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

On July 14, 2026, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2027 Revisions to Payment Policies under the Medicare Physician Payment Schedule (PFS) and Other Changes to Part B Payment and Coverage Policies proposed rule and fact sheet. The proposed rule includes proposals related to Medicare physician payment and the Quality Payment Program (QPP). If finalized, these policies will take effect on January 1, 2027, unless otherwise noted. The American Medical Association (AMA) will submit detailed comments by the September 14, 2026 deadline and encourages Federation members to do the same. The AMA will provide a draft version of its comments to Federation members in advance of the deadline.

I. PAYMENT PROVISIONS

CY 2027 Medicare Conversion Factors

For the second year, there are four proposed conversion factors, as outlined below:

Medicare Conversion Factor		Medicare Anesthesia Conversion Factor	
For APM QPs	For non-APM QPs	For APM QPs	For non-APM QPs
$33.1693 (-1.19%)	$32.8409 (-1.68%)	$20.4165 (-0.89%)	$20.2143 (-1.38%)

These conversion factors reflect:

- Expiration of the temporary 2.5 percent update for CY 2026 included in H.R. 1
- A 0.53 percent budget neutrality adjustment to balance proposed coding and payment policy changes
- 0.5 percent higher update for Qualified Participants (QPs) in Advanced Alternative Payment Models (APMs) under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

The AMA continues to strongly advocate for annual Medicare payment updates to reflect the growth in physician practice costs as measured by the Medicare Economic Index (MEI), which CMS projects will be 2.5 percent. On July 15, Representatives John Joyce, M.D. (PA-13), Greg Murphy, M.D. (NC-03), and Kim Schrier, M.D. (WA-08), chairs of the GOP and Democratic Doctors Caucuses, introduced the *Patients First Act* (HR 9693), a comprehensive, bipartisan, AMA-supported MACRA reform legislation that includes an inflation-based update tied to MEI, budget neutrality reform, a MIPS replacement, APM reforms, and a new primary care payment pilot that would not impact budget neutrality.

In its 2026 report, the Medicare Payment Advisory Commission (MedPAC) recommended increasing payment rates for physician services "to bring fee for service Medicare's overall payment levels closer in line with providers' costs." The 2026 Medicare Trustees Report likewise warned MACRA "raises important long-range concerns that will almost certainly need to be addressed by future legislation… physician payment updates …do not vary based on underlying economic conditions, nor are they expected to keep pace with …physician cost increases… Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term."

Practice Expense (PE) Methodology – Newly Proposed Changes

In response to the AMA's previous request, CMS published the algorithm utilized to calculate PE relative value units (RVUs) to promote transparency. CMS proposes the following changes effective Jan. 1, 2027:

- Allocate indirect practice expense based on both physician work RVUs and clinical labor for all services except 10- and 90-day global period codes. CMS does not provide a rationale for excluding 10- and 90-day global codes, which would be disadvantaged in any redistribution that results from this change.
- Simplify the methodology by removing the indirect practice cost indices (IPCI) from the calculation of the practice expense RVUs over a two-year transition period. The specialty level IPCIs are published on the CMS website and vary from 0.6 to 2.2. This modification would result in specialty redistribution.
- Introduce a stabilization adjustment to practice expense RVUs to ensure services not otherwise modified (new, revised or revalued) are not impacted in practice expense adjustments by more than five percent relative to the previous year. This stabilization adjustment will occur prior to the statutory phase-in, which limits all codes that are not new or revised to a 19 percent decrease in total RVUs in a given year.

Medicare Economic Index (MEI)

CMS proposes to continue the MEI cost shares for physician work, PE, and professional liability insurance for 2027, which the AMA supports. A previous CMS alternative would have resulted in a significant decrease in the proportion of physician payment allocated to physician work and was opposed by organized medicine.

Update to Practice Expense Site of Service Payment Differential

In 2026, CMS implemented a controversial methodology change to reduce the indirect practice expense payment for all services provided in the facility setting, citing concern that duplicative payments were made between the physician and hospital payment systems. CMS reduced the portion of facility practice expense RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs. This resulted in a seven percent cut to facility-based payment, while non-facility-based payment to physicians increased by four percent. Resulting payment changes to individual physicians and specialties were substantial. The AMA pushed back strongly against the proposal and called for CMS to make changes based on reviewing individual services, rather than broad disruptive policies, highlighting the results of our Physician Practice Information Survey.

