July 17, 2026

CMS Issues Proposed CY 2027 Medicare Physician Fee Schedule

On Tuesday (July 14), the Centers for Medicare & Medicaid Services (CMS) issued its Calendar Year (CY) 2027 Medicare Physician Fee Schedule (MPFS) Proposed Rule, which includes updates to Medicare Part B payments and policies, the Medicare Shared Savings Program (MSSP), the Inflation Reduction Act (IRA) rebate program, and more.

The rule includes several updates to the methodology for determining the physician fee schedule aimed at improving reimbursement for primary and preventive care. In a press release, CMS Administrator Mehmet Oz said, "We're proposing some of the most significant Medicare reforms in recent years to strengthen primary care, expand accountable care, and modernize physician payment." He added, "These changes would make it easier for clinicians to focus on prevention, improve coordination for patients, and ensure Medicare rewards better outcomes rather than more services."

John Brooks, CMS Deputy Administrator and Director of the Center for Medicare, said, "Expanding accountable care is a critical part of making the Medicare program work well for patients." He added, "Our goal is simple: deliver better outcomes for patients by appropriately incentivizing providers, improving quality measurement, and reducing administrative burden."

The proposed rule will be open for comment until September 14.

- Press release, Fact sheet on the proposed rule, Fact sheet on the Quality Payment Program, Proposed rule

Summary of Key Provisions

PFS conversion factor. CMS calculates the Medicare physician fee schedule using three factors: Relative value units (RVUs) based on the cost and location of services; geographic price indices that adjust RVUs using local cost data; and a conversion factor (CF) that converts those numbers into dollar amounts.

CMS proposes to decrease the qualifying conversion factor (CF) by 1.19%, or$0.40, in CY 2027 as compared with CY 2026 and to decrease the non-qualifying CF by 1.68%, or $0.56. CMS in the rule determined that because Congress last year enacted a one-time physician fee schedule CF increase of 2.5%, the agency under current law is required to reduce the CF by 2.5% for 2027. This means to calculate the CY 2027 CFs CMS used the CY 2026 CF that would have been in place without Congress' one-year 2.5% increase (See Tables 1 and 2). The CF for anesthesia is 20.4165 for qualifying APM and 20.2143 for nonqualifying APM.

Under MACRA, Advanced APM participants will receive a 0.75% update, and all others will receive a 0.25% update for 2027 (See Table 3).

Table 1: Calculation of CY 2027 qualifying CF

CY 2026 conversion factor (for comparison)	*33.5675*
CY 2026 conversion factor without Congress' one-year 2.5% increase	32.7488
Qualifying APM update factor	0.75% (1.0075)
RVU budget neutrality adjustment	0.53% (1.0053)
CY 2027 conversion factor	**33.1693**

Table 2: Calculation of CY 2027 non-qualifying CF

CY 2026 conversion factor (for comparison)	*33.4009*
CY 2026 conversion factor without Congress' one-year 2.5% increase	32.5863
Non-qualifying APM update factor	0.25% (1.0025)
RVU budget neutrality adjustment	0.53% (1.0053)
CY 2027 conversion factor	**32.8409**

Table 3: Timeline of MACRA required updates to PFS payment rates

	2016	2017	2018	2019	2020	2021*	2022*	2023*	2024*	2025	2026* and beyond
Fee schedule updates	0.5% per year			0.25%	0% per year						0.25% or 0.75% for A-APM

** Congress enacted one-time payment rate increases for respective years*

Actual payment rates to practitioners are affected by several policy changes related to RVUs for physician work, practice expense (PE), and malpractice, and vary by both specialty and the individual practitioner's mix of services. CMS estimates that the CY 2027 payment impact by specialty will range from -9% (dermatology) to +12% (clinical social work). CMS estimates that some specialties, including clinical psychologist, clinical social worker, diagnostic testing, geriatrics, interventional radiology, physical/occupational therapy, and psychiatry, would see positive increases in their PFS payment. In contrast, other specialties, including colon and rectal surgery, dermatology, hand surgery, otolaryngology, podiatry, and others, would see payment decreases. Many specialties also would see neutral payment updates under the current proposed rule. Additionally, some of the proposed policies in this rule are estimated to have significant differential effects depending on the site of service. See Table D-B5 in the proposed rule for a full list of estimated payment impact by specialty and site of service.

Practice Expense updates. The RVU, which is part of the calculation for setting the conversion factor, consists of three components: 1) Work RVUs that account for a clinician's time and skill to provide a service; 2) Practice Expense (PE) RVUs to account for the operational costs of running a medical practice (both direct and indirect); and 3) Malpractice RVUs to account for the cost of liability insurance.

As part of the proposed rule, CMS included updates to the methodology for calculating PE RVUs as part of the agency's multi-year effort to shift away from relying on AMA survey data toward an approach that "relies on more

objective, routinely updated and auditable cost data" that is more transparent and sensitive to market pressures and that will "open broader possibilities for right-sizing payments across outpatient care settings."

