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INSIGHTS

Calendar Year 2027 Medicare Physician Fee Schedule Proposed Rule

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On July 14, 2026, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2027 Medicare Physician Fee Schedule (PFS) Proposed Rule. The CMS press release can be found here. A fact sheet from CMS is available here. A separate fact sheet on the Medicare Shared Savings Program (MSSP) proposals can be found here. The 60-day comment period under the Administrative Procedure Act (APA) for the CY27 PFS proposed rule ends on September 14, 2026.

CONVERSION FACTOR

As part of the rule, CMS proposes a CY27 conversion factor (CF) of $33.17 for Alternative Payment Model (APM) participants, known as Qualifying Participants (QPs), a -1.19% decrease ($0.40) from the CY26 QP CF of $33.57. For non-qualifying participants (non-QPs), the aggregate proposed CF is $32.84, reflecting a -1.68% decrease ($0.56) from the CY26 non-QP CF of $33.40. A summary of the components of those aggregate payment updates is below.

- Under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, the statutory update for CY27 is 0.75% for QPs and 0.25% for non-QPs. These are the same bifurcated statutory updates that first took effect in CY26 and that are intended to incentivize clinician participation in Advanced APMs.
- The one-year 2.50% CF increase provided by the One Big Beautiful Bill Act (OBBBA), which CMS refers to in the rule as the Working Families Tax Cut (WFTC) legislation, applies only to CY26 and expires at the end of this year. The expiration of that adjustment functionally imposes a 2.50% payment reduction under the PFS relative to CY26, absent further congressional action.
- The proposed CFs also include an estimated positive 0.53% adjustment to account for proposed changes in the work relative value units (RVUs) for certain services. The combination of the statutory updates, the expiration of the WFTC increase, and the work RVU adjustment produces the net negative CF updates described above.

E/M VISITS FURNISHED DURING GLOBAL SURGICAL PERIODS

CMS proposes reducing payment when a separately identifiable office/outpatient evaluation and management (E/M) visit is furnished by the same physician (or a physician in the same group practice) on the same day as a procedure with a 0-, 10-, or 90-day global period. Under the proposal, the most expensive service (whether the surgical procedure or the E/M visit) would be paid at 100% of its rate, and all other surgical procedures or E/M visits furnished that day would be paid at 50%. CMS advanced a similar proposal in the CY19 PFS proposed rule but did not finalize it at that time. In the CY27 rule,

the agency reiterates its view that efficiencies exist when the same physician or group furnishes an E/M service in conjunction with a global procedure and that the current methodology therefore duplicates payment.

E/M VISIT COMPLEXITY ADD-ON (G2211)

In the CY21 PFS final rule, CMS finalized separate payment for the office/outpatient E/M visit complexity add-on code, HCPCS code G2211. Implementation was delayed by statute and took effect for CY25. For CY27, CMS proposes two changes to this policy.

- CMS proposes converting G2211 from a stand-alone add-on code into a modifier (placeholder modifier MOD1) appended to the associated E/M base code. The modifier would increase payment for the associated E/M code by 16% rather than providing a flat dollar amount, maintaining an equal percentage increase across all E/M levels.
- CMS also proposes a second modifier (placeholder modifier MOD2) available only to practitioners participating in a Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO) or serving as Participant Providers in a Long-term Enhanced ACO Design (LEAD) Model ACO. The MOD2 modifier would increase payment for the associated E/M visit by 32% to recognize the additional costs of longitudinal care, including total cost of care accountability and aligned quality reporting. Use of MOD2 would be voluntary and billable for all beneficiaries served by the practitioner, not only ACO-assigned or ACO-aligned beneficiaries. Claims submitted with MOD2 would be included in MSSP beneficiary assignment calculations, historical benchmark expenditures, and performance year expenditures.

PRACTICE EXPENSE

CMS describes a multi-year effort to transition the practice expense (PE) methodology away from reliance on American Medical Association (AMA) survey data and toward more objective, routinely updated, and auditable cost data. The agency states that the surveys underlying current PE values suffer from low response rates and significant discrepancies with alternative empirical data sources. The CY27 rule contains several proposals in furtherance of that transition.

- CMS proposes phasing out the portion of the PE methodology that anchors aggregate specialty-level PE RVUs to practice expense per hour (PE/HR) survey data from 2007 or earlier, known as the indirect practice cost index (IPCI). The phase-out would occur over a two-year transition, with half of the measured IPCI variation applied in the first year and none in the second year.
- In place of the stabilizing effect of the old survey data, CMS proposes a new PE stabilization adjustment that would cap year-over-year increases or decreases in a code's PE RVU at 5%. The cap would not apply to new, revised, or revalued codes, and it would be applied prior to the separate statutory phase-in that limits total RVU reductions to 19% per year.