In this proposed rule, CMS acknowledges "unintended, but significant" issues that resulted from this policy. The Agency proposes to address one particular anomaly to ensure that nursing facility visit payments will again be equalized in 2027. CMS further states that there are ongoing concerns with the policy as 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." CMS requests comment on alternatives, including a percentage less than 50 percent; utilizing a new modifier to identify employed physicians to isolate payment reductions; or other methods to address their concern about duplicative practice expense payment.

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

Professional and Technical Components

A file is posted to the CMS website that displays the non-facility (office) practice expense RVUs and the facility practice expense RVUs, labeling facility RVUs as "26 – professional" and the difference between the non-facility and facility RVU as "TC-technical." CMS states that it is sharing this information to provide transparency and to "facilitate more consistent comparisons across services and settings." CMS requests comment on how it could use this information to assess payment differences across settings.

Global Surgical Packages

CMS continues to express concern about the accuracy of global surgery payment, specifically that post-operative visits are not being provided. This hypothesis is largely derived from a flawed attempt to require some physicians to report 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 for certain services*. The AMA has previously detailed the concern with this data collection effort and resulting CMS analyses, beginning on page 31 of the AMA comment letter on the 2022 PFS proposed rule. CMS now proposes to pause the data collection effort for CPT code 99024, citing undue burden to physicians. However, the Agency requests comment on whether the CPT code 99024 reporting requirement should be expanded to all physicians or if other data sources are available to demonstrate the number of visits provided. An Excel file is posted to the CMS website that computes relative values without the post-operative visits for all 10- and 90-day global period services and CMS also calls for comment on potential revaluation strategies to consider in future rulemaking.

Valuation of Specific Codes

CMS proposes to accept 88 percent of the AMA/Specialty Society RVS Update Committee (RUC) recommendations and 100 percent of the RUC Health Care Professionals Advisory Committee (HCPAC) Review Board recommendations for new/revised CPT codes and codes identified via the RUC's potentially misvalued services process. CMS also proposes to accept nearly 100 percent of the AMA's direct PE recommendations. CPT 2027 will include a major restructuring of maternity care services and speech-language pathology services, and several other coding and payment changes ranging from prostate biopsy to magnetic resonance angiography - head and neck.

Maternity Care Services

The AMA is pleased that CMS adopted AMA's recommendations to update the Maternity Care Services coding structure. Beginning January 1, 2027, the CPT codes will be updated to comprehensively revise the maternity codes, reflecting modern obstetric practice. The new code structure will provide much needed transparency for patients, and the increased granularity will improve the ability of physicians and researchers to better understand the drivers of maternal mortality. The AMA believes CMS' solicitation for comments on maintaining current coding through the creation of HCPCS G-codes will create unnecessary confusion and urges CMS to finalize the Maternity Care Services CPT code set without maintaining the historical global structure via HCPCS G-codes.

Remote Monitoring

CMS began payment of CPT codes for remote physiologic monitoring (RPM) in 2019. Codes for remote therapy monitoring (RTM) followed, as well as expansion of coding for RPM. CMS has required that RPM services be furnished only to established patients since 2021. For 2027, CMS proposes that RTM services also be furnished only to established patients. Clinicians reporting RPM or RTM services must furnish a separately reportable initiating visit in association with the onset of RPM or RTM services. For 2027, CMS is proposing to only allow payment for RPM or RTM services when performed by clinical staff employed by the practice and not when those services are delivered by contractors.

Citing their belief that a lack of data regarding the typical device used in the provision of RPM and RTM services has led to possible overpayment, CMS proposes to decrease the PE RVUs for several of these services using crosswalks to other services and eliminating all direct practice costs for the treatment management codes. These changes will result in significant payment reductions in RPM and RTM services in 2027.

As payment reductions are limited to 19 percent per year, several of these codes will continue to be reduced in future years until CMS' proposed values are fully implemented. However, CMS is not bound by the 19 percent reduction for new codes. Accordingly, CMS proposes bundling the RPM and RTM CPT codes and creating four new

HCPCS G-Codes in 2027 to describe remote monitoring services, which would lead to immediate implementation of significant cuts to the monthly supply codes.

