2027 Medicare Physician Payment Schedule and Quality Payment Program Final Rule Summary

On November 4, 2026, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2027 Medicare Physician Payment Schedule (PFS) final rule and associated fact sheet. Published in the November 9, 2026, Federal Register, the rule revises Part B payment and coverage policies and the Quality Payment Program (QPP). The American Medical Association (AMA) submitted detailed comments on the proposed policies on September 14, 2026. Unless otherwise noted, the finalized changes take effect on January 1, 2027.

I. Payment Provisions

CY 2027 Medicare Conversion Factors

The 2027 conversion factor (CF) is $32.6286 for physicians who are not qualifying alternative payment model (APM) participants (QPs), a 2.31 percent decrease from 2026, and $32.9548 for QPs, a 1.83 percent decrease.

2027 Medicare Conversion Factors (CFs)							
	2026 CFs	**Expiration of CY 2026 2.5 percent increase (÷1.025)**	**APM or non-APM update factor (1.0075 or 1.0025)**	**CY 2027 RVU budget neutrality adjustment (0.9988)**	**Anesthesia-only PE and PLI adjustments**	**2027 CFs**	**Percentage Changes**
APM QP	$33.5675	$32.7488	$32.9944	$32.9548	N/A	$32.9548	**-1.83%**
Non-APM QP	$33.4009	$32.5863	$32.6678	$32.6286	N/A	$32.6286	**-2.31%**
Anesthesia APM QP	$20.5998	$20.0974	$20.2481	$20.2238	$20.3068	$20.3068	**-1.42%**
Anesthesia Non-APM QP	$20.4976	$19.9976	$20.0476	$20.0235	$20.1056	$20.1056	**-1.91%**

The 2027 CFs reflect:

- Expiration of the temporary 2.5 percent update for CY 2026 included in H.R. 1, which has not been extended as of November 10, 2026, and is removed before the CY 2027 updates are applied.
- The statutory updates under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) of 0.75 percent for QPs in Advanced APMs and 0.25 percent for all other physicians.
- A negative 0.12 percent budget neutrality adjustment to balance finalized coding and payment policy changes compared with a positive 0.53 percent in the proposed rule.
- For the anesthesia CFs only, a positive 0.41 percent adjustment to reflect practice expense (PE) and professional liability insurance (PLI) changes.

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AMA Advocacy and Congressional Action

Absent congressional action, physicians face a net Medicare payment cut in 2027, even as CMS projects that the Medicare Economic Index (MEI) will rise 2.6 percent. The AMA continues to advocate for annual payment updates that reflect growth in physician practice costs, as measured by the MEI.

The AMA strongly supports the bipartisan Patients First Act (H.R. 9693), introduced July 15 by the chairs of the GOP and Democratic Doctors Caucuses. The bill would:

- Establish an annual MEI-based update and reform budget neutrality.
- Replace Merit-based Incentive Payment System (MIPS) and expand APM opportunities and incentives.
- Create a primary care payment pilot outside budget neutrality.

The AMA is urging Congress to act before the cuts take effect on January 1 and will engage lawmakers during the lame-duck session.

Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods

In response to advocacy by the AMA and more than 150 national medical specialty societies, state medical organizations, and other healthcare organizations in a joint sign-on letter, CMS scaled back its proposal to reduce payment when a separately identifiable office/outpatient (O/O) evaluation and management (E/M) visit is reported with modifier -25 on the same day as a procedure with a global period.

CMS had proposed paying the highest-valued service in full and reducing payment for every other same-day service by 50 percent. The proposal applied to procedures with 0-, 10-, and 90-day global periods furnished by the same physician or a physician in the same group practice. CMS had proposed a similar policy, limited to 0-day global procedures, in the CY 2019 PFS proposed rule but did not finalize it.

Effective January 1, 2027, CMS finalized a 20 percent payment reduction for all services except the highest-valued service when an O/O E/M visit reported with modifier -25 is furnished on the same day as a 0-day global procedure. Compared with the proposal, CMS:

- limited the policy to 0-day global procedures, dropping 10- and 90-day global procedures;
- reduced the payment cut from 50 percent to 20 percent, so affected services are paid at 80 percent rather than 50 percent; and
- limited the policy to services furnished by the same physician or a physician of the same specialty in the same group practice, so same-day services by physicians of different specialties in the same group are not affected.

The policy applies only to O/O E/M visits (Current Procedural Terminology [CPT®] codes 99202-99205 and 99211-99215). CMS did not extend it to inpatient or other E/M services.

Estimated Payment Impacts

CMS expects the largest impacts on dermatology, otolaryngology, and podiatry, although the reductions are smaller than proposed. CMS estimates that limiting the policy to 0-day global procedures alone reduces specialty impacts by around 1 percent. The *CY 2027 PFS Estimated Impact on Total Allowed Charges by Specialty* public use file on the CY 2027 PFS final rule webpage combines all relative value unit (RVU) changes. It excludes conversion factor changes, including expiration of the temporary 2.5 percent increase.

To isolate the modifier -25 policy, the AMA analyzed CMS' 2027 RVUs, conversion factor, and utilization assumptions. The AMA estimates a $263 million, or 0.3 percent, reduction in PFS payments before savings are redistributed across services under budget neutrality. The largest percentage reductions are:

- Otolaryngology: 2.9 percent.
- Podiatry: 1.8 percent.

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- Hand surgery: 1.4 percent.
- Dermatology: 1.2 percent.
- Colon and rectal surgery: 1.0 percent.

The AMA's specialty impact table is included at the end of this document.

AMA Concerns and Next Steps

The AMA strongly opposed the proposal in its comments and urged CMS not to finalize it. The AMA noted that CMS offered no evidence demonstrating that duplicate payment exists or showing its magnitude. It explained that any overlap for services typically furnished together has already been removed through the AMA/Specialty Society RVS Update Committee (RUC) and CMS processes, which exclude work associated with separately identifiable E/M services. The AMA also noted that any residual overlap is largely confined to portions of the pre-service evaluation, post-service time and practice expense components, yet the policy reduces the entire service, including physician work, practice expense, and professional liability insurance. It added that the burden would fall most heavily on independent, office-based practices. The final policy reflects meaningful changes that substantially reduce its impact. However, the AMA remains concerned that a uniform payment reduction, even at a lower level, rests on the same unsupported premise. Consistent with recent AMA policy, the AMA will continue to oppose the modifier 25 payment reduction through regulatory and legislative advocacy and other appropriate avenues. The AMA also opposes any reduction in payment for a significant, separately identifiable E/M service appropriately reported with modifier 25 by any payer. The AMA will continue to press for state and federal action to block or reverse modifier 25 payment reductions and urge CMS to address any genuine overlap, if it exists, through code-specific review, rather than an across-the-board payment reduction.

Modifications to the Practice Expense (PE) Methodology

CMS finalized all four interrelated PE methodology changes as proposed. The AMA had urged CMS to delay the changes until it published specialty-level impacts for each policy, and to phase in any changes over multiple years. CMS declined. It said the policies interact, so publishing their impacts separately would misrepresent their combined effect. CMS also said the new plus or minus 5 percent PE cap will phase in changes more gradually than a four-year transition would for many codes.

