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CMS Issues CY 2027 Physician Fee Schedule Proposed Rule with Reduced Physician Payment Rates, Telehealth Expansions, and MSSP Reforms

On July 14, 2026, the Centers for Medicare & Medicaid Services (CMS) issued its proposed calendar year (CY) 2027 Physician Fee Schedule (PFS), which proposes policies for physician payment and other outpatient services covered under Medicare Part B. CMS released a rule overview fact sheet and an official press release outlining key proposals, along with a fact sheet on proposals related to the Medicare Shared Savings Program (MSSP).

Key proposals include:

- Decrease CY 2027 Medicare Part B physician payment rates under the PFS;
- Modify the practice expense (PE) methodology by phasing out reliance on historical specialty-level survey data;
- Extend statutory Medicare telehealth flexibilities, add new telehealth HCPCS codes and claims modifiers, and expand teaching physician virtual presence policies;
- Create new HCPCS codes for advance care planning (ACP) services furnished by clinical staff;
- Update payment and telehealth policies for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs);
- Refine the Ambulatory Specialty Model (ASM) through technical, operational, and quality measurement changes;
- Implement statutory changes limiting Medicare eligibility for certain noncitizens and establish related enrollment, termination, and special enrollment period policies;
- Update the Medicare Part B and Part D Inflation Rebate Programs and continue the current discarded drug refund policy;
- Implement conforming updates to the Clinical Laboratory Fee Schedule (CLFS) required by the Consolidated Appropriations Act, 2026 (CAA, 2026); and
- Modify the Medicare Shared Savings Program (MSSP) through changes to beneficiary assignment, financial benchmarks, beneficiary engagement, and participation policies.

The proposed rule also includes multiple Requests for Information (RFIs) on redesigning primary care payment, the future of the CPT® coding system, community-based palliative

care, intensive lifestyle interventions for Alzheimer's disease, future MSSP policy, and approaches to reduce duplicative laboratory and imaging testing while improving interoperability.

This proposed rule is scheduled to be published in the *Federal Register* on July 16, 2026. Comments are due September 14, 2026.

CMS PROPOSES DECREASE TO PHYSICIAN PAYMENT RATES FOR 2027, UPDATES TO PRACTICE EXPENSE METHODOLOGY

Pages 1,142-1,144[1]

CMS proposes a decrease in Medicare Part B payments to physicians and other health professionals who provide services such as office visits, surgeries, and diagnostic or therapeutic procedures. As required by section 1848(d)(1)(A) of the Social Security Act (the Act) and first implemented in CY 2026, there will be two separate conversion factors (CF) for 2027: one for items and services furnished by qualifying alternative payment model (APM) participants (QPs), and another for non-qualifying APM participants (non-QPs). For 2027, CMS proposes a CF of **$33.1693 (a 1.19 percent decrease) for QPs** and **$32.8409 (a 1.68 percent decrease) for non-QPs**. Both reflect their respective CY 2026 conversion factors (excluding the temporary 2.5 percent statutory payment increase that applied only during CY 2026) multiplied by a 0.53 percent positive budget neutrality adjustment.[2]

Table 1. Physician Fee Schedule CF Comparison[3]

2026 CF		Proposed 2027 CF	
Qualifying APM Participant	**Non-Qualifying APM Participant**	**Qualifying APM Participant**	**Non-Qualifying APM Participant**
$33.5675	$33.4009	$33.1693	$32.8409

Because the temporary 2.5 percent payment increase enacted for CY 2026 expires, both groups would see lower payment rates in CY 2027 despite positive statutory updates and a positive budget neutrality adjustment.

Proposed Updates to Practice Expense Methodology

Pages 26-27, 49-54

CMS proposes to modify the PFS PE methodology by phasing out the indirect practice cost index (IPCI) over two years. Specifically, CMS would eliminate Steps 12 through 17 of the PE RVU calculation, which currently rescale indirect PE RVUs using specialty-specific PE per hour

[1] All page numbers listed are from the unpublished proposed rule.
[2] Section 1848(c)(2)(B)(ii)(II) of the Act
[3] See Table D-B1 and Table D-B2 on pages 1,143-1,144 of the unpublished rule.