The RUC is scheduled to re-examine the RPM codes in January 2028 and determine if the RTM codes need to be examined in 2030 after claims data are available.

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

CMS proposes to replace E/M Visit Complexity add-on HCPCS code G2211 with a modifier referred to as MOD1. CMS believes that the resource costs of furnishing longitudinal care for beneficiaries are not best characterized as a separate service and code. Rather, CMS believes that since the work is an inherent part of the visit, it would be more accurately valued as a modifier to the base E/M code. MOD1 would be reported under the same circumstances that HCPCS code G2211 is reported now with a slightly different descriptor: *Visit complexity inherent to new or established office/outpatient or home or residence evaluation and management service, associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition*. CMS proposes payment for MOD1 as 16 percent of the E/M base code using a weighted average of the percentage increase that G2211 comprised relative to two office or other outpatient visit E/M codes, weighted by utilization, and adjusted for budget neutrality. The Agency would also create a separate modifier MOD2 to be exclusively available to Accountable Care Organization (ACO) participants, paid at 32 percent of the E/M base code.

Additional Newly Covered Services

CMS is proposing to create G codes and cover a number of new services in 2027, including: shared medical visits; advance care planning by clinical staff; vaccine adverse effects management; health coaches; and vascular embolization or occlusion procedure with use of a pressure-generating catheter.

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

CMS proposes to change payment for services using Modifier -25 *Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service*. CMS proposes to reduce payment when a separately identifiable E/M office visit is furnished by the same physician (or a physician in the same group practice) on the same day as a 0-, 10-, or 90-day global procedure. Under this proposal, the most expensive service (either surgical or E/M visit) would be paid 100 percent, and all other surgical procedure(s) or E/M visit(s) would be paid at 50 percent. The AMA will vigorously oppose this policy as the procedure codes most impacted by this proposal have already been valued to only include the work and resource costs that are above and beyond the E/M office visit. This proposal is inherently unfair to office-based physicians who perform minor procedures in their office. CMS is also seeking comment on how this policy might apply to an E/M visit reported on the same day as CPT code 67028 *Intravitreal injection of a pharmacologic agent.*

Software as a Medical Service (SaMS) Laboratory Analyses

CMS proposes a change in terminology from Software as a Service (SaaS) to Software as a Medical Service (SaMS). SaMS will refer to software-based technologies that support clinical decision making through algorithmic analysis, including those that provide clinical or diagnostic functionality.

CMS takes the position that a SaMS should be treated the same way whether its algorithm analyzes an imaging test (e.g. a CT scan) or data produced by a laboratory test. In its view, all such algorithmic analyses are comparable to other SaMS analyses and fall within the broader proposed framework for SaMS. CMS expects that applying this consistent approach to SaMS technologies would support stability and predictability in payment for similar services.

Accordingly, for CY 2027, CMS is proposing to contractor price ten HCPCS codes that describe various SaMS analyses performed on laboratory tests under the PFS. These ten codes were identified using each code's CPT descriptor. Where a descriptor included no laboratory method and described only a computer analysis, CMS classified the code as a SaMS analysis performed on laboratory tests. CMS solicits comments on the ten-code proposal and any other SaMS analysis performed on lab tests that should be removed from the Clinical Laboratory Fee Schedule (CLFS) and contractor priced under the PFS, as well as input on approaches to payment for these services.

Potentially Misvalued Services

The positive budget neutrality RVU adjustment is partially due to the savings produced from the RUC's identification and review of potentially misvalued services. For 2027, CMS received 13 nominations identifying potentially misvalued services for future review. CMS reviewed these comments and welcomes additional comments and review by the RUC on several areas.

Medicare Telehealth Services

CMS did not receive any requests for additions to the Medicare Telehealth List, but proposes to add several of the new services mentioned above to this list: 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 establishes modifiers BB and BC for this purpose. CMS also proposes changing 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 is changing its policy on teaching physicians providing virtual supervision of residents. The current policy requires that the teaching physician, resident, and patient be in three different locations. The new policy will allow teaching physicians to bill for services involving residents when either the teaching physician or the resident is in the same physical location as the patient.