For CY 2027, CMS proposes to phase out steps from the current PE methodology (Steps 12 through 17) that use the indirect practice cost index (IPCI) over a two-year period. Under year one, half of the measured variation in the IPCI would be applied and in year two the IPCI would no longer be applied. Instead, CMS would use a PE stabilization factor to complete the calculation.

CMS also proposes to modify step 8 of the PE methodology to calculate indirect PE based on both work RVUs and clinical labor RVUs for all services except 010- and 090-day global period codes.

In addition, CMS proposes to apply the site of service differential policy finalized last year, which reduced indirect PE payments for physicians working in facilities, to visits furnished to beneficiaries in a Part A stay in a skilled nursing facility. CMS also included a request for comment on whether the site of service payment differential between facility and non-facility is still appropriate, or whether the agency should consider an alternative approach for calculating indirect practice costs, particularly for physicians employed by a hospital, health system, or other entity.

Evaluation and management updates. CMS proposes to reduce payments to providers charging separately identifiable office/outpatient evaluation and management (E/M) visits on the same day as a 0-, 10- or 90-day global procedure furnished by the provider or a provider in the same group practice. CMS proposes to pay the most expensive service at 100%, whether it is surgical or an E/M visit, and then reduce payment for all other surgical procedures(s) or E/M visit(s) furnished on the same day by 50%. CMS noted that the proposal would have the biggest negative impact on otolaryngology, dermatology, and podiatry, and to a smaller extent, hand surgery, physician assistants, and colon and rectal surgery.

CMS said the proposal, which is similar to a 2019 proposal, aims to address payment duplication that occurs when the same physician (or a physician in the same group) provides E/M service for a patient who underwent a procedure with a global period code. CMS also said this aligns with the agency's multiple procedure payment reduction policy. CMS solicited comment on whether a different reduction value, such as 25%, would be appropriate and whether the agency should also include inpatient E/M visits.

CMS also proposes transitioning the complexity add-on code for separate payments for office/outpatient E/M visits (HCPCS G2211) from an add-on code to a modifier (MOD1). CMS also proposes to update the valuation of MOD1 to be 16% of the base E/M code, instead of the current flat rate. Similarly, CMS proposes a second level for the modifier (MOD2) to be used by clinicians participating in a Medicare Shared Savings Program (MSSP) accountable care organization (ACO) or a Long-term Enhanced ACO Design (LEAD) Model ACO. CMS said the proposed changes would better reflect the time and resources needed to provide ongoing, longitudinal care to a beneficiary.

Remote monitoring updates. CMS proposes several updates to its reimbursement policies for remote physiologic monitoring (RPM) and remote therapy monitoring (RTM). For CY 2027, CMS proposes to require that RTM services only be furnished to established patients, bringing the policy into alignment with RPM established patient requirements. CMS also proposes to require practitioners reporting RPM or RTM services furnish a separately reportable in-person initiating visit to discuss RPM or RTM services with the patient.

In addition, CMS proposes to require RPM and RTM services to be performed by clinical staff employed by the health care provider billing Medicare. Currently, health systems and providers are able to bill Medicare when they use a third-party vendor to deliver or manage RPM or RTM services. CMS wrote, "Provision of these services by entities having only a loose association with the treating practitioner can detract from longitudinal, patient-centered care," adding, "We do not believe that RPM or RTM services provided by clinical staff contracted by a third party can ensure the billing practitioner has adequate oversight, management, or collaboration to bill." CMS requested comment on the proposal and, specifically, how often third-party billing occurs and the impact finalizing the policy would have on remote monitoring services.

Improving global surgery payment accuracy. For CY 2027, CMS proposes to pause data collection required under Section 523 of the Medicare Access and CHIP Reauthorization Act (MACRA). CMS said the current data suggests providers are being paid for post-operative visits that are not taking place and it is concerned about the burden the current data collection places on practitioners. CMS requests comment on ways to expand and improve data collection, including other data sources to improve the accuracy of global surgery payments. Along with the proposed rule, CMS posted a public use file with RVUs associated with the 10-and 90-day post-operative visits that shows "a purely arithmetic approach to understand the valuation of the services."

New and/or updated codes. CMS proposes to establish several new billing codes. CMS proposes:

- To establish coding and payment for shared medical appointments (SMAs) for CY 2027. CMS proposes limiting SMAs to beneficiaries who have received a professional service from the billing physician or other qualified health professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice within the previous 12 months.
- To establish two new HCPCS codes to describe advance care planning (ACP) services furnished by clinical staff under the direct supervision of the billing physician or other practitioner. CMS proposes that the existing CPT codes 99497 and 99498 would only be used to report time personally spent by the billing practitioner.