(PE/HR) survey data from the American Medical Association (AMA). Under the proposal, PE RVUs would instead be based on code-level inputs, including work RVUs, direct PE inputs, and specialty-specific indirect allocators, with a PE stabilizer replacing the current rescaling step during the transition.

To align with its CY 2026 site-of-service payment differential policy finalized in the CY 2026 PFS Final Rule,[4] CMS also proposes to revise the indirect PE allocation for visits furnished during a Medicare Part A skilled nursing facility stay.

If finalized, the proposal would change how PE RVUs are calculated by reducing the role of historical specialty-level survey data in favor of code-level inputs. These changes could redistribute Medicare payments across physician specialties and services as the new methodology is phased in.

CMS PROPOSES TELEHEALTH EXPANSIONS, NEW CLAIMS MODIFIERS, AND BROADER TEACHING PHYSICIAN FLEXIBILITY

Pages 60-68

- **Extension of Statutory Telehealth Flexibilities:** CMS proposes to implement the telehealth flexibilities extended through the CAA, 2026, including continued waivers of geographic restrictions, expanded originating sites and practitioner eligibility, coverage of audio-only telehealth services through December 31, 2027, and delaying the in-person mental health telehealth requirement until January 1, 2028.
- **Telehealth Originating-Site Facility Fee:** CMS proposes increasing the originating-site facility fee (HCPCS Q3014) from $31.85 in CY 2026 to **$32.65** in CY 2027.
- **Medicare Telehealth Services List:** Telehealth Coding Updates: CMS proposes adding five HCPCS G-codes for ACP (GACP1, GACP2), shared medical appointments (GSMAS), pediatric speech-language services (GSLPP), and vaccine adverse effects management (GADV1). CMS also proposes establishing Modifier BB for services furnished through certain virtual telehealth platforms and Modifier BC for telehealth services furnished "incident to" another professional service, as well as revising HCPCS codes G0508 and G0509 to align telehealth critical care consultation reporting with in-person critical care services.
- **Teaching Physician Virtual Presence:** CMS proposes to permit billing for Medicare telehealth services involving residents when either the teaching physician or the resident is physically present with the patient and the other participates by real-time audio-video technology (eliminating the current requirement that all three be in separate locations). The policy would apply only to services on the Medicare Telehealth

[4] 90 FR 49292 through 49297

Services List, with existing documentation and teaching physician oversight requirements remaining in place.

The proposed telehealth provisions represent a modest update and continuation of prior policy, rather than a major shift.

CMS PROPOSES TWO NEW HCPCS CODES TO DESCRIBE ACP SERVICES FURNISHED BY CLINICAL STAFF

Pages 288-295

For CY 2027, CMS proposes creating two new HCPCS codes (GACP1 and GACP2[5]) to describe ACP services furnished by clinical staff under the direct supervision of the billing physician or other practitioner (and incidental to their professional services). In turn, the existing CPT codes 99497 and 99498 would only be used to report the time personally spent by the billing practitioner. CMS also proposes adding both HCPCS codes to the Medicare Telehealth Services List and establishing work RVUs of 1.00 for GACP1 and 0.70 for GACP2, based on crosswalks to existing chronic care management services, with 20 minutes of clinical labor proposed for each code's direct PE. Under the proposal, the new G-codes and CPT codes 99497 and 99498 could be reported together when the applicable time thresholds are met. CMS also seeks comment on whether a single code representing the combined time of the billing practitioner and clinical staff would better reflect clinical practice and on the proposed coding structure for ACP services.

Requests for Feedback

Pages 295-303

CMS also includes two RFIs to inform potential future Medicare policy development:

- **Community-Based Palliative Care:** CMS seeks feedback on the future development of community-based palliative care services outside the hospice benefit. Specifically, CMS requests input on beneficiary eligibility, care management requirements for seriously ill beneficiaries, quality reporting, payment approaches, and safeguards to prevent fraud, waste, and abuse.
- **Intensive Lifestyle Interventions for Alzheimer's Disease:** CMS seeks information to better understand the evidence, resource requirements, and payment considerations associated with intensive lifestyle interventions to reduce the risk or slow the progression of Alzheimer's disease and Alzheimer's disease-related dementias (AD/ADRD).