1. Indirect PE allocation

CMS finalized allocating indirect PE (overhead such as rent, equipment, and administrative staff) based on the sum of a service's work RVU and clinical labor RVU for all services except those with 10- and 90-day global periods. Since 2007, CMS has used the sum only for services that can be billed with professional and technical components, typically diagnostic and imaging services, and has allocated indirect PE for all other services based on the greater of the two. CMS said this "inadvertently advantages" those services with professional and technical components, citing analysis by the RAND Corporation. The AMA had noted that the RAND analysis did not exclude 10- and 90-day global services and that CMS had provided no rationale for doing so. In the final rule, CMS acknowledged that it inadvertently omitted its rationale from the proposed rule. CMS explained that it excluded these services because their bundled valuation covers all pre-, intra-, and post-operative work, clinical staff time, and PE across the global period, without clear visibility into how each component contributes to payment. CMS tied this explanation to its broader concerns about the accuracy of global surgical valuation.

2. Elimination of the indirect practice cost index (IPCI)

CMS finalized phasing out the IPCI over two years, applying half of its effect in 2027 and eliminating it in 2028. The IPCI rescales indirect PE RVUs so that each specialty's share approximates its indirect costs as reported in the 2007 AMA Physician Practice Information (PPI) Survey. CMS said the IPCI favors dated survey data over code-level information and produces "unpredictable and counterintuitive results," and that removing it will improve the transparency and stability of PE RVUs. Specialty-level survey data will continue to be used elsewhere in the methodology, though CMS said it may consider reducing reliance on those data in future rulemaking. The AMA noted that its updated PPI Survey, a multi-year effort shared with CMS in January 2025, provides the current, specialty-level practice cost information CMS says is lacking. The AMA also noted that CMS' own contractor, RAND, recommended developing improved, recurring data sources rather than removing data-driven components of the methodology. CMS declined to use the updated data, citing

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concerns about the survey's response rates and sampling. The AMA continues to urge CMS to work with the AMA on how updated practice cost data can be used so that PE payments reflect the current costs of running a practice.

3. PE stabilization adjustment

CMS finalized a stabilization adjustment that limits year-to-year changes in a service's PE RVUs to plus or minus 5 percent. The adjustment does not apply to new, revised, or newly nationally priced codes, or to revalued codes, including codes revalued because of a change to a single direct PE input. CMS declined commenters' requests to adopt a different percentage, set a fixed duration, or apply the adjustment to revalued codes. It said it remains interested in a method for extending the adjustment to new and revised codes. The adjustment operates separately from the statutory limit on annual RVU reductions of 19 percent, so some codes may be subject to both. The AMA had expressed general support for transition policies that stabilize RVUs from year to year and urged that, to the extent practicable, such protections apply to all services.

4. Utilization adjustments (setup file)

CMS finalized a new method of adjusting utilization data used in the PE methodology. For each claim line, CMS uses the ratio of allowed charges to the national payment amount to account for payment modifiers, special payment rules such as multiple procedure payment reductions, and geographic differences. CMS will use the same ratio to adjust time, except for anesthesia services, and said the change will have a minimal effect on PE RVUs. In its comments, the AMA flagged large, unexplained changes in the proposed rule's utilization data for pathology, independent laboratories, and physical and occupational therapy. In response to the AMA and other commenters raising this issue, CMS identified and corrected a technical error affecting codes reported in multiple units, such as those billed in time or square-centimeter increments. The error had produced erroneous decreases in estimated total allowed charges for these specialties in the proposed rule.

MEI Weights

For 2027, CMS will continue to use the current PE/HR data and 2006-based MEI cost shares for physician work, PE, and professional liability insurance, which the AMA supports. CMS previously considered transitioning to the 2017-based MEI cost shares, which would have significantly decreased the proportion of physician payment allocated to physician work and was opposed by organized medicine. CMS said it may consider updating the cost shares in future rulemaking.

Update to PE Site of Service Payment Differential

In 2026, CMS implemented a controversial methodology change to reduce indirect PE payment for all services provided in the facility setting, citing concern about duplicative payments between the physician and hospital payment systems. CMS reduced the portion of facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs. This resulted in an average seven percent cut to facility-based payment, while non-facility-based payment increased by an average of four percent. The resulting payment changes to individual physicians and specialties were substantial. The AMA strongly opposed this policy and called for CMS to make changes based on reviewing individual services, rather than broad disruptive policies, highlighting the results of the AMA PPI Survey.

CMS acknowledged that the 2026 policy produced an "unintended, but significant" payment differential for nursing facility visits based solely on whether a patient's stay is covered under Medicare Part A. Under the 2026 policy, the PE payment for a subsequent nursing facility visit (CPT code 99309) was 35 percent lower for a patient in a skilled nursing stay, even though the physician's practice costs do not change based on how the patient is classified. CMS finalized its proposal to correct this by equalizing the facility and non-facility PE RVUs for nursing facility visits (CPT codes 99304-99310, 99315, and 99316), effective January 1, 2027. The AMA and other commenters unanimously supported this correction.

CMS did not propose, and did not finalize, any other changes to the 2026 policy. In the proposed rule, CMS noted that the "current binary of facility and non-facility does not account for the range of employment models associated with physician services that drive significant differences in actual practice expenses" and requested comment on alternatives. The AMA strongly urged CMS to repeal the 50 percent adjustment effective January 1, 2027, until a more data-driven approach is developed. The AMA also urged CMS to use the 2024 PPI Survey data, which show $57 in indirect PE per hour of direct patient care for hospital-based medicine and $62 for hospital-based surgery, and to phase in any future changes over four years. In the final rule, CMS noted that commenters agreed that using the facility setting as a proxy for

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physician employment is imprecise and broadly urged a more data-driven approach. CMS said it may consider these comments in future rulemaking.

Strategies to Improve Payment Transparency, Accuracy, and Congruency Across Payment Systems

Professional and Technical Components

With the proposed rule release, CMS posted a public use file that displays the non-facility (office) PE RVUs and the facility PE RVUs, labeling facility RVUs as "26 – professional" and the difference between the non-facility and facility RVU as "TC-technical." CMS stated that it is sharing this information to provide transparency and to "facilitate more consistent comparisons across services and settings" and requested comment on how it could use this information to assess payment differences across settings.

In the final rule, CMS emphasized that it did not use the file for payment comparisons and said it will consider commenters' methodological concerns before any future proposal that relies on cross-setting comparisons. CMS also said it may expand the file or publish direct and indirect PE RVUs in future rulemaking. This is consistent with the AMA's broader request that CMS provide more transparency in PE rate-setting, including identifying codes with professional and technical components that do not use TC or 26 modifiers.

Global Surgical Packages

CMS finalized its proposal to pause the collection of data on post-operative visits through non-covered CPT code 99024 (*Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure)*. CMS cited the burden on physicians and said the pause will allow it to evaluate the data's limitations and refine its approach. However, CMS maintained that the data it has collected show post-operative visits are not occurring, and it remains interested in how best to capture post-operative data to inform valuation of global surgical services.