To adopt AMA-recommended updates to the Maternity Care Services code set and increasing work RVUs for new labor and delivery codes by approximately 15% to better align payment with current maternity care practice patterns. **Behavioral health updates.** CMS proposes to continue the four-year phase in to increase the valuation for timed behavioral health services by applying an upward adjustment to the work RVUs for psychotherapy codes payable under the PFS. CMS also proposes to include smoking and tobacco use cessation services and SBIRT services in the transition for timed behavioral health codes.

Inflation Reduction Act (IRA) Drug Rebate Programs. The proposed rule includes new policies related to the IRA's Part B and Part D inflation rebate programs. Among other changes, the rule clarifies that the Consumer Price Index for All Urban Consumers (CPI-U) data used to determine the benchmark period CPI-U for subsequently approved drugs when such data are unavailable is the first month for which CPI-U data are available following the month for which CPI-U data are unavailable.

The rule also proposes to require 340B providers and suppliers to submit to CMS certain data elements associated with each claim for units of a covered Part D drug billed to Medicare Part D and dispensed by the covered entity or contract pharmacy. CMS said the data would be submitted to the Medicare Part D Claims Data 340B Repository beginning with claims with a date of service on or after January 1, 2027

Quality Payment Program (QPP). The proposed rule also includes a variety of updates to the QPP. CMS proposes to sunset the Merit-Based Incentive Payment System (MIPS) reporting by 2029 and transition to MIPS Value Pathways (MVPs). CMS said MIPS eligible clinicians would have until the end of 2028 to transition to an MVP. Clinicians participating in an APM would not be subject to the transition. CMS proposes three new MVPs for CY 2027 that are focused on diabetes, hospital-based care, and hypertension.

CMS also proposes updates to MIPS performance categories. CMS proposes:

- A new MIPS core measure designation for the quality performance category.
- Replacing the outcome / high priority measure reporting requirement in traditional MIPS and MVPs with a MIPS core measure reporting requirement.
- Removing the ONC attestations for the CY 2026 performance period and the Security Risk Analysis measure for the CY 2027 performance period for the Promoting Interoperability performance category.
- Making the Electronic Prior Authorization measure an optional/bonus measure for the CY 2027 performance period for the Promoting Interoperability performance category; the measure would become required starting with the CY 2028 performance period.
- Creating a new Electronic Prior Authorization for Prescription Drugs measure that would become required starting with the CY 2028 performance period for the Promoting Interoperability performance category.

The agency also proposes updates to Advanced APMs, including paying at the taxpayer identification number/national provider identifier (TIN/NPI) combination level, instead of the NPI level. CMS said this change would prevent about $2.4 billion from going to clinicians that are not actively participating in an APM.

The proposed rule also implements updates to the quality payment and patient thresholds included in the Consolidation Appropriations Act, 2026.

Medicare Shared Savings Program (MSSP). The proposed rule includes several changes to the MSSP, including new provider incentives, reforms to ACO benchmarking, shared savings rate increases for certain ACOs, and a new Medicare Part B cost-sharing benefit for certain beneficiaries. CMS says, "these proposals aim to accelerate accountable care service delivery, further CMS' goal of aligning spending and value in Original Medicare, and support achieving other related strategic objectives."

For example, the rule proposes to increase the prior savings adjustment scaling factor from 50% to 75% and establish new guardrails on the Accountable Care Prospective Trend (ACPT), which is used to project future spending growth. CMS also proposes to increase shared savings rate for BASIC Track Level E ACOs from 50% to 60% and lower the maximum positive regional adjustment from 50% to 35% in the ENHANCED Track, making the two risk tracks more financially comparable.

CMS also proposes to create a new benchmark growth adjustment that would reward ACOs for recruiting physician practices that are new to value-based care arrangements. In addition, beginning April 1, 2027, CMS proposes to allow eligible ACOs with approved implementation plans to reduce or eliminate Medicare Part B cost sharing for certain beneficiaries and services.

Other updates.

- CMS notes that beginning in CY 2027, Clinical Laboratory Fee Schedule (CLFS) Payment would be subject to a phase-in reduction of up to 15% per year through CY 2029 without intervention from Congress.
- Implements provisions of H.R. 1 that limit Medicare eligibility to individuals who are either: A U.S. citizen or national, an alien lawfully admitted for permanent residence under the Immigration and Nationality Act; an alien who has been granted the status of Cuban and Haitian entrant; or an individual who lawfully resides in the U.S. in accordance with a Compact of Free Association.

Requests for comment.

- Regarding the influence of the CPT® coding system and AMA process on physician payment policy as part of the Secretarial priority to Make America Healthy Again.
- Ways to improve primary care service valuation within the physician fee schedule and to support the shift from reactive medicine to preventive medicine.
- Ways to improve imaging and laboratory testing interoperability to reduce duplicate testing orders.

If you have questions, please contact Heather Meade or Heather Bell.