[5] See page 292 of the unpublished rule for the proposed descriptors.

The proposal would formalize separate payment for clinical staff time spent furnishing ACP services, while maintaining separate billing for practitioner time. CMS's accompanying RFI suggests it is considering whether additional changes to ACP coding and broader palliative care payment policies may be warranted in the future.

CMS PROPOSES UPDATES TO RHCS AND FQHCS

Increasing Access to DSMT and MNT Services in RHCs

Pages 324-330

CMS proposes to revise § 405.2463(a) and (b)(2) to recognize Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) services as qualified preventive services that are covered and paid the all-inclusive rate (AIR) as stand-alone billable visits under the RHC benefit.

Implementing CAA, 2026

Pages 330-332

Congress recently extended COVID-era payment flexibilities under section 6209(c) of CAA, 2026. In implementing CAA, 2026, CMS proposes to pay RHCs and FQHCs for non-behavioral health visits furnished via telecommunication technology and waive in-person visit requirements for mental health visits through December 31, 2027.

Proposed CY 2027 FQHC Market Basket Update

Pages 332-333

For CY 2027, CMS proposes to update the CY 2026 FQHC PPS base rate by the historical percentage increase in the productivity-adjusted FQHC market basket through the second quarter of 2026. For CY 2027, the proposed FQHC market basket update is estimated at 2.5 percent and is based on the expected historical percentage increase in the productivity-adjusted 2022-based FQHC market basket.

CMS PROPOSES BROAD TECHNICAL AND OPERATIONAL REFINEMENTS TO THE AMBULATORY SPECIALTY MODEL

Pages 345-453

CMS proposes a series of technical and operational refinements to the mandatory ASM, which will run from 2027 through 2031. The proposals retain ASM's core structure and individual clinician accountability framework while clarifying participation rules, reducing reporting burden, strengthening quality measurement, and aligning the model more closely with the Merit-based Incentive Payment System (MIPS).

- **Participant Eligibility and Exceptions:** CMS proposes to clarify that clinicians generally remain ASM participants for the duration of the model but are subject to reporting, scoring, payment adjustments, and model protections only while eligible. The agency would expand exceptions for clinicians who change Taxpayer Identification Numbers (TIN), or otherwise stop reassigning billing rights (including due to retirement), and establish an exception for certain participants specializing in heart failure who redesignate to specified cardiac subspecialties. Prior-year payment adjustments would continue to apply after an exception is granted.

- **Program Administration:** CMS proposes authority to terminate participants for program integrity, patient safety, legal, or model compliance concerns. CMS would also allow improvement activity reporting at the individual or group level and would continue to permit small practices to report quality measures individually or as a group. However, if CMS receives any group-level quality submission from a small practice, the group score would apply to all ASM participants in that practice.

- **Quality Measurement:** For the low back pain cohort, CMS proposes adding a claims-based measure of potentially unnecessary lumbar MRI use and replacing the discontinued Functional Status Change measure with the Functional Outcome Assessment measure. CMS also proposes scoring administrative claims measures at the individual TIN/NPI level and excluding measures without valid benchmarks from quality scoring.

- **Patient-Reported Outcomes:** CMS proposes a voluntary patient-reported outcome initiative under which participants submitting qualifying baseline and follow-up data for at least 20 beneficiaries could receive up to five additional quality-category points. The data would support future PRO measure development.

- **Promoting Interoperability:** CMS proposes to further align ASM with MIPS by making electronic prior authorization reporting optional in 2027 and required beginning in 2028, adopting a prescription drug prior authorization measure, expanding measure exclusions, eliminating certain attestations, and establishing a measure suppression policy.

- **Scoring Adjustments:** CMS proposes a five-point rural scoring adjustment for eligible participants and would update performance reports to display both the rural adjustment and PRO incentive.

- **Collaborative Care Arrangements:** CMS proposes to allow multiple ASM participants within the same TIN to enter a single collaborative care agreement with a primary care practice and would revise requirements governing remuneration, valuation, reconciliation, repayment, and documentation.