The AMA strongly disputes CMS' characterization of these data. Only some physicians were required to report CPT code 99024, and the AMA has long explained that the resulting data are incomplete and unreliable for revaluing global surgical packages, as detailed beginning on page 31 of the AMA comment letter on the 2022 PFS proposed rule. In its 2027 comments, the AMA urged CMS not to expand reporting to all physicians, as CMS had asked about in the proposed rule. The AMA also explained that surgical global values were not built by adding up the value of individual visits. CMS also sought comment on potential revaluation strategies and posted a public use file that computes relative values without post-operative visits for all 10- and 90-day global period services. The AMA urged CMS to rely on the RUC process instead, and to incorporate the full 2021 increases in E/M work and physician time into the post-operative visits included in 10- and 90-day global services. In the final rule, CMS noted that commenters generally supported the pause and opposed expanding reporting or using the CPT code 99024 data or the public use file to revalue global services. It did not respond to the AMA's request regarding the 2021 E/M increases and said it will consider comments on revaluation strategies in future rulemaking.

Valuation of Specific Codes

CMS accepted 90 percent of the RUC's relative value recommendations for 2027, including for maternity care services, prostate biopsy, and magnetic resonance angiography, head and neck services. CMS had initially proposed to reduce the RUC recommendations for shoulder, hip, and knee arthroplasty, but finalized 2027 work RVUs at the RUC-recommended values. CMS also accepted 100 percent of the RUC Health Care Professionals Advisory Committee Review Board recommendations, including speech-language pathology services, and nearly all of the RUC's direct practice expense recommendations.

Maternity Care Services

The AMA is pleased that CMS finalized the revised Maternity Care Services CPT codes, which take effect January 1, 2027. The new code structure, developed over nearly two years by obstetricians, family physicians, certified nurse midwives, payers, and other stakeholders, comprehensively revises the maternity care codes to reflect modern obstetric practice. The revised Maternity Care Services CPT codes will provide much-needed transparency for patients, and the

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increased granularity will improve the ability of physicians and researchers to better understand the drivers of maternal mortality.

Following AMA advocacy, CMS did not finalize an alternative on which it had sought comment: creating Healthcare Common Procedure Coding System (HCPCS) G-codes to maintain the historical global structure and payment for maternity care services under the PFS. The AMA, along with the American College of Obstetricians and Gynecologists (ACOG) and other commenters, opposed the G-code alternative. Because CMS had already proposed to adopt the new CPT codes for hospital outpatient payment, parallel G-codes for physicians would have created two competing code sets within Medicare alone, adding confusion and administrative burden for physicians, hospitals, health plans, and patients.

Separately, on October 30, 2026, CMS announced, on behalf of the Department of Health and Human Services (HHS), temporary enforcement discretion under the Health Insurance Portability and Accountability Act (HIPAA) code set requirement. It applies to maternity care episodes that began in 2026 and end in 2027. Starting January 1, 2027, HHS will not take enforcement action against HIPAA covered entities that use the 2026 CPT maternity care codes for these episodes, as long as they follow business rules issued by payers and health plans. The enforcement discretion ends December 31, 2027. CMS noted that the letter does not constitute CMS payment policy and that it would **"defer to AMA and ACOG guidance on the correct billing structure for pregnancies that begin in CY 2026 and continue into CY 2027."** AMA guidance on the correct billing for pregnancies that bridge CY 2026 and 2027 is available here. Physicians should check each payer's business rules.

Remote Monitoring

CMS began paying for CPT codes for remote physiologic monitoring (RPM) in 2019. Codes for remote therapeutic monitoring (RTM) followed, as well as expanded coding for RPM. Citing a lack of data on the typical device used to provide these services and recommendations from the HHS Office of Inspector General (OIG), CMS proposed several changes to RPM and RTM coding, payment, and billing requirements for 2027. The final rule addresses each proposal as follows:

1. *Established patients.* CMS finalized its proposal to require that RTM services be furnished only to established patients, consistent with the requirement that has applied to RPM since 2021. CMS clarified that it will use the definition of "established patient" used elsewhere in the PFS: a patient who has received professional services from a physician, or another physician of the same specialty in the same group practice, within the past three years. A patient may also be considered established once the initiating visit requirement below has been met.

2. *Initiating visit.* CMS finalized its proposal to require clinicians reporting RPM or RTM services to furnish an initiating visit before these services begin. The AMA agreed that it is good practice to document the need for remote monitoring at the visit where it is ordered but opposed imposing new regulatory burden on practices and asked CMS to clarify what "separately reportable" means. In response, CMS clarified that:

    - The initiating visit must be face-to-face, either in person or via telehealth, and RPM or RTM must be discussed at the visit. It does not need to be the sole purpose of the visit, and it can be, but does not have to be, separately billable.
    - The visit is required only once, before monitoring begins. It is not required again for a change in device, a clinical change, or a change in billing practitioner within the same practice.
    - No time limit applies between the initiating visit and the start of monitoring, and CMS is not adding documentation requirements.
    - Patients already receiving remote monitoring before January 1, 2027, will not need an initiating visit.

3. *Practice-employed clinical staff.* CMS finalized, with a two-year delay, its proposal to pay for RPM and RTM services only when they are furnished by clinical staff employed by the practitioner or practice. Beginning January 1, 2029, these services may not be billed when furnished by contracted third-party staff. Before then, CMS will issue sub-regulatory guidance clarifying which clinical staff arrangements may be appropriate. CMS emphasized that in the meantime, practices using third-party companies must still meet all existing "incident to" and other billing requirements, including meaningful oversight by the billing practitioner. The AMA had urged CMS to withdraw this proposal, warning that it would disrupt arrangements used by academic medical centers, health systems, and small, rural, and safety-net practices and reduce patients' access to remote monitoring.

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4. *Valuation.* CMS finalized its proposal to reduce payment for RPM and RTM device supply and set-up codes by cross-walking their direct PE inputs to other services. However, CMS did not finalize its proposal to eliminate direct PE inputs for the treatment management codes (CPT codes 99470, 99457, 99458, 98979, 98980, and 98981). CMS agreed with commenters that clinical staff are often used to furnish these services. In direct response to CMS' concerns about a lack of data, the RUC moved up its review of PE inputs for all RPM and RTM codes to January 2027. The AMA urged CMS to maintain the current direct PE inputs until that review is complete. CMS acknowledged the RUC's review and said it looks forward to considering the results in future rulemaking. For most codes, the statutory 19 percent limit on annual reductions will phase in the cuts over multiple years. The exceptions are CPT codes 98978 and 98986, which are newly nationally priced and therefore not subject to the phase-in. CMS will now value them the same as the other RTM device supply codes.

5. *New HCPCS G-codes.* CMS did not create the four HCPCS G-codes it had considered and sought comment on, which would have bundled 17 RPM and RTM CPT codes into set-up and monthly monitoring codes. The AMA had opposed the G-codes because they would have reduced coding specificity and, as new codes not subject to the 19 percent limit on annual reductions, would have imposed the full payment reduction in 2027. CMS said it will consider the comments in possible future rulemaking.

Evaluation and Management (E/M) Visit Complexity Add-On (HCPCS Code G2211)

CMS finalized its proposal to replace the E/M visit complexity add-on code, HCPCS code G2211, with modifier B1 (referred to as MOD1 in the proposed rule). Modifier B1 will be reported under the same circumstances as G2211 today and will be paid at 16 percent of the base E/M code. CMS also finalized a separate modifier, B2 (referred to as MOD2 in the proposed rule), paid at 32 percent of the base E/M code. Modifier B2 is available only to Shared Savings Program (SSP) Accountable Care Organization (ACO) participants, ACO professionals, ACO provider/suppliers, and LEAD model participant providers. Both modifiers will take effect January 1, 2027, and can be appended to O/O and home or residence E/M visits, including those furnished via telehealth.