Outpatient Rehab Facility Services and KX Modifier Thresholds

CMS proposes 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), which would increase from $2,480 to $2,540 for CY 2027 based on a proposed MEI update of 2.5 percent. The KX modifier thresholds would be updated in the final rule using more recent MEI data. 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 proposes two new HCPCS codes for advance care planning (ACP) services provided by clinical staff under the direct supervision of a physician or other qualified health professional. The existing ACP codes would be limited to time personally spent by the billing practitioner. The proposal reflects growing recognition that ACP is a longitudinal, team-based service and could help practices incorporate these conversations more routinely into ongoing care, expand patient access, and preserve physician involvement when clinical expertise is required.

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

CMS proposes 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 RHC professional staff. Currently, these services are not separately payable when furnished during an RHC encounter, and CMS cites low utilization as justification (in 2024, DSMT reached just 0.005 percent of RHC beneficiaries, with utilization rates 22 times higher in FQHCs and 17 times higher in rural physician offices). As in FQHCs, if DSMT or MNT is furnished on the same day as another qualifying visit, the RHC would be paid at a single per-visit rate. CMS states that it does not expect to propose additional preventive services beyond those already payable in FQHCs and physician offices.

CMS proposes other routine updates for CY 2027 including the annual FQHC prospective payment system market basket update of 2.5 percent, which would raise the base payment rate from $207.72 to $212.91 (to be updated in the final rule using more recent MEI data), as well as other conforming regulatory text changes.

Proposed 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%, growing to +/- 12% by 2033. These scores will be based on participants' performance on measures relative to other physicians in ASM.

CMS is proposing to make a number of "technical refinements and adjustments," several of which are responsive to the AMA's prior recommendations, including:

- A specialty group practice would be permitted to have a single Collaborative Care Agreement (CCA) with a primary care practice that covers all the specialists in the group, rather than every individual specialist in the group being required to have their own separate CCA with that practice.
- Cardiologists could be exempted from ASM if they notify CMS that their primary specialty is cardiac electrophysiology, cardiac surgery, interventional cardiology, advanced heart failure and transplant cardiology, or adult congenital heart disease rather than general cardiology. The AMA objected to having specialty determinations made by CMS based on out-of-date or inaccurate information, which led to inappropriately including subspecialists.
- The Functional Status Change for Patients with Low Back Impairments measure would be removed and replaced with the Functional Outcome Assessment measure, which would measure whether functional outcome assessments are conducted, rather than attempting to determine whether functional status has improved.
- CMS proposed several AMA-sought revisions to Promoting Interoperability (PI) requirements for ASM participants to reduce reporting burden. Specifically, a separate attestation to completing a security risk analysis would no longer be required; the Office of the National Coordinator for Health Information Technology (ONC) Direct Review and ONC-Authorized Certification Body (ACB) Surveillance attestations would be removed; and the Electronic Prior Authorization (ePA) measure would be optional (and unscored) for 2027. These changes align with those proposed in the MIPS PI Category.

Unfortunately, other proposed ASM changes are potentially burdensome or problematic, including:

- Performance scores for physicians practicing in a rural area (regardless of their practice size) would be increased by five points (i.e., 5 percent). Because of the tournament structure of ASM, this could make it more likely non-rural physicians receive a payment reduction despite good quality performance.

- Performance scores would be increased by five points (i.e., 5 percent) if a physician voluntarily submits patient-reported outcome data and risk adjustment data in a manner specified by CMS. However, CMS has left this largely undefined. Larger and better-resourced practices may be more equipped to receive these additional points, which could negatively impact physicians in small and independent practices.
- Administrative claims-based quality measures would be calculated at the individual level, even if a small practice reports quality measures as a group, which could penalize physicians focused on complex patients.
- A modified version of the Magnetic Resonance Imaging of Lumbar Spine for Low Back Pain measure would be added back into the low back pain component of ASM, despite previously having been removed due to concerns from the AMA and other stakeholders. The proposed new measure would attribute an MRI to any physician who delivered other low back pain-related services to a patient up to a year prior.