- **Model Protections:** CMS would clarify that the model safe harbor and MIPS waiver protections apply only during periods when a participant is actively performing under ASM and is not ineligible or excepted from model requirements.

The proposed changes to the ASM address operational concerns raised after the model was finalized, and provide needed additional guidance on how the model will be aligned with MIPS.

CMS PROPOSES TO LIMIT MEDICARE COVERAGE FOR CERTAIN INDIVIDUALS

Pages 454-479

CMS proposes updates to implement the statutory changes made by section 71201 of Public Law 119-21, which amended Title XVIII of the Act by limiting Medicare eligibility to certain groups. CMS proposes to add a new definition of "eligible noncitizen" to include individuals who 1) are lawfully admitted for permanent residence under the Immigration and Nationality Act (INA); 2) have been granted the status of Cuban and Haitian entrant (CHE) as defined in section 501(e) of the Refugee Education Assistance Act of 1980 (Pub. L. 96–422); or 3) who lawfully resides in the U.S. in accordance with a Compact of Free Association (COFA) referred to in 8 U.S.C. 1612(b)(2)(G). CMS proposes that, effective July 4, 2025, an individual must be a citizen or national of the U.S. or an eligible noncitizen as a basis for entitlement. There will be a grace period spanning the 18 months after July 4, 2025, for those who are no longer eligible for Medicare under these proposed changes.

CMS also proposes amending regulations to implement termination processes for individuals no longer eligible for Medicare under these provisions. For the scenario in which an individual later becomes eligible for Medicare due to changes in their nationality, citizenship, or immigration status, or to category changes, CMS proposes establishing a special enrollment period (SEP).

This proposal codifies statutory changes to Medicare eligibility rules.

CMS PROPOSES UPDATES TO INFLATION REBATE PROGRAM

Pages 480-513

The Inflation Reduction Act of 2022[6] requires manufacturers to pay inflation rebates to the federal government if they raise prices for certain Medicare Part B and Part D drugs faster than the rate of inflation, based on the Consumer Price Index for All Urban Consumers (CPI-U). Rebates are calculated quarterly for Part B drugs and annually for Part D drugs. In this proposed rule, CMS proposes policies impacting both Part B and Part D drugs.

[6] Pub. L. 117-169

Medicare Part B Drug Inflation Rebate Program Proposals

- **Definition of "First Marketed Date":** CMS proposes to clarify that when the first marketed date is missing from Average Sales Price (ASP) data, it will use the first marketed date from an alternative public source, such as the National Drug Code (NDC) Directory, or, if unavailable, the Food & Drug Administration (FDA) approval date in the Orange Book or Purple Book.

- **Modification to Skin Substitutes Excluded Product Category:** Skin substitutes are currently excluded from inflation rebates. CMS proposes to narrow the exclusion by clarifying that skin substitutes licensed as drugs or biological products would be subject to Part B inflation rebates. No skin substitutes currently meet this definition, but CMS's intent is to clarify the application of this policy for future products.

- **Determining Benchmark Period CPI-U and Rebate Period CPI-U When CPI-U Data is Unavailable:** In response to a scenario that occurred in 2025, where the CPI-U needed for CMS to perform the inflation rebates calculation was unavailable for a month, CMS proposes that, if CPI-U data are unavailable, it will use CPI-U data for the first month for which CPI-U data are available following the month of unavailability.

Medicare Part D Drug Inflation Rebate Program Proposals

- **Definition of "Applicable Period CPI-U" When CPI-U Data Are Unavailable for the First Month of the Applicable Period:** In response to a scenario that occurred in 2025, where the CPI-U needed for CMS to perform the inflation rebates calculation was unavailable for a month, CMS proposes that when the first month's CPI-U data is unavailable, CMS will use the first month for which CPI-U data are available following the month of unavailability.

- **Determining Benchmark Period CPI-U When CPI-U Data Are Unavailable:** In alignment with the policy proposed for Part B drugs to address the missing October 2025 CPI-U data, the agency is proposing that if CPI-U data are unavailable, it will use CPI-U data for the first month for which CPI-U data are available following the month of unavailability.

