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INSIGHTS

Calendar Year 2027 Medicare Physician Fee Schedule Final Rule

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On November 4, 2026, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2027 Medicare Physician Fee Schedule (PFS) Final 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) changes can be found here. The policies generally take effect January 1, 2027, except where a different implementation date is specified.

CONVERSION FACTOR

As part of the rule, CMS finalizes a CY27 conversion factor (CF) of $32.95 for Qualifying Alternative Payment Model (APM) Participants (QPs), a 1.83% decrease from the CY26 QP CF of $33.57. For non-qualifying participants (non-QPs), the final CF is $32.63, reflecting a 2.31% decrease from the CY26 non-QP CF of $33.40. These amounts are below the proposed CFs of $33.17 and $32.84, respectively. A summary of the components of those 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 final CY27 CFs therefore exclude that temporary increase.
- The final CFs also include a negative 0.12% budget neutrality adjustment associated with changes to relative value units (RVUs) and other payment policies, compared with the proposed positive 0.53% adjustment. The statutory updates, expiration of the WFTC increase, and final budget neutrality adjustment produce the net CF reductions described above.

E/M VISITS FURNISHED DURING GLOBAL SURGICAL PERIODS

CMS finalizes a narrower payment reduction for separately identifiable office/outpatient evaluation and management (E/M) visits furnished on the same day as procedures with a 0-day global period. The policy applies when the services are furnished by the same practitioner or practitioners of the same specialty in the same group practice. The highest-valued service is paid at 100% of its rate, and the other affected services are paid at 80%. The proposal would have paid those lower-valued services at 50% and also covered procedures with 10- or 90-day global periods. CMS excludes those longer global periods from the final policy and reduces the payment adjustment to account for overlap already addressed through existing valuation processes.

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 CY24. For CY27, CMS finalizes two changes to this policy.

- CMS replaces G2211 with modifier B1 (identified as MOD1 in the proposal), appended to the associated E/M base code. As proposed, the modifier increases 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 finalizes modifier B2 (identified as MOD2 in the proposal) for 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. As proposed, B2 increases payment for the associated E/M visit by 32% to recognize additional longitudinal care costs, including total cost of care accountability and aligned quality reporting. Use is voluntary and available for all beneficiaries served by the practitioner, not only ACO-assigned or ACO-aligned beneficiaries. Claims submitted with B2 are 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 what it argues will be a 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 finalizes the following changes to that methodology.

- CMS finalizes the proposed phase-out of the indirect practice cost index (IPCI), which anchors aggregate specialty-level PE RVUs to practice expense per hour (PE/HR) survey data from 2007 or earlier. The transition applies half of the measured IPCI variation in CY27 and eliminates it in CY28.
- CMS finalizes the proposed PE stabilization adjustment, capping year-over-year increases or decreases in a code's PE RVU at 5%. The cap excludes new, revised, newly nationally priced, and revalued codes. It applies before the separate statutory phase-in that limits total RVU reductions to 19% per year.
- As proposed, CMS will allocate indirect PE using both work RVUs and clinical labor RVUs for all services except codes with 010- and 090-day global periods. Previously, that combined allocation approach applied only to services billable with professional and technical components.

- CMS finalizes equal facility and non-facility PE RVUs for nursing facility E/M visits (CPT codes 99304 through 99310, 99315, and 99316), as proposed. CMS notes this is being done to address an unintended consequence of the site of service differential finalized in the CY26 rule, under which payment varied based solely on whether the beneficiary was in a Part A skilled nursing facility stay.
- CMS reviews comments on the broader facility versus non-facility differential, including whether the current 50% indirect PE allocation for facility-based services should be reduced for hospital-employed physicians, potentially to 0%, and whether a modifier should identify employed physicians. The agency does not finalize a further change to that differential in response to this solicitation.

