening



"To truly reduce the costs of health care, we must invest in health, and health starts with primary care."

– Shawn Martin, CEO & EVP of the AAFP
March 2026

"We need to pay family physicians for preventing disease, not incentivizing the delivery of more services to treat it."

– Dr. Steven Furr, MD, FAAFP, Past President of the AAFP
May 2026

Patients First Act: What Family Physicians Should Know

Payment update	• MEI-based conversion factor update beginning in 2027, with a floor/ceiling mechanism and higher update for qualifying APM clinicians • Raises the work GPCI floor in "high inflation years," with an additional bump for rural localities
Primary care PMPM pilot	• Five-year PMPM model for primary care clinicians in independent practice • Services covered include office visits, care management, BHI, and tech-based communications • Patient cost-sharing waived
Measurement reform	• Replaces MIPS with POINTS after a five-year phase in, maintains low-volume exemption, and caps payment adjustments during transition • New physician-majority task force to develop specialty-specific quality measures for CMS
APM reforms	• Freezes current advanced APM threshold for three years • Provides the Secretary with additional flexibility to lower the threshold in order to increase participation in new models
Budget neutrality	• Raises the budget neutrality threshold • Requires CMS to correct over- or under-utilization assumptions • Requires more timely updates to practice expend cost inputs • Limits annual changes to the CF to 2.5%, outside of the required inflationary update

Primary Care PMPM Pilot: Why It Matters

PREDICTABLE PAYMENT

PMPM payments would be paid prospectively, and encompass care management, office visits, behavioral health integration and technology-based communications.

PATIENT ACCESS

Waives patient cost-sharing for PMPM payments, reducing financial barriers to longitudinal, comprehensive care.

FOCUS ON PRIMARY CARE CLINICIANS

Eligibility is focused on physician-majority-owned settings and primary care clinicians (family medicine, geriatrics, peds, general IM, and APPs providing at least 60% primary care services).

NOT A ZERO-SUM CUT

PMPM payments would exempt from Medicare budget neutrality, ensuring there aren’ t broad cuts as a result.

2027 Medicare Physician Fee Schedule: Policy Updates

Conversion factor updates	• CY 2027 APM CF: $33.1693 (a decrease of $0.40 or 1.19 percent) • CY 2027 nonqualifying APM CF: $32.8409 (a decrease of $0.56 or 1.68 percent). • Cut driven by the expiration of the statutorily-provided temporary 2.5 percent payment increase • Estimated impact on total allowed charges by family physicians will be +1% in 2027
Teaching physician policy	• Proposes that all levels of an office E/M service provided in primary care centers may be provided under direct teaching physician in such cases where the teaching physician believes such care is clinically appropriate without teaching physician • Allows billing for telehealth services when the resident is physically present with the beneficiary and the teaching participates virtually, or vice versa
E/M resource overlap	• Proposes to reduce payment when a separately identifiable office visit is furnished by the same physician (or a same group practice) on the same day as a 0-, 10-, and 90-day global procedure • Most expensive service would be paid at 100%, and all other procedure(s) or E/ visit(s) would be paid at 50
G2211 payment updates	• Proposes to replace code G2211 with a modifier (temporarily labeled MOD1 and MOD2) that would increase the code to which it’ s appended by 16% (non-ACOs) and 32% (ACOs)
New relevant codes	• Creation of new advance care planning (ACP) codes that more explicitly describe and value the contributions of provision of services • Proposes to create coding and valuation specifically for shared medical appointments, also known as group visit, code for “vaccine adverse effects management”

2027 Medicare Physician Fee Schedule: RFIs Galore

Redesigning Primary Care to MAHA RFI	• Seeking information on relative undervaluation of primary care services, how CMS might pay for technology-enabled primary care, and the potential for CMS to establish prospective primary care payments (PPCP) • Requests feedback on distinguishing between one-time consultative visits and care that is part of a longitudinal relationship within the office/outpatient E/M code set, revisions to care management codes to improve value and uptake, and improvements to the IPPE and AWV
RFI on PE RVUs and Global Surgical Services	• Proposes to pause the data collection related to how to best value global surgical services and asks whether all physicians should be required to report 99024 when providing a postoperative follow-up visit otherwise included in a global surgical service. • Seeks comments on various issues related to PE RVUs, including: whether a modifier should be established for employed physicians and how to address the problem that the current structure of global surgery services has effectively obscured how the components of care are individually valued and limited CMS' ability to disaggregate them
CPT RFI	• Examining the role of the AMA's CPT coding system and RUC in physician payment policy, seeking comments on the impact of AMA's control of CPT licensing, whether the current process appropriately reflects medical necessity, potential alternatives to CPT as the national coding standard, and whether payment systems based on ICD-10 codes or other grouping methodologies could serve as an alternative

Next: Medicaid

Implementation of H.R. 1: Medicaid Provisions

Community Engagement Requirement Interim Final Rule

- Implements H.R. 1's Medicaid "community engagement" (work reporting) provisions; states must begin by January 1, 2027.
- CMS goes beyond the law: it keeps H.R. 1's five medical-frailty categories but also requires states to assess whether the condition significantly impairs the patient's ability to meet the requirement.