- **Requiring Covered Entities to Submit Part D 340B Data to the 340B Repository:** Beginning with plan year 2026, CMS is required to exclude 340B-acquired units of Part D rebatable drugs from inflation rebate calculations. Because CMS currently lacks claim-level data to identify those units, the agency previously established a claims-based methodology (the Prescriber-Pharmacy Methodology) and a voluntary 340B repository. CMS proposes two changes to existing policies:

    - CMS proposes to make submission of Part D 340B data to the 340B repository mandatory, beginning in 2027. The repository is expected to be operational by Fall 2026 for voluntary submissions, and providers are strongly encouraged to begin submitting data before submission is mandatory. CMS also proposes

documentation, data, and operational requirements to operationalize submission and data collection.

- CMS also proposes to identify prescription drug event (PDE) records for beneficiaries with AIDS Drug Assistance Program (ADAP) supplemental coverage and exclude all associated units from inflation rebate calculations after determining that ADAPs and other Federal grantee sites account for a greater share of 340B antiretroviral claims than previously anticipated.

For both Part B and Part D inflation rebates, CMS makes technical corrections to the date of receipt for rebate report examples included in the CY 2025 PFS Final Rule and provides clarification regarding its enforcement policy for manufacturer payment.

CMS's proposals provide operational clarity. The requirement to submit Part D 340B data to the repository will likely improve the accuracy of inflation rebates calculations, but also introduces new burden for providers.

CMS PROPOSES CONTINUING ITS CURRENT DISCARDED DRUG REFUND POLICY, DOES NOT GRANT AN INCREASED APPLICABLE PERCENTAGE FOR AN APPLICANT

Pages 309-317

In this rule, CMS does not propose any changes to the discarded drug refund policy, which requires drug manufacturers to provide a refund to CMS for certain discarded amounts from a refundable single-dose container or single-use package drug. CMS received an application requesting an increased applicable percentage for Leukine® (sargramostim), a refundable drug. CMS is proposing to deny the request but is requesting public comment on the application.

CMS PROPOSES CONFORMING CLFS UPDATES AND TECHNICAL CORRECTIONS TO IMPLEMENT CAA, 2026

Pages 336-344

CMS proposes to revise the definitions of the "data collection period" to mean the 6-month period from January 1 through June 30 and the "data reporting period" to mean the 3-month period from May 1 through July 31 for clinical diagnostic laboratory tests (CDLTs) that are not advanced diagnostic laboratory tests (ADLTs), while maintaining a January 1 through March 31 reporting period for ADLTs. CMS also proposes conforming changes to the phase-in of payment reductions, specifying that payment reductions are limited to 0 percent in CY 2026 and to up to 15 percent annually in CYs 2027 through 2029, compared with the preceding year. Separately, CMS proposes a technical correction to restore regulatory text implementing the

statutory $2 increase in the specimen collection fee for specimens collected from Medicare beneficiaries in skilled nursing facilities or by laboratories on behalf of home health agencies.

CMS PROPOSES MODIFICATIONS TO MSSP TO INCREASE PARTICIPATION

Pages 514-851

CMS outlines a series of reforms to the Medicare Shared Savings Program (MSSP) aimed at strengthening financial incentives, increasing beneficiary engagement, and reducing participation burden. Because several proposals would modify the program's financial methodology, CMS also proposes providing ACOs applying for a January 1, 2027, agreement start date a limited opportunity to change their selection between the BASIC and ENHANCED tracks.

Changes to Beneficiary Assignment

Pages 525-580

For CY 2027, CMS proposes to exclude allowed charges for primary care services billed by an ACO professional under a non-ACO TIN when determining beneficiary assignment. This proposal would affect only beneficiary assignment and would not change the MSSP financial methodology.

CMS also proposes to update the definition of primary care services used for beneficiary assignment beginning with the January 1, 2027, performance year by adding new codes for Screening, Brief Intervention, and Referral to Treatment (SBIRT), Vaccine Adverse Effects Management, and Advance Care Planning, among other services.

Proposed Changes to the SSP Financial Methodology

Pages 674-786

CMS proposes several changes to the financial methodology of MSSP to increase participation in the program and increase savings for the Trust Fund.