- CMS proposes allocating indirect PE using both work RVUs and clinical labor RVUs for all services, except codes with 010- and 090-day global periods. Under current policy, that combined allocation approach applies only to services billable with professional and technical components.
- CMS proposes equalizing the facility and non-facility PE RVUs for nursing facility E/M visits (CPT codes 99304 through 99310, 99315, and 99316). This change addresses an unintended consequence of the site of service payment differential finalized in the CY26 final rule, under which payment for these visits varied based solely on whether the beneficiary was in a Part A skilled nursing facility stay.
- CMS is seeking comment on the broader facility versus non-facility site of service differential, including how indirect costs vary for physicians employed by hospitals, health systems, or other entities. The agency specifically asks whether the current 50% indirect PE allocation for facility-based services is accurate for hospital-employed physicians or whether a lower allocation (potentially 0%) would be appropriate, and whether a new HCPCS modifier should be created to identify employed physicians.

REMOTE MONITORING

CMS proposes several changes to payment for remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) services. The agency proposes requiring that RTM services be furnished only to established patients, requiring practitioners to furnish a separately reportable initiating visit in association with the onset of RPM or RTM services, and allowing payment only when the services are performed by clinical staff employed by the practice rather than by contractors. CMS also proposes updating the valuation of these services to reflect its understanding that monitoring devices may now be available at lower cost than initially estimated. Finally, CMS is seeking comment on bundling the RPM and RTM CPT codes into four new HCPCS G-codes, an approach the agency states would address recommendations from recent HHS Office of Inspector General (OIG) reports.

GLOBAL SURGERY DATA COLLECTION

CMS proposes pausing the global surgery data collection required by section 523 of MACRA. The agency states that several years of collected data show that post-operative visits assumed within 10- and 90-day global surgical packages are frequently not occurring, even though providers continue to be paid for those visits under the current bundled payment policy. CMS also states that the current data collection requirements may impose undue burden on practitioners. CMS is posting a public-use file that displays imputed RVUs for 10- and 90-day post-operative visits using an arithmetic approach. The agency is soliciting comments on expanded data collection, alternative data sources, and revaluation strategies for global surgical services in future rulemaking.

LIMITS ON MEDICARE ELIGIBILITY FOR CERTAIN INDIVIDUALS

CMS proposes regulations implementing section 71201 of the WFTC legislation (OBBBA), which amended the Social Security Act to limit Medicare eligibility to four groups. Those groups are U.S. citizens or nationals, lawful permanent residents, individuals granted Cuban and Haitian entrant status, and individuals lawfully residing in the U.S. under a Compact of Free Association. The proposed regulations would incorporate the newly specified eligibility groups, establish procedures for terminating coverage for individuals found ineligible, provide applicable appeal rights, and set out enrollment options for individuals who later gain or regain eligibility.

MEDICARE PRESCRIPTION DRUG INFLATION REBATE PROGRAM

The rule proposes updates to the Part B and Part D drug inflation rebate programs established under the Inflation Reduction Act of 2022 (IRA). Among other items, CMS proposes clarifying which Consumer Price Index for All Urban Consumers (CPI-U) data are used to determine benchmark values for subsequently approved drugs when CPI-U data for the relevant month are unavailable, clarifying the definition of "first marketed date," and clarifying that certain skin substitutes would not be excluded from the definition of a Part B rebatable drug. Separately, CMS proposes requiring providers and suppliers that are 340B covered entities to submit specified claim-level data elements to the Medicare Part D Claims Data 340B Repository for covered Part D drugs dispensed with a 340B discount, beginning with claims with dates of service on or after January 1, 2027.

CLINICAL LABORATORY FEE SCHEDULE (CLFS)

CMS proposes conforming regulatory changes to implement CAA, 2026 amendments to the CLFS. The changes would update the data collection and reporting requirements for clinical diagnostic laboratory tests (CDLTs) as well as the phase-in of payment reductions based on private payor rate data. The next data reporting period for CDLTs that are not advanced diagnostic laboratory tests runs from May 1, 2026, through July 31, 2026, based on applicable information collected from January 1, 2025, through June 30, 2025. Beginning in CY27, payment reductions resulting from the private payor rate data would be subject to a phase-in cap of up to 15% per year through CY29.

AMBULATORY SPECIALTY MODEL (ASM)

The CY26 PFS final rule established the ASM, a mandatory alternative payment model administered through the CMS Innovation Center that focuses on specialists treating Medicare beneficiaries with heart failure and low back pain. The model runs from 2027 through 2031, with the first performance year beginning January 1, 2027, and payment adjustments applied two years after each performance year. Participating specialists are assessed individually (at the Taxpayer Identification Number/National Provider Identifier (TIN/NPI) level) across four performance categories, which are quality, cost, improvement activities, and

Promoting Interoperability. Performance relative to peers treating the same condition determines two-sided adjustments to Medicare Part B payments ranging from -9% to +9% in the first two payment years (2029 and 2030) and gradually increasing to 12% by the final payment year (2033).