CMS did not address several outstanding issues the AMA previously identified as problematic, including:

- Despite the AMA's strong opposition, ASM would remain a mandatory model.
- The model design continues to use a "redistribution percentage" of 85 percent, which guarantees that the majority of participating physicians will receive a reduction in their Medicare payments regardless of how well they perform on the measures. The AMA recommended increasing the percentage to 100 percent.
- Physicians would 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. The AMA recommended setting performance thresholds in advance so physicians know what they need to do to avoid a penalty. CMS would also only provide performance feedback after the performance year has ended.
- 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.
- Physicians treating as few as 20 relevant patients would be required to participate, even if ASM patients are a small subset of their patients. The AMA recommended a higher threshold.
- No additional points would be awarded for improved quality and spending performance.
- The AMA remains concerned that the proposed quality measures would not accurately or adequately assess whether Medicare beneficiaries had achieved better outcomes nor prevent patient safety concerns, while the cost measures could penalize physicians for aspects of spending they cannot control, such as when services are ordered by other specialists, or when drug prices increase.
- No additional payments would be provided to support enhanced preventive care, coordination with primary care physicians, care management, and other services that could improve outcomes for ASM patients.

CMS indicated that it was exploring "whether including additional conditions and specialists would be appropriate," although it did not propose any expansion of the model in this proposed rule.

Limiting Medicare Coverage of Certain Individuals

The proposed rule would add a new Medicare specific definition of "eligible noncitizen." Specifically, an "eligible noncitizen" would be an individual who is (1) an alien lawfully admitted for permanent residence under the Immigration and Nationality Act; (2) an alien who has been granted the status of a Cuban or Haitian Entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980 (Pub. L. 96-422); or (3) an individual who lawfully resides in the United States in accordance with a Compact of Free Association (COFA) referred to in 8 U.S.C. 1612(b)(2)(G). The rule expressly states noncitizen U.S. nationals who are eligible for Medicare under section 1899C(a)(1) of the Act would no longer be considered "eligible noncitizens." However, legal permanent residents who meet the five-year continuous residency requirement and other applicable Medicare requirements would maintain their Medicare benefit. On January 1, 2027, individuals that do not meet the proposed revised definition of an "eligible noncitizen" would no longer be able to obtain benefits under Medicare. CMS includes a proposed 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," i.e. reduce federal payouts to ACOs. CMS predicts that collectively, these changes will reduce SSP outlays by $5.5 billion over the next decade.

For beneficiary assignment, CMS proposes to 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 (PY 2028). Both changes are expected to slightly increase the number of assignable ACO beneficiaries for the vast 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 proposes to add the following services to the list of primary care services used for assignment: screening, brief intervention, referral to treatment, vaccine adverse effects management, and Advance Care Planning.

Regarding financial methodologies, CMS proposes changes aimed at "recalibrating incentives" between the BASIC and ENHANCED tracks to ensure ACOs do not advance to higher levels of risk too quickly, then drop out. Specifically, CMS proposes to increase the sharing rate for ACOs in BASIC Level E from 50 to 60 percent and to lower the maximum positive regional adjustments for ENHANCED ACOs from 50 to 35 percent. CMS also proposes to increase the prior savings adjustment from 50 to 75 percent to encourage continued participation by existing ACOs. To incentivize ACOs to expand into new participating practices and beneficiary populations, CMS proposes to add a new "growth adjustment factor" that would be applied on top of the existing adjustment factors (up to the cap). CMS also proposes to risk-adjust the five percent benchmark adjustment cap to allow ACOs with complex patient populations to more fully benefit from benchmark adjustments. All these changes would apply to new agreement periods starting in 2027 or later. CMS proposes to adjust the Accountable Care Prospective Trend (ACPT) component of the benchmark update factor on an annual basis and to apply the same annual rate to all ACOs regardless of start date to promote consistency across cohorts. CMS would apply guardrails to mitigate large fluctuations. Lastly, CMS proposes to replace the visit complexity add-on code G2211 with modifiers that would reimburse physicians at 32 percent of the E/M base code for ACO participants, twice the amount as for non-ACO participating physicians.

CMS proposes to discontinue prepaid shared savings due to limited uptake in 2026, the first year they were available. Uptake was limited due to strict guardrails overqualified spending categories and mandatory itemized spend plans. Out of 23 ACOs that applied, only four were approved. AMA plans to push back on this proposal and reiterate previous asks to loosen restrictions on this funding.

CMS intends to improve the accuracy of advance investment payment calculations by adding a rural component and replacing Area Deprivation Index with a flat per beneficiary rate for non-rural, non-Low-Income Subsidy/dually eligible beneficiaries starting in PY 2028.