- Increase the sharing rate for Level E of the BASIC track from 50 percent to 60 percent to close the gap between BASIC and ENHANCED, and
- Reduce the maximum weight on regional adjustment for lower-spending ACOs in the ENHANCED track from 50 percent to 35 percent.

CMS offers several other changes to the financial methodology, including:

- Increase the prior savings adjustment scaling factor from 50 percent to 75 percent.
- Risk-adjust the 5 percent cap on upward adjustments to the historical benchmark to better reflect beneficiary clinical complexity.

- Establish a growth adjustment to the historical benchmark, capped at 5 percent, that would be applied in addition to the existing regional, prior savings, and population adjustments to encourage ACO growth.
- Reform the Accountable Care Prospective Trend (ACPT) component of the benchmark update factor by using a year-over-year growth rate instead of an annualized rate and implementing guardrails of -1.0 to +1.5 percentage points.

Proposals to Increase Beneficiary Engagement

Pages 786-808

For CY 2027, CMS proposes two changes to expand ACOs' ability to support beneficiary engagement in their care. First, CMS proposes to discontinue the prepaid shared savings option, which was established in the CY 2025 PFS Final Rule.

Second, following the flexibilities available under the ACO REACH Model, CMS proposes to allow MSSP ACOs to enter into Part B cost-sharing support agreements. Under the proposal, ACOs could cover all or part of a beneficiary's Medicare fee-for-service (FFS) Part B deductible and/or coinsurance.

Modifications to the Advance Investment Payments

Pages 808-819

For CY 2027, CMS proposes to modify the methodology used to calculate quarterly advance investment payments. Currently, payment amounts are based on a risk-factor score that includes, among other factors, an Area Deprivation Index (ADI) score. CMS proposes removing the ADI due to methodological concerns, adding a rural criterion to encourage participation by low-revenue ACOs, and replacing the current methodology with a flat payment of $45 per beneficiary, capped at 10,000 beneficiaries.

Clarification of an Experienced vs. an Inexperienced ACO

Pages 819-826

As part of determining MSSP eligibility, CMS classifies ACOs as experienced or inexperienced with financial responsibility based, in part, on prior participation in Medicare ACO initiatives. For CY 2027, CMS proposes to revise the definition of a "legacy" TIN so that ACO TINs appearing in claims history solely due to financial reconciliation, but without a written agreement to participate in a performance-based initiative, would be considered inexperienced beginning January 1, 2027.

Change to Beneficiary Notifications

Pages 826-832

CMS proposes replacing the requirement to provide beneficiary notice after a beneficiary's first primary care visit with a requirement to provide a CMS-developed written notice at least once during an agreement period. CMS also proposes eliminating the requirement to provide

follow-up verbal or written communication within 180 days of the initial notice. CMS notes these changes would align the MSSP with CMS Innovation Center ACO models.

Request for Information on Future Policy Developments

Pages 832-851

CMS also includes two RFIs seeking stakeholder feedback on potential approaches to expand specialty care participation in the Shared Savings Program and implement a primary care-focused capitated payment model.

CMS is proposing to alter incentives to promote participation in two-sided risk tracks and offering some flexibilities for ACO participants. Overall, CMS estimates that these proposals would reduce Trust Fund expenditures by $5.5 billion from 2027 through 2036.

REQUESTS FOR INFORMATION

CMS includes several Requests for Information (RFIs) to inform potential future Medicare policy development, including:

- **Primary Care Payment (Pages 252-284):** CMS seeks feedback on how primary care payment should evolve in response to technological innovation, including the relative valuation of primary care services, technology-enabled care, and the role of FFS, outcomes-based, and prospective payment models, including prospective primary care payment (PPCP).
- **Current Procedural Terminology (CPT®) Coding System (Pages 304-308):** CMS requests input on the role of the American Medical Association's (AMA) CPT coding system and Relative Value Scale Update Committee (RUC) in physician payment policy, including potential alternatives to CPT-4, the role of medical necessity in code development, and the use of the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) as an alternative basis for physician payment.
- **Duplicate Testing and Interoperability (Pages 867-873):** CMS seeks feedback on approaches to reduce duplicative laboratory and imaging testing, including frequency limitations, payment edits, billing guidance, and opportunities to improve interoperability and diagnostic result sharing.

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