How will this impact family physicians?

1. Increased Documentation Requests: Expect requests to document diagnoses, functional limitations, and exemption forms to verify medical frailty.
2. Ongoing Reverification Requirements: States must reverify frailty annually; self-attestation ends after 2027, and documentation rules tighten in 2028.
3. Risk of Coverage Loss for Clinically Stable Patients: Stable, chronically ill patients could lose coverage if they can't show enough functional impairment.

Key AAFP recommendations to CMS:

- Revise the rule to align with the statute and state capacity
- Broaden the definition of medical frailty
- Continue self-attestation when reliable data are unavailable
- Clarify that physicians provide clinical documentation only, not eligibility determinations

Implementation of H.R. 1: Medicaid Provisions

State Directed Payment and Targeted Practitioner Payments Proposed Rule

Changes two Medicaid payment mechanisms—State Directed Payments (SDPs) and targeted Fee-for-Service payments—adding Medicare-based caps and new reporting rules.

How will this impact family physicians?

Likely to limit states' use of Medicaid supplemental payment (SDP) programs for primary care and value-based care. States use SDPs to raise primary care rates and address workforce shortages.

The proposal would cap SDP payments at 100% of Medicare rates (110% in non-expansion states). It starts with four statutory categories, expanding to all SDPs in 2029.

Key AAFP recommendations to CMS:

- Limit caps to statutory service categories.
- Preserve flexibility for primary care payments.
- Exempt services without Medicare equivalents.
- Protect value-based payment arrangements.

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Reducing Administrative Burden

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Fixing Prior Authorization for Seniors

Support the Improving Seniors' Timely Access to Care Act (H.R. 3514 / S. 1816)

94%
of physicians report prior authorization delays care

30%
of patients experience delays in treatment

How the Seniors' Act helps

Streamline & standardize
Modernize prior authorization across Medicare Advantage plans.

Boost transparency
Add accountability and clear rules for insurers.

Reduce burden
Ease administrative load on physicians and care teams.

Protect access
Help seniors get medically necessary care without harmful delays.

Status: Passed the House Energy & Commerce Health Subcommittee and Ways & Means Committee—now ready for a full House vote.

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Investing and Strengthening the Primary Care Workforce

Sustaining CHCs & the NHSC

Community health centers and the National Health Service Corps ensure patients can access primary care regardless of where they live or their ability to pay—but funding is set to expire at the end of this year.

32M+

patients receive primary care at community health centers nationwide

19M

patients served annually by NHSC clinicians

Why these programs matter

Reach every community

Serve rural, urban, tribal and other medically underserved communities.

Comprehensive care

Medical, dental, behavioral health and substance use services, regardless of insurance or ability to pay.

NHSC workforce

Nearly 2,800 primary care clinicians and over 80,000 alumni, recruited through loan repayment and scholarships.

Stability at risk

Temporary extensions create uncertainty for hiring, planning services and meeting growing patient needs.

Action needed: Funding for community health centers and the NHSC expires December 31—Congress must act to give communities, physicians and patients long-term stability.

Protecting Patient Access: H-1B Visa Fee Relief

Support H.R. 7961 — the H-1Bs for Physicians and the Healthcare Workforce Act

01

The problem

A September 2025 proclamation put a $100,000 fee on each new H-1B visa petition — with no exemptions for physicians, stalling recruitment already underway.

02

The legislation

H.R. 7961, the bipartisan H-1Bs for Physicians and the Healthcare Workforce Act, exempts physicians and health professionals from the fee.

03

The ask

Urge your members of Congress to cosponsor and pass H.R. 7961 to protect patient access in communities facing physician shortages.

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Healthcare for All

Health care for all

- Affordability – ACA, HSA reform
- Vaccines
- Physician-patient relationship

Expanding Access to Chronic Care Management

Support H.R. 8261 — the Chronic Care Management Improvement Act of 2026

01

The problem

Medicare charges patients a 20% coinsurance for Chronic Care Management (CCM), billing them for care delivered between visits. This drives confusion and refusals — only 4% of eligible beneficiaries, about 882,000 of more than 22 million, receive CCM.

02

The legislation

H.R. 8261, the Chronic Care Management Improvement Act of 2026, eliminates CCM cost-sharing so more patients with chronic conditions can get ongoing support between visits.

03

The ask

Urge your members of Congress to cosponsor and pass H.R. 8261 — it expands access and lowers costs, with CCM patients averaging $95 less in Medicare spending per month.

Thank you!