In the CY27 rule, CMS proposes a series of technical refinements to the model that would take effect at its start. Key proposals include adding an administrative claims-based imaging quality measure for low back pain, replacing the low back pain patient-reported outcome measure with a functional status outcome process measure, adjusting quality measure benchmarking and scoring policies, adding a quality scoring incentive for voluntary submission of patient-reported outcome data, incorporating a rural scoring adjustment, and aligning the model's Promoting Interoperability requirements with proposed MIPS changes. CMS also proposes participant-level flexibilities, including exceptions for participants affected by TIN changes or specialty redesignations, an option to terminate participants under certain circumstances, an option to submit improvement activities data at the individual or group level, and revisions to collaborative care arrangement requirements.

QUALITY PAYMENT PROGRAM (QPP)

The proposed rule includes significant changes to the QPP. Most notably, CMS proposes sunsetting traditional Merit-based Incentive Payment System (MIPS) reporting beginning with the CY29 performance period (2031 payment year). At that point, MIPS Value Pathways (MVPs) would become the only MIPS reporting option for clinicians not reporting through the APM Performance Pathway. Additional QPP proposals include:

- Adding three new MVPs focused on diabetic disease, hypertension, and hospitalist care, which would bring the MVP inventory to 30 pathways.
- Establishing a CY27 quality measure inventory of 180 measures, reflecting 20 measure removals, 10 measure additions, and 43 substantive changes. CMS also proposes creating a new "MIPS core measure" designation and requiring clinicians to report at least one core measure in place of the current outcome or high priority measure requirement, with an exemption for small practices.
- Updating the improvement activities inventory by adding six new activities (including a new Advancing Health and Wellness subcategory aligned with the Make America Healthy Again initiative), modifying five activities, and removing eleven activities.
- Revising the Promoting Interoperability category, including removing the Security Risk Analysis measure and restructuring the Electronic Prior Authorization measure so that it is optional (and worth bonus points) for CY27 before becoming required in CY28 alongside a new required Electronic Prior Authorization for Prescription Drugs measure.
- Applying Qualifying Participant (QP) status at the TIN/NPI level under which the clinician achieves that status and modifying the QP thresholds in accordance with the CAA, 2026.

MEDICARE SHARED SAVINGS PROGRAM (MSSP)

The CY27 PFS proposed rule includes numerous updates to the MSSP, including:

- Rebalancing financial incentives across risk tracks, including raising the shared savings rate for Level E of the BASIC track from 50% to 60%, lowering the maximum weight of the positive regional benchmark adjustment for ENHANCED track ACOs from 50% to 35%, raising the prior savings adjustment scaling factor from 50% to 75%, risk adjusting the 5% cap on upward benchmark adjustments, and adding a new growth adjustment that rewards ACOs for bringing clinicians and beneficiaries new to value-based care into the program.
- Adding a guardrail to the Accountable Care Prospective Trend (ACPT) component of the benchmark update factor so the ACPT is no more than 1 percentage point below (or 1.5 percentage points above) observed national expenditure growth. The lower guardrail would apply retroactively to ACOs with 2024 through 2026 start dates, and CMS is delaying performance year 2025 financial reconciliation until November 2026 to implement the change if finalized.
- Allowing ACOs, upon CMS approval of an implementation plan, to reduce or eliminate Part B cost sharing for beneficiaries beginning April 1, 2027 (excluding durable medical equipment, prosthetics, orthotics, supplies, and prescription drugs), while removing the prepaid shared savings payment option due to low uptake.
- Modifying the beneficiary assignment methodology for performance year 2028 and beyond, including excluding primary care charges billed through non-ACO taxpayer identification numbers from assignment calculations.
- Streamlining quality and certified electronic health record technology (CEHRT) requirements, including extending the MIPS Clinical Quality Measures collection type and its reporting incentive, creating a new Medicare electronic Clinical Quality Measure (eCQM) collection type, reducing the APP Plus quality measure set to eight measures, and replacing the current Promoting Interoperability reporting requirement with a simplified three-option CEHRT use attestation.

REQUESTS FOR INFORMATION (RFIS) AND COMMENT SOLICITATIONS

As part of the proposed rule, CMS issued several RFIs and comment solicitations, seeking stakeholder feedback on issues including:

- How CMS might redesign primary care valuation to support a shift toward preventive medicine, covering three topics, which are reconsidering relative primary care payment under the PFS, understanding the payment implications of incorporating technology into primary care, and establishing prospective primary care payment within the MSSP and potentially Original Medicare more broadly.

- How to address duplicate laboratory testing and imaging resulting from siloed diagnostic results, including potential actions to improve result sharing and interoperability across care settings.
- Whether and how the facility versus non-facility site of service differential should be refined, including the appropriate indirect PE allocation for hospital-employed physicians.
- How to improve data collection and valuation accuracy for global surgical packages, including potential revaluation strategies for future rulemaking.
- Whether the RPM and RTM code families should be restructured into bundled HCPCS G-codes.
- The anticipated timeline, milestones, and implementation considerations for transitioning to FHIR-based digital quality reporting across the QPP and other CMS quality programs.
- The influence of the American Medical Association's (AMA) CPT coding system and RUC valuation process on physician payment policy, including questions about the AMA's licensing monopoly, conflicts of interest in service valuation, and potential alternatives for data collection and payment recommendations.

We trust you found this summary useful. Please reach out to us with any questions.