The AMA raised concerns that the new modifiers carry no RVUs of their own, so physicians compensated under RVU-based productivity models may no longer receive RVU credit for this work. The AMA also raised concerns that CMS did not provide data or a methodology to support paying ACO participants twice the rate of other physicians for the same visit work. In addition, the AMA noted that CMS substantially overestimated G2211 utilization when the code was introduced, which reduced the 2024 conversion factor by more than the actual data supported. The AMA urged CMS to avoid repeating that error and to publicly report utilization of the new modifiers by specialty, care setting, and E/M visit level.

CMS' responses were mixed. In a step that partially addresses the AMA's concerns about RVU credit, CMS published a public use file that maps modifier B1 and B2 payments to comparable RVUs at each E/M level, which physicians can use to account for this work in productivity-based compensation. CMS otherwise declined the AMA's request for more transparency, stating that it has historically published only the combined specialty-level impacts of all policies, and did not address its earlier G2211 utilization estimates. CMS also acknowledged objections to paying ACO participants twice the rate for what commenters viewed as identical clinical work, saying the higher rate recognizes ACOs' investment in care coordination and population health management and encourages ACO participation. CMS noted that billing modifier B2 is optional and that ACOs may offer cost-sharing support to offset the higher beneficiary cost-sharing.

Additional Newly Covered Services

CMS finalized coding and payment changes for several new services in 2027:

- *Shared medical appointments.* CMS finalized HCPCS code G0686 for group-based medical sessions with 2-10 patients, with a modified descriptor. In response to comments, CMS also created an add-on code (G0687) that allows up to two additional 30-minute units, for sessions of up to 120 minutes. Sessions are limited to one per week per beneficiary.
- *Vaccine adverse effects management.* CMS finalized, as proposed, add-on HCPCS code G0576 for the diagnosis and treatment of suspected vaccine adverse effects, reported with O/O and home or residence E/M visits.
- *Health and well-being coaching.* CMS finalized national pricing for existing CPT codes 0591T-0593T, which have been contractor priced since 2020. In response to comments, CMS increased the valuation of 0591T and 0592T and finalized general supervision rather than the proposed direct supervision.

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Software as a Medical Service (SaMS) Laboratory Analyses

CMS finalized its proposal to change its terminology from "Software as a Service" to SaMS, consistent with the CY 2027 Outpatient Prospective Payment System (OPPS) final rule. SaMS refers to software-based technologies that support clinical decision-making through algorithmic analysis, including those that provide clinical or diagnostic functionality. The AMA supported the new term, provided that SaMS functions as an interim designation rather than a parallel clinical or coding taxonomy, and that CMS builds on existing frameworks, including CPT Appendix S and the CPT Editorial Panel's ongoing Clinically Meaningful Algorithmic Analyses work, so that Medicare and coding classifications do not diverge.

Despite AMA opposition, CMS finalized removing codes describing SaMS analyses of laboratory tests from the Clinical Laboratory Fee Schedule (CLFS) and paying for them under the PFS beginning January 1, 2027. CMS revised the code list in response to commenter feedback, so 14 codes are affected rather than the 10 proposed. In a significant change from the proposed rule, CMS will nationally price these services rather than contractor price them. It will do so by dividing the CY 2027 OPPS payment rate (derived based on a crosswalk from CY 2026 CLFS rates) by the PFS conversion factor and assigning the result as the service's PE RVUs. Unlike contractor-priced services, nationally priced services count toward PFS budget neutrality. The resulting PE RVUs range from 10.74 to 68.97, with most codes at 23.00 (roughly $750 per service), far higher than typical physician services.

The AMA had urged CMS to withdraw the list pending a code-by-code technical review with the College of American Pathologists and other stakeholders, noting that descriptor-based classification is not reliable. The AMA also explained that the PFS, a resource-based system for valuing physician services, is not an appropriate payment system for these services, and that adding them would put downward pressure on payment for all other physician services under budget neutrality as their use grows. National pricing at OPPS-derived rates heightens exactly this concern, which mirrors the AMA's longstanding objection to high-cost supplies embedded in PFS services. CMS did not directly respond to that concern, citing instead payment predictability and site-neutral pricing with the OPPS.

Potentially Misvalued Services

Savings from the RUC's identification and review of potentially misvalued services help offset the cost of other coding and payment changes. For 2027, CMS received 13 nominations identifying potentially misvalued services for future review. CMS finalized 6 nominations as potentially misvalued and requested RUC review or comments for 23 services.

Medicare Telehealth Services

CMS did not receive any requests for additions to the Medicare Telehealth List but finalized its proposal to add several of the new services mentioned above: advance care planning services provided by clinical staff under the direction of the treating physician; group-based medical sessions; treatment of speech and certain other disorders for pediatric patients; and visits to diagnose and treat vaccine adverse effects.

The Consolidated Appropriations Act (CAA), 2026, extended flexibilities that allow Medicare telehealth services to be delivered nationwide and patients to receive services in their homes through 2027. Audio-only services are also extended, and in-person visit requirements for telehealth for mental health services are delayed through 2027. The CAA 2026 also requires CMS to create modifiers for telehealth furnished through a virtual telehealth platform by a physician who contracts with or has a payment arrangement with an entity that owns the platform. CMS established modifiers BB and BC for this purpose; they are for reporting only and do not affect payment. The AMA urged CMS to issue its planned sub-regulatory guidance on the modifiers in draft form for public comment. The final rule does not provide any additional information on these modifiers.

CMS also finalized its proposal to change the G-codes for telehealth critical care to mirror the two CPT codes for critical care, so there will now be G-codes for the first 30 to 74 minutes and for each additional 30 minutes.

Finally, CMS finalized its proposal to change its policy on teaching physicians providing virtual supervision of residents. The current (2026) policy requires that the teaching physician, resident, and patient be in three different locations. Under the final (2027) policy, teaching physicians may bill for services on the Medicare Telehealth List involving residents when either the teaching physician or the resident is in the same physical location as the patient. The AMA supported this change and also urged CMS to allow billing when the teaching physician and resident are in the same location and the patient receives the service elsewhere, which CMS says it may consider in future rulemaking.

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Outpatient Rehab Facility Services and KX Modifier Thresholds

CMS finalized routine and technical changes, including technical corrections to fix outdated cross-references and the statutorily required annual inflation update to the KX modifier thresholds (formerly known as therapy caps). The KX modifier thresholds will increase from $2,480 to $2,540 for CY 2027 based on the final MEI update of 2.6 percent. The targeted medical review threshold remains at $3,000 through CY 2027, as set by statute, and will begin receiving annual MEI-based updates in CY 2028.