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, updates to the 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 proposes several 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 supports. The APP Plus quality measure set would include a total of eight measures in 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 unified stakeholder opposition led by the AMA and other stakeholders, CMS proposes to reverse its previously finalized change from the 2024 PFS final rule that SSP ACO participants, regardless of track or Advanced APM QP status, must report all MIPS PI measures in order to satisfy SSP CEHRT use requirements. Instead, CMS proposes to allow SSP ACO participants to satisfy CEHRT use requirements through one of the following three flexible options: 1) successfully report at least one ACO-reported measure in the APP Plus quality measure set through eCQMs or Medicare eCQMs; 2) attest to using Fast Healthcare Interoperability Resources (FHIR) capabilities in certified health IT to support reporting of at least one ACO-reported measure; or 3) attest to one of three ACO CEHRT use metrics, a longtime AMA ask.

In another victory for AMA advocacy, CMS proposes to reverse another burdensome previously-finalized 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 would 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 for those with special status, a MIPS exception, or a hardship exception. CMS also proposes to extend enforcement discretion related to these proposals through the 2026 performance year so that failure to satisfy PI requirements will not negatively impact an ACO's shared savings or losses. CMS does clarify that SSP ACO participants that are not Qualified Advanced APM Participants will still be required to report PI measures (unless they are otherwise excluded) for purposes of MIPS participation as before.

Effective Jan. 1, 2027, CMS proposes to revise beneficiary notification requirements to reduce operational burden on ACOs. Specifically, timing for initial beneficiary notification requirements would be a set date that aligns with the ACO REACH Program, rather than prior to or at the first primary care service visit. CMS also proposes to eliminate the beneficiary follow-up communication requirement, citing a lack of evidence that it improves beneficiaries' understanding of ACOs or value-based care. Lastly, CMS proposes to allow ACOs to elect to reduce or waive beneficiary cost sharing for certain services, including deductibles and/or coinsurance amounts. Applications would be collected in early 2027 and applied by a target date of April 1, 2027.

Clinical Laboratory Fee Schedule

CMS is proposing conforming regulatory changes to implement statutory amendments to the Protecting Access to Medicare Act of 2014 (PAMA) enacted in CAA, 2026, specifically data reporting and payment phase-in requirements including use of 2025 private payor data to establish updated CLFS rates beginning in 2027 and annual payment reductions of no more than 15 percent through 2029. These changes do not address underlying structural issues in the PAMA methodology, including concerns about whether the reported data adequately represent physician-office, hospital outreach, rural, and other laboratories. CMS cannot alter the statutory methodology through rulemaking; Congress must act to permanently reform PAMA and address potential payment reductions. 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)

Despite strong objections by the AMA, CMS has proposed to sunset traditional MIPS and transition to MVPs in 2029. CMS is proposing to expand the MVP portfolio to include Diabetic Disease, Hypertension and Hospitalist MVPs starting with PY 2027. In addition, CMS is proposing to modify 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. In addition, CMS is proposing to rename the *Rehabilitative Support for Musculoskeletal Care* MVP to *Rehabilitative Support* MVP. Furthermore, CMS is proposing that virtual groups would be able to report an MVP beginning with in PY 2029. Despite AMA support, CMS proposes to rescind its policy to not publicly report any MVP data 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 is proposing 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 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 submitted an attestation that they did not have an applicable MIPS core measure and submitted another measure in its place. CMS has proposed to designate 78 MIPS quality measures, many of which were previously designated as outcome/high priority. In general, the AMA has not been supportive of the outcome measure requirement or moving to core measures, as measurement should be based on what is most appropriate for a physician's scope of practice or following an episode of care, not arbitrary metrics and reporting for the sake of reporting.

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 has proposed 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 proposes a number of changes to the PY 2027 quality measure inventory including removing 20 existing quality measures, adding 10 new measures, and substantive changes to 43 quality measures, all of which are summarized in Appendix 1. Qualified Clinical Data Registry (QCDR) measures are not included in Appendix 1 because they are subject to a separate review process.

Cost

CMS does not propose to adopt any new, remove any existing, or propose substantive changes to any existing MIPS cost measures for the 2027 performance year. However, CMS proposes non-substantive updates to the list of care episode and patient condition codes to reflect coding changes, summarized here. The AMA will continue to advocate for more targeted and clinically relevant cost measures.