REMOTE MONITORING

CMS finalizes several changes to remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM). Beginning in CY27, RTM must be furnished to established patients, and both RPM and RTM require an initiating visit with the billing practitioner, which may be in person or via Medicare-covered telehealth. Patients already receiving these services before January 1, 2027, do not need a new initiating visit solely because of the policy change. CMS also finalizes the requirement that clinical staff furnishing these services be directly employed by the practitioner or practice, but delays implementation until January 1, 2029. The agency finalizes lower device-related valuations while retaining the existing direct PE inputs for six treatment-management codes, instead of adopting the proposed reductions to those inputs. CMS does not finalize the potential consolidation of the RPM and RTM code families into four HCPCS G-codes, which was a comment solicitation.

GLOBAL SURGERY DATA COLLECTION

CMS finalizes the proposed pause in global surgery data collection under section 523 of MACRA. The agency states that collected data show fewer post-operative visits than assumed in 10- and 90-day global surgical packages, while acknowledging concerns about reporting limitations and burden. CMS has posted a public-use file displaying imputed RVUs for post-operative visits using an arithmetic approach. The final rule discusses comments on expanded data collection, alternative data sources, and revaluation strategies. CMS does not finalize a broader revaluation of global surgical packages through this solicitation.

LIMITS ON MEDICARE ELIGIBILITY FOR CERTAIN INDIVIDUALS

CMS finalizes 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 regulations

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 finalizes updates to the Part B and Part D drug inflation rebate programs established under the Inflation Reduction Act of 2022 (IRA). CMS clarifies which Consumer Price Index for All Urban Consumers (CPI-U) data apply when relevant monthly data are unavailable, the definition of "first marketed date," and the treatment of certain skin substitutes as Part B rebatable drugs. As proposed, providers and suppliers that are 340B covered entities must submit specified claim-level data to the Medicare Part D Claims Data 340B Repository for covered Part D drugs dispensed with a 340B discount beginning January 1, 2027. CMS delays the first submission deadline from June 30 to September 30, 2027. That deadline covers claims with dates of service from January through June 2027.

CLINICAL LABORATORY FEE SCHEDULE (CLFS)

CMS finalizes conforming regulatory changes implementing the Consolidated Appropriations Act, 2026 (CAA, 2026) amendments to the CLFS. The changes address data collection and reporting for clinical diagnostic laboratory tests (CDLTs) and the phase-in of payment reductions based on private payor rates. The reporting period for CDLTs that are not advanced diagnostic laboratory tests ran from May 1 through July 31, 2026, using information collected from January 1 through June 30, 2025. As proposed, payment reductions based on those data are capped at 15% per year in CY27 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 (TIN)/ National Provider Identifier (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 finalizes technical refinements for the model's launch. These include an administrative claims-based imaging quality measure for low back pain, replacement of the low back pain patient-reported outcome measure with a functional status outcome process measure, revised quality benchmarking and scoring, and a scoring incentive for voluntary patient-reported outcome data. The rule adds a five-point rural scoring adjustment and aligns Promoting Interoperability requirements with the final MIPS changes. CMS also finalizes exceptions for participants affected by TIN changes or specialty redesignations, authority to terminate participants under specified circumstances, an option to submit improvement activities data at the individual or group level, and revised collaborative care arrangement requirements

QUALITY PAYMENT PROGRAM (QPP)

The final rule includes significant changes to the QPP. CMS sunsets traditional Merit-based Incentive Payment System (MIPS) reporting beginning with the CY31 performance period (2033 payment year), two years later than proposed. At that point, MIPS Value Pathways (MVPs) become the only MIPS reporting option for clinicians not reporting through the APM Performance Pathway. Additional final QPP policies include:

- Adding the three proposed MVPs focused on diabetic disease, hypertension, and hospitalist care, bringing the inventory to 30 pathways.
- Establishing the proposed CY27 quality measure inventory of 180 measures, reflecting 20 removals, 10 additions, and 43 substantive changes. CMS creates the "MIPS core measure" designation and replaces the outcome or high priority measure requirement with a requirement to report at least one core measure. Small practices are exempt. Other clinicians without an applicable core measure must attest to that fact and report another measure.
- Updating the improvement activities inventory as proposed by adding six activities, modifying five, and removing eleven. The additions include activities in the new Advancing Health and Wellness subcategory.
- Revising Promoting Interoperability as proposed, including removing the Security Risk Analysis measure and making the Electronic Prior Authorization measure optional for CY27, with 10 bonus points. That measure becomes required in CY28 alongside a new required Electronic Prior Authorization for Prescription Drugs measure.
- Applying QP status at the TIN/NPI level and modifying QP thresholds under the CAA, 2026. CMS adds a modification for clinicians whose QP or Partial QP status is determined individually: Partial QP status applies across their TIN reassignments, allowing a choice of whether to participate in MIPS.

MEDICARE SHARED SAVINGS PROGRAM (MSSP)

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

- Finalizing the proposed financial changes across risk tracks, including raising the shared savings rate for Level E of the BASIC track from 50% to 60%, lowering the maximum positive regional benchmark adjustment weight 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 growth adjustment for bringing clinicians and beneficiaries new to value-based care into the program.
- Adding the proposed Accountable Care Prospective Trend (ACPT) guardrail for agreement periods beginning in 2027 or later, limiting the ACPT to no more than 1 percentage point below or 1.5 percentage points above observed national expenditure growth. The lower guardrail also applies to ACOs with 2024 through 2026 start dates for performance year 2025 and subsequent years in those agreements. CMS has delayed 2025 financial reconciliation until November 2026 to implement the change.
- Allowing ACOs, with CMS approval of an implementation plan, to reduce or eliminate Part B cost sharing beginning April 1, 2027, as proposed. Durable medical equipment, prosthetics, orthotics, supplies, and prescription drugs are excluded. CMS is ending the prepaid shared savings payment option, with participating ACOs receiving payments through December 31, 2027, and no new cohorts after the 2027 application cycle.
- Modifying beneficiary assignment for performance year 2028 and beyond, including excluding primary care charges billed through non-ACO taxpayer identification numbers by ACO professionals used in assignment.
- Streamlining quality and certified electronic health record technology (CEHRT) requirements as proposed, including extending the MIPS Clinical Quality Measures collection type and reporting incentive, creating Medicare electronic Clinical Quality Measures (eCQMs), and reducing the APP Plus measure set to eight measures. ACOs may meet CEHRT requirements through qualifying electronic quality reporting, quality reporting using Fast Healthcare Interoperability Resources-based data, or attestation to an approved ACO CEHRT use metric.

REQUESTS FOR INFORMATION (RFIS) AND COMMENT SOLICITATIONS

The final rule discusses responses to the proposed rule's RFIs and comment solicitations. These requests did not themselves establish new payment policies. CMS sought 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. Commenters broadly supported better valuation of primary care and voluntary hybrid prospective payments, while specialty groups opposed financing those changes through cuts to their services.
- 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. Commenters generally supported reducing unnecessary testing and improving result sharing, but some opposed payment denials when repeat tests are clinically necessary or prior results are unavailable.
- 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. Commenters questioned place of service as a proxy for employment and generally sought better cost data, but disagreed on how to revise the differential.
- How to improve data collection and valuation accuracy for global surgical packages, including potential revaluation strategies for future rulemaking. Commenters generally supported the reporting pause, while many opposed expanded reporting and using incomplete post-operative visit data to revalue global packages.
- Whether the RPM and RTM code families should be restructured into bundled HCPCS G-codes. CMS acknowledges receiving comments but does not summarize support or opposition to bundling, and leaves potential changes for future rulemaking.
- The anticipated timeline, milestones, and implementation considerations for transitioning to FHIR-based digital quality reporting across the QPP and other CMS quality programs. CMS reports receiving many comments without summarizing their substance and leaves the transition timeline, technical requirements, and scoring policies for future rulemaking.
- The influence of the AMA's 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. Most feedback focused on RUC reforms, including better data, transparency, and representation, while many commenters cautioned against replacing CPT with competing coding standards.

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

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