Supporting Beneficiaries Planning for Future Medical Decisions (Advance Care Planning Services)

CMS finalized new HCPCS G-codes for advance care planning (ACP) services provided by clinical staff, with modifications. G0572 covers the first 20 minutes of clinical staff time, and G0573 covers each additional 20 minutes. CMS retained the proposed direct supervision requirement, which may be satisfied through audiovisual technology, but allowed practitioner time to count toward the new codes' time thresholds when clinical staff time alone is insufficient. The existing ACP codes (CPT 99497 and 99498) will be limited to time personally spent by the billing practitioner, although both code sets may be billed when their respective time thresholds are met. CMS assigned work RVUs of 1.00 and 0.70, respectively, based on existing chronic care management codes. Effective January 1, 2027, CMS also added the new codes to the Medicare Telehealth Services List and to the primary care services used for SSP beneficiary assignment.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

CMS finalized its proposal to recognize diabetes self-management training (DSMT) and medical nutrition therapy (MNT) as stand-alone billable RHC visits paid at the all-inclusive rate, provided the services are furnished by a certified provider under the direct supervision of an RHC practitioner. CMS clarified that direct supervision may be met through the practitioner's virtual presence using real-time audio-video technology, but not audio-only, to help address workforce limitations in rural areas. CMS declined commenters' requests to allow general supervision, but acknowledged that it could help RHCs without a full-time dietitian by allowing them to contract with external or telehealth-based dietitian networks, and said it will continue to evaluate the feedback for potential future refinements. CMS said the change aligns RHC payment with FQHCs and physician offices, where these services are separately payable and used more often, and suggested the current payment structure may be a barrier to access in RHCs. CMS also noted that DSMT and MNT account for a very small share of Medicare spending. As in FQHCs, if DSMT or MNT is furnished on the same day as another qualifying visit, the RHC will be paid at a single per-visit rate. Group DSMT and MNT sessions do not qualify as billable RHC visits.

CMS also finalized other routine updates for CY 2027, including the annual FQHC prospective payment system market basket update of 2.6 percent, which raises the base payment rate from $207.72 to $213.12. The proposed rule had estimated $212.91, based on a 2.5 percent update. CMS also finalized conforming regulatory changes, including extending through December 31, 2027, the delay of the in-person visit requirement for RHC and FQHC mental health services furnished via telehealth.

Changes to the Ambulatory Specialty Model (ASM)

In 2026, CMS finalized ASM as a mandatory payment model that will run for five years beginning in 2027. Several types of specialists in 240 geographic areas will be required to participate: (1) cardiologists who deliver services to 20 or more patients with heart failure, and (2) anesthesiologists, pain management physicians, neurosurgeons, orthopedic surgeons, and physiatrists who deliver services to 20 or more patients with low back pain. Beginning in 2029, specialists participating in ASM will face payment adjustments based on their ASM scores from two years earlier of +/- 9 percent, growing to +/- 12 percent by 2033. These scores will be based on participants' performance on measures relative to other physicians in ASM.

Although key features of ASM were finalized during the 2026 rulemaking cycle, in the 2027 proposed rule CMS proposed technical refinements and adjustments. The final rule adopts several changes to ASM policies that were recommended in AMA comments:

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- CMS eliminated the requirement that ASM participants notify CMS of a taxpayer identification number (TIN) or specialty change, agreeing that this information can be determined from data already available to CMS.
- CMS agreed that subspecialty cardiologists do not need to be board certified in their subspecialty in order to be exempt from ASM.
- CMS removed the Functional Status Change for Patients with Low Back Impairments measure, but it is being replaced with the Functional Outcome Assessment measure, which the AMA does not support.
- CMS finalized several AMA-sought revisions to Promoting Interoperability (PI) requirements for ASM participants to reduce reporting burden that align with those for the MIPS PI category.

Although the AMA reiterated its previous concerns about more fundamental elements of ASM in comments on this rule, CMS still has not addressed these policies, including:

- Despite the AMA's strong opposition, ASM remains a mandatory model.
- The model design continues to use a "redistribution percentage" of 85 percent, guaranteeing that most participating physicians will see Medicare payment cuts regardless of their ASM performance.
- Physicians will be rewarded or penalized based on whether their performance score is higher or lower than the scores received by the other physicians in ASM during the same year instead of having performance thresholds set in advance so physicians know what they need to do to avoid a penalty.
- Unlike other models in which downside risk is phased in over time, physicians in ASM could see their payments cut by up to 9 percent during the first year of the program. The AMA recommended reducing the maximum risk level in the initial two years to two percent.

Finally, although the AMA joined several other national organizations in urging CMS to delay the launch of ASM, the final rule states that CMS still plans to implement ASM in January 2027.

Limiting Medicare Coverage of Certain Individuals

CMS finalized, as proposed, a new Medicare-specific definition of "eligible noncitizen," implementing section 71201 of the 2025 reconciliation law. An eligible noncitizen is an individual who is (1) lawfully admitted for permanent residence; (2) a Cuban or Haitian Entrant; or (3) lawfully residing in the United States under a Compact of Free Association. Noncitizen U.S. nationals remain separately eligible for Medicare. Individuals who were entitled to or enrolled in Medicare as of July 4, 2025, but who do not meet the new requirements will lose Medicare eligibility 18 months after that date, in early January 2027. CMS also finalized a termination, enrollment, and notification framework to implement these changes.

Medicare Shared Savings Program (SSP)

This year's rule includes myriad SSP changes, mainly to increase beneficiary enrollment, reduce administrative burden on ACOs, and make the program more "efficient." CMS predicts that collectively, these changes will reduce SSP outlays by $5.5 billion over the next decade.

For beneficiary assignment, CMS will exclude allowed charges for primary care services billed through a non-ACO TIN and slightly loosen eligibility criteria pertaining to Medicare enrollment status starting in performance year 2028. Both changes are expected to slightly increase the number of assignable ACO beneficiaries for the majority of ACOs, with a larger impact on a select few. Because these newly assignable beneficiaries are anticipated to have higher costs and be more medically complex, these changes are anticipated to negatively impact gross savings/losses. In addition, CMS added the following services to the list of primary care services used for assignment: screening, brief intervention, and referral to treatment, vaccine adverse effects management, and advance care planning.

For purposes of determining prior SSP experience, which impacts certain model calculations and which track an ACO is eligible for, a TIN that did not have a written participation agreement will no longer be considered to have participated in a performance-based risk Medicare ACO initiative, even if the TIN is used for financial reconciliation purposes.

Regarding financial methodologies, CMS increased the sharing rate for ACOs in BASIC Level E from 50 to 60 percent

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and lowered the maximum positive regional adjustments for ENHANCED ACOs from 50 to 35 percent. These changes are intended to "recalibrate incentives" between the BASIC and ENHANCED tracks to ensure ACOs do not advance to higher levels of risk too quickly and then drop out. Given the changes, CMS will allow ACOs applying for an agreement period start date of January 1, 2027, to change their track selection in their Phase 2 request for information (RFI) responses due November 17, 2026. CMS increased the prior savings adjustment from 50 to 75 percent to encourage continued participation by existing ACOs and added a new "growth adjustment factor" to incentivize expanding into new participating practices and beneficiary populations. The five percent benchmark adjustment cap will also now be risk-adjusted. All of these changes will apply to new agreement periods starting in 2027 or later. CMS made technical changes to the Accountable Care Prospective Trend (ACPT) component of the benchmark update factor and advance investment payment calculations to improve their accuracy. Despite AMA objections, CMS discontinued prepaid shared savings due to limited uptake. CMS is replacing the visit complexity add-on code G2211 with modifiers reimbursed at 32 percent of the E/M base code for ACO participants, which is twice the amount paid to non-ACO participating physicians.

This year's rule includes substantial quality reporting changes for SSP ACOs, many of which align with long-standing AMA asks, including extending the availability of the MIPS clinical quality measure (CQM) collection type, establishing Medicare electronic CQMs (eCQMs) as a collection type (in addition to Medicare CQMs), amending MIPS data completeness requirements beginning with the 2026 performance year, updating the APM Performance Pathway (APP) Plus quality measure set, applying flat benchmarks to measures reported through Medicare CQMs and Medicare eCQMs, and revising scoring policies for excluded measures and non-benchmarked measures. CMS finalized several proposed changes to the APP Plus quality measure set for SSP ACOs, including the removal of Initiation and Engagement of Substance Use Disorder Treatment (Quality ID: 305) and Adult Immunization Status (Quality ID: 493), which the AMA supported. The APP Plus quality measure set would include a total of eight measures in performance year (PY) 2027, including five eCQMs/MIPS CQMs/Medicare CQMs/Medicare eCQMs; two administrative claims-based measures; and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey measure.

In response to AMA-led stakeholder opposition, CMS reversed changes from the 2024 PFS rule under which SSP ACO participants, regardless of track or Advanced APM QP status, must report all MIPS PI measures in order to satisfy SSP certified electronic health record technology (CEHRT) use requirements. Instead, SSP ACO participants will be able to satisfy CEHRT use requirements through one of the following three flexible options:

1. successfully reporting at least one ACO-reported measure in the APP Plus quality measure set through eCQMs or Medicare eCQMs;
2. attesting to using Fast Healthcare Interoperability Resources (FHIR) capabilities in certified health IT to support reporting of at least one ACO-reported measure; or
3. attesting to one of three ACO CEHRT use metrics.

In response to AMA advocacy, CMS reversed the burdensome requirement that every ACO provider/supplier in the ACO must successfully report on a PI measure for an ACO to satisfy CEHRT use requirements. Instead, ACOs will be allowed to attest "Yes" to CEHRT use metrics for purposes of satisfying CEHRT use requirements if at least one ACO provider/supplier in each of the ACO's participating TINs performed the relevant action, with certain exclusions. CMS will also extend enforcement discretion related to these policies through the 2026 performance year. CMS clarified that SSP ACO participants that are not QPs will still be required to report PI measures (unless otherwise excluded) for MIPS participation as before.

Lastly, CMS revised beneficiary notification requirements to reduce operational burden on ACOs and will allow ACOs to elect to reduce or waive beneficiary cost sharing for certain beneficiary services, including deductibles and coinsurance amounts (and expressly excluding cost sharing support for DMEPOS and prescription drugs). CMS aims to collect applications in early 2027 and apply reductions by April 1, 2027.

Clinical Laboratory Fee Schedule

CMS finalized its proposed conforming regulatory changes to implement statutory amendments to the Protecting Access to Medicare Act of 2014 (PAMA) enacted in the CAA, 2026, specifically data reporting and payment phase-in requirements. These changes include use of 2025 private payer data to establish updated CLFS rates beginning in 2027 and annual payment reductions of no more than 15 percent through 2029. These updates do not address underlying

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structural issues in the PAMA methodology, including longstanding concerns about whether the reported data adequately represent physician-office, hospital outreach, rural, and other laboratories. Because CMS cannot alter the statutory methodology through rulemaking, Congress must act to permanently reform PAMA and address potential payment reductions. The AMA is actively working in concert with multiple stakeholders on a congressional fix.

II. Quality Payment Program (QPP) Provisions

Merit-based Incentive Payment System (MIPS)

Following ongoing advocacy by the AMA, last year CMS finalized policy to maintain the threshold to avoid a MIPS penalty at 75 points through the CY 2028 performance year/2030 MIPS payment year.

MIPS Value Pathways (MVPs)

Following AMA advocacy, CMS finalized a policy to sunset traditional MIPS after the CY 2030 performance period, a two-year delay from the original proposal. Beginning with the CY 2031 performance period/2033 payment year, MIPS eligible clinicians who do not participate in a MIPS APM will be required to report an MVP. The AMA will continue to urge CMS to incentivize, rather than mandate, MVP reporting, and to redesign MVPs to focus on the specific health conditions and procedures that an individual physician treats. At a minimum, CMS should not mandate participation in MVPs until fundamental issues are addressed. These include the lack of applicable MVPs for many specialties and subspecialties, and the need for rules that enable meaningful clinical comparisons and fair and accurate scoring, rather than scoring discrepancies driven more by a physician's specialty than by actual performance. The AMA will continue to work with specialties and CMS to address these issues and improve MVPs.

In response to concerns raised by commenters, including the AMA, CMS also clarified in the final rule that its MVP subgroup reporting requirement for multispecialty groups that are not small practices (15 or fewer clinicians) is flexible. CMS noted that its subgroup policies include no restrictions on the composition of subgroups other than the requirement that each subgroup include at least one clinician who is MIPS eligible at the individual level. CMS also did not establish a minimum number of subgroups that must be formed, because it intends for groups to form subgroups and select MVPs in the manner that best represents the scope of care the group provides. CMS also stated that its subgroup policies provide "significant flexibility for a multispecialty group to implement MVP reporting in the manner that best fits its clinicians and scope of care." CMS said it will continue to consider concerns about multispecialty group readiness and subgroup reporting burden in future rulemaking.

CMS also finalized three new MVPs, Diabetic Disease, Hypertension, and Hospitalist, starting with the CY 2027 performance period, bringing the total to 30 MVPs. CMS also finalized updates to all 27 existing MVPs to:

- include MIPS core measure selections for each MVP,
- add measures that expand upon a clinical concept or capture additional specialties most applicable to report an MVP,
- address maintenance requests from the public, and
- remove measures and activities that would either be finalized for removal from their respective MIPS inventory or replaced by more robust measures.

CMS renamed the *Rehabilitative Support for Musculoskeletal Care* MVP as the *Rehabilitative Support* MVP. CMS also finalized its proposal to allow virtual groups to report an MVP beginning with the CY 2029 performance period.

Despite AMA support for the existing policy, CMS finalized a policy to publicly report MVP data for any new Improvement Activity or Promoting Interoperability measure, objective, or activity during the first year it is included in an MVP.

Quality

Starting with PY 2027, CMS finalized policy to replace the outcome/high-priority measure reporting requirement in traditional MIPS and MVPs with a MIPS core measure reporting requirement. Eligible clinicians or group practices would have to report a core measure as one of their six measures in MIPS or as one of their four measures in an MVP. **Small practices would be exempt from this requirement.** Any eligible clinician, group, virtual group, subgroup, or APM

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entity that does not report a MIPS core measure and is not a small practice would receive zero points for one of their required measures unless they submit an attestation that they did not have an applicable MIPS core measure and submitted another measure in its place. CMS finalized policy to designate 78 MIPS quality measures as core measures, many of which were previously designated as outcome/high priority. The AMA was supportive of CMS' proposal to eliminate the outcome/high-priority measure requirement because there has been a limited number of outcome measures to report on and this requirement has been specifically challenging for specialists and subspecialists. However, the AMA urged CMS to delay the requirement to report on a core measure until the CY 2028 MIPS performance period to obtain more input into which measures should initially be classified as core measures and ensure EHR and registry vendors are ready to support the policy change.

Beginning with PY 2027, topped-out MIPS core measures subject to the seven-point scoring cap (i.e., those topped out for two or more consecutive performance periods) would no longer be subject to that cap and would instead be scored according to the defined topped-out measure benchmark (with a 10-point maximum). CMS finalized policy to designate 17 measures as topped out but with the defined measure benchmark and not subject to the seven-point scoring cap due to limited measure choice.

CMS also finalized a number of changes to the PY 2027 quality measure inventory, including removing 20 existing quality measures, adding 10 new measures, and making substantive changes to 43 quality measures, all of which are summarized in Appendices B and C of the CMS QPP Fact Sheet. Qualified Clinical Data Registry (QCDR) measures are not included in Appendices B or C because they are subject to a separate review process.

Cost

CMS did not add any new measures, remove any existing measures, or finalize any substantive changes to any existing MIPS cost measures for the 2027 performance year. However, the agency did finalize several non-substantive updates to the list of care episode and patient condition codes to reflect coding changes. The AMA will continue to advocate for more targeted and clinically relevant cost measures.

Promoting Interoperability (PI)

CMS finalized several changes to the MIPS PI category, including AMA-supported changes to reduce administrative burden. Beginning with the CY 2027 performance period, CMS updates the definition of CEHRT to align with the Office of the National Coordinator for Health Information Technology's (ONC's) revised Health IT Certification Program, removing references to certification criteria for family health history, patient health information capture, automated measure calculation, and optional clinical quality measure filtering. CMS also removes the required ONC Direct Review and optional ONC-ACB Surveillance physician attestations beginning with the CY 2026 performance period. Beginning with the CY 2027 performance period, CMS removes the Security Risk Analysis measure and its associated physician reporting requirements. Security risk analysis and risk management activities remain separately required under the HIPAA Security Rule.

CMS finalized its proposal to make the electronic prior authorization (ePA) measure for medical items and services optional for the CY 2027 performance period, with 10 bonus points available for physicians who attest "Yes" and no scoring penalty for those who do not report it. The attestation measure becomes mandatory beginning in CY 2028. CMS also finalized technology requirements, replacing "using data from CEHRT" with "using CEHRT." In 2027, physicians must use the certified health IT modules necessary to satisfy the measure. Payer approval is not required.

Lastly, CMS finalized a new mandatory attestation ePA for Prescription Drugs measure beginning with the CY 2028 performance period. Physicians must attest to requesting prior authorization electronically through CEHRT for at least one prescription drug covered under a pharmacy benefit, using certified electronic prescribing and real-time prescription benefit technology. Exclusions apply to physicians who prescribe no applicable drugs requiring prior authorization, whose payers do not support the specified standard for any applicable prescribed drugs requiring authorization, or who prescribe fewer than 100 permissible prescriptions during the performance period. Beginning in 2028, failure to attest "Yes" or claim an applicable exclusion for the mandatory ePA measure results in a zero for the entire PI category.

Improvement Activities

CMS finalized various updates to the inventory of improvement activities, including adding six new, modifying five, and removing 11 activities. These changes are summarized in Appendix 2.

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Advanced APMs

Despite strong opposition from the AMA, CMS finalized a new policy to apply Qualifying APM Participant (QP) status and Partial MIPS-eligible status at the TIN/NPI combination level. That means, beginning with the 2027 performance/2029 payment year, any APM-related financial incentives, including APM Incentive Payments and the QP conversion factor differential, would apply *only* to claims associated with Advanced APM-participating TINs, rather than all of a clinician's TINs. CMS did make one slight modification, finalizing that CMS would apply partial QP status to all of a clinician's TINs if the clinician qualified as an individual. The agency says this will "prevent an increasing windfall for TINs that do not participate in Advanced APMs" and estimates that this change will result in approximately $2.38 billion less being paid out to APM participants over the next decade. However, this number is anticipated to grow exponentially in future years due to the cumulative impact of the 0.5 percentage point higher conversion factor for APM QPs every year. The AMA had urged CMS not to finalize the change, arguing that the change exceeds CMS' authority under MACRA, will result in unnecessary operational complexity, and will discourage APM participation, particularly among specialty, small, rural, and independent practices. The AMA will continue to push back against this policy.

CAA 2026 reinstated the APM Incentive Payment for payment year 2028 (based on 2026 performance) at 3.1 percent. Absent further congressional action, the APM incentive payment will expire at the end of the 2026 performance year/2028 payment year. The QP thresholds are also set to increase from 50 to 75 percent of Medicare payments, and from 35 to 50 percent of Medicare patients. The AMA continues to advocate for Congress to extend the APM incentive payment, freeze the QP thresholds, and adopt permanent flexibility for the Secretary to adjust QP thresholds as needed. The latter two are in the Patients First Act (H.R. 9693).

III. Requests for Information (RFIs)

CMS included several RFIs in the proposed rule, including one that targets the CPT code set and another that takes a broader look at primary care payment.

Current Procedural Terminology (CPT) RFI

CMS included an RFI on the CPT code set, CPT licensing, the CPT code development process, and the RUC. The RFI questioned the AMA's role and sought input on alternatives to CPT as the national code set for physician services, including paying for physician services using ICD-10-PCS or other bundled approaches. In its comments, the AMA explained that CPT is a clinically grounded national standard, maintained for 60 years, that CMS uses at no cost. It clarified that the CPT Editorial Panel creates codes and the RUC recommends resource inputs, while CMS alone determines payment. It also cautioned that replacing CPT or introducing competing code sets would add cost and disrupt claims processing, quality measurement, and interoperability.

In the final rule, CMS made no changes and noted that commenters broadly supported a single national coding standard and opposed alternative code sets to CPT. CMS noted that it "highly value[s] the expertise of volunteer groups of physicians who submit relative resource recommendations," reaffirmed "the crucial role for physicians to provide input to the federal government based on their firsthand expertise," and encouraged the RUC and other organizations to submit data to support valuation. CMS said most comments focused on the RUC and that it is "considering a number of potential avenues for improving this process," citing commenters' recommendations on transparency, data sources, committee composition, and independence. CMS also stated a desire for additional empiric data and for reporting of expected clinical outcomes and may establish this additional information as a requirement in future rulemaking.

Redesigning Primary Care to Make America Healthy Again

In the proposed rule, CMS sought comment on a broad reexamination of how Medicare pays for primary care, including (1) whether the PFS appropriately values primary care services relative to other services; (2) how payment policies should evolve to account for the growing role of technology in delivering primary care; and (3) whether Medicare should transition from traditional fee-for-service toward prospective, population-based, or outcomes-based payments for primary care, beginning with the Medicare SSP. The AMA supported exploring voluntary prospective payment approaches, including a pathway outside the SSP, and strongly opposed creating separate longitudinal, acute, and consultative office visit categories or corresponding Medicare-specific G-codes because these categories overlap in clinical practice, do not reflect the time and resources required to furnish care, and would create unnecessary billing complexity and audit risk.

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The AMA also urged CMS to base payment for technology-enabled care on evidence of its actual effects on clinical practice and resource use, rather than assumed benefits or time savings.

CMS' summary of comments on the primary care RFI indicates broad alignment with the AMA's recommendations, particularly on visit classification, technology-neutral care management, and technology-supported Annual Wellness Visit (AWV) delivery. On visit classification, commenters emphasized that acute and longitudinal care often occur within the same encounter and that existing E/M, G2211, and advanced primary care management (APCM) payments could better account for this work without creating separate visit categories. Commenters also supported voluntary hybrid payment models combining visit-based and prospective monthly payments. Similarly, commenters largely opposed creating separate technology-enabled and traditional care management tracks, favoring distinctions based on clinical needs rather than the technology used to deliver care. Regarding clinical artificial intelligence (AI), commenters supported tools that improve information synthesis, preventive care, and administrative efficiency, while raising concerns about safety, accuracy, and demonstrated clinical value. CMS deferred decisions on these issues to future rulemaking. However, for AWVs, the agency clarified that AI may support specific preparatory and administrative functions under existing requirements, provided clinicians retain responsibility for clinical judgment, review, and approval of the prevention plan.

Other RFIs (In order of appearance)

- Community-based palliative care (91 FR 71190)
- Intensive lifestyle interventions to slow progression of Alzheimer's Disease (91 FR 71191)
- Applying electronic prior authorization measures to SSP ACOs (91 FR 71393)
- Specialty care in the SSP (91 FR 71499)
- Duplicate laboratory testing, imaging, and result sharing and interoperability (91 FR 71506)
- Fast Healthcare Interoperability Resources (FHIR) (91 FR 71509)
- FHIR-Based Digital Quality Measurement in the QPP and Other CMS Quality Programs (91 FR 71526)
- Future Potential Performance-Based Measures of Electronic Prior Authorization (91 FR 71583)
- MVP scoring (91 FR 71613)
- Star Rating Assignment Methodology for Administrative Claims Quality Measures (91 FR 71626)

Additional Resources:

- Final rule text
- CMS Press Release
- Physician Payment Schedule Fact Sheet
- Medicare Shared Savings Program Fact Sheet
- Quality Payment Program (QPP) Fact Sheet

Reach out to AMA.advocacy@ama-assn.org with questions.

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2027 Specialty Impact Table of Modifier 25 Policy

Medicare Specialty	Estimated 2027 Payments		Payment Difference	Percentage Difference
	Excluding Mod 25 Policy	Including Mod 25 Policy		
Dermatology	$3,888 M	$3,844 M	$45 M	-1.2%
Podiatry	$1,962 M	$1,927 M	$36 M	-1.8%
Otolaryngology	$1,181 M	$1,147 M	$35 M	-2.9%
Orthopedic surgery	$3,112 M	$3,084 M	$29 M	-0.9%
Physician Assistant	$3,655 M	$3,627 M	$28 M	-0.8%
Ophthalmology	$4,333 M	$4,317 M	$16 M	-0.4%
Nurse Practitioner	$7,714 M	$7,699 M	$15 M	-0.2%
Family practice	$5,713 M	$5,700 M	$13 M	-0.2%
Urology	$1,554 M	$1,542 M	$12 M	-0.7%
Physical medicine	$1,207 M	$1,202 M	$4 M	-0.4%
Internal medicine	$9,653 M	$9,649 M	$4 M	0.0%
Hand surgery	$269 M	$265 M	$4 M	-1.4%
Interventional pain management	$847 M	$844 M	$4 M	-0.4%
Rheumatology	$539 M	$536 M	$3 M	-0.5%
Obstetrics/gynecology	$542 M	$539 M	$3 M	-0.5%
General Surgery	$1,494 M	$1,492 M	$2 M	-0.1%
Anesthesiology	$527 M	$526 M	$2 M	-0.3%
Multispecialty Clinic/Other Phys	$163 M	$162 M	$2 M	-0.9%
Colon and rectal surgery	$142 M	$140 M	$1 M	-1.0%
Emergency medicine	$2,557 M	$2,555 M	$1 M	0.0%
Neurology	$1,358 M	$1,357 M	$1 M	-0.1%
Plastic surgery	$275 M	$274 M	$1 M	-0.3%
General practice	$410 M	$410 M	$1 M	-0.1%
Cardiology	$6,270 M	$6,269 M	$1 M	0.0%
Vascular surgery	$1,027 M	$1,026 M	$1 M	0.0%
Gastroenterology	$1,294 M	$1,293 M	$0 M	0.0%
Optometry	$1,427 M	$1,427 M	$0 M	0.0%
Chiropractor	$619 M	$619 M	$0 M	0.0%
Infectious disease	$574 M	$573 M	$0 M	-0.1%
Pulmonary disease	$1,229 M	$1,229 M	$0 M	0.0%
Radiation oncology and radiation therapy centers	$1,580 M	$1,580 M	$0 M	0.0%
Allergy/immunology	$230 M	$229 M	$0 M	-0.1%
Pediatrics	$61 M	$61 M	$0 M	-0.2%

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Medicare Specialty	Estimated 2027 Payments		Payment Difference	Percentage Difference
	Excluding Mod 25 Policy	Including Mod 25 Policy		
Other	$54 M	$54 M	$0 M	-0.2%
Pathology	$1,209 M	$1,209 M	$0 M	0.0%
Interventional radiology	$556 M	$556 M	$0 M	0.0%
Psychiatry	$881 M	$881 M	$0 M	0.0%
Radiology	$4,669 M	$4,669 M	$0 M	0.0%
Geriatrics	$206 M	$206 M	$0 M	0.0%
Neurosurgery	$661 M	$661 M	$0 M	0.0%
Critical care	$336 M	$336 M	$0 M	0.0%
Thoracic surgery	$295 M	$295 M	$0 M	0.0%
Nephrology	$1,616 M	$1,616 M	$0 M	0.0%
Hematology/oncology	$1,505 M	$1,505 M	$0 M	0.0%
Oral/maxillofacial surgery	$33 M	$33 M	$0 M	-0.1%
Cardiac surgery	$144 M	$144 M	$0 M	0.0%
Endocrinology	$548 M	$548 M	$0 M	0.0%
Nurse anesthetist / anesthesiologist assistants	$20 M	$20 M	$0 M	-0.1%
Physical/occupational therapy	$5,926 M	$5,926 M	$0 M	0.0%
Nuclear medicine	$49 M	$49 M	$0 M	0.0%
Clinical social worker	$1,067 M	$1,067 M	$0 M	0.0%
Clinical psychologist	$837 M	$837 M	$0 M	0.0%
Audiologist	$77 M	$77 M	$0 M	0.0%
Portable x-ray supplier	$77 M	$77 M	$0 M	0.0%
Diagnostic testing facility	$1,002 M	$1,002 M	$0 M	0.0%
Independent laboratory	$572 M	$572 M	$0 M	0.0%
All	$89,746 M	$89,483 M	$263 M	-0.3%

Note: Data from the 2027 Medicare Physician Fee Schedule Final Rule (released in November 2026) were used for the RVUs, conversion factor, and service utilization. The 2027 conversion factor used is the non-QP conversion factor of $32.6286. For the scenario excluding the modifier 25 policy, discounted allowed services were used for service utilization. For the scenario including the modifier 25 policy, discounted allowed services applying the modifier 25 adjustment factor were used for service utilization.

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