Promoting Interoperability (PI)

In response to longstanding AMA advocacy, CMS proposes several changes to the MIPS PI category to reduce administrative burden and focus on high-value, outcome-oriented measures. Specifically, CMS proposes to update the definition of CEHRT to align with ONC's changing Health IT Certification Program, remove the ONC Direct Review and the optional ONC-ACB Surveillance attestations retroactive to the CY 2026 performance year, and remove the Security Risk Analysis measure to reduce redundancy, as security risk analysis and risk management activities are already separately required under the HIPAA Security Rule.

CMS proposes to make the previously finalized electronic prior authorization measure optional for the 2027 performance year, with an opportunity to earn 10 bonus points. The attestation-based measure would then become

mandatory in 2028. CMS proposes more explicit technology requirements, including use of ONC CEHRT, and use of CEHRT that includes health IT certified to all three ONC ePA criteria.

Lastly, CMS proposes a new attestation-based electronic prior authorization (ePA) for prescription drugs measure to assess utilization of standards-based ePA. For PY 2028, CMS proposes that a MIPS-eligible clinician attest to having requested PA electronically using CEHRT for at least one prescription drug ordered. There are several proposed exclusions, including clinicians that do not prescribe drugs that require PA. A summary of proposed requirements for the PI Category can be found in Table C-G 6.

Improvement Activities

CMS proposes 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.

Advanced APMs

CMS proposes to apply Qualifying APM Participant (QP) status and Partial MIPS-eligible at the TIN/NPI combination level. 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. CMS says this will "prevent an increasing windfall for TINs that do not participate in Advanced APMs, particularly given that the higher qualifying conversion factor update." The agency estimates that "relatively few QPs would be affected" because the majority of QPs are participating in an Advanced APM through all TINs. CMS estimates that this change would result in approximately $2.38 billion less being paid out to APM participants over the next decade.

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 to adopt permanent flexibility for the Secretary to adjust QP thresholds as needed. The latter two are included in the *Patients First Act*.

III. REQUESTS FOR INFORMATION (RFIs)

CMS included several RFIs in the proposed rule, including one that targets the CPT code set and the processes used to develop and value it, and another that takes a broader look at primary care payment, signaling CMS may be considering more significant changes in the future, as explained further below.

Current Procedural Terminology (CPT) RFI

CMS includes an RFI examining the AMA's CPT coding system, CPT licensing, the CPT code development process, and the RUC. The RFI asks about alleged harms associated with the AMA's "monopoly over CPT-4 licenses" and cites concerns about reliance on a private organization with an "obvious conflict of interest" in recommending physician service values, seeking input on CPT licensing costs and effects, the role of medical necessity in code development, possible alternatives or supplements to CPT as the national physician services code set, alternative governance and valuation processes, and whether physician services could instead be paid using ICD-10-PCS or other bundled payment approaches.

Redesigning Primary Care to Make America Healthy Again

CMS is seeking comment on a broad reexamination of how Medicare pays for primary care, with the goal of better supporting prevention, longitudinal care, and practice transformation. Specifically, CMS is requesting feedback on

three areas: (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 payment toward prospective, population-based payments or outcomes-based payments for primary care, beginning with the Medicare SSP and potentially expanding more broadly across Original Medicare. The RFI reflects an important shift in CMS' thinking about primary care payment signaling it may place greater emphasis on longitudinal accountability for patient outcomes, rather than reimbursement for discrete visits and services in the future.

Other RFIs (In order of appearance)

- Community-based palliative care (page 108)
- Intensive lifestyle interventions to slow progression of Alzheimer's Disease (page 109)
- Applying electronic prior authorization measures to SSP ACOs (page 225)
- Specialty care in the SSP (page 287)
- Duplicate laboratory testing, imaging, and result sharing and interoperability (page 298)
- Fast Healthcare Interoperability Resources (FHIR) (page 302)
- FHIR-Based Digital Quality Measurement in the QPP and Other CMS Quality Programs (page 310)
- Future Potential Performance-Based Measures of Electronic Prior Authorization (page 341)
- MVP scoring (page 365)
- Star Rating Assignment Methodology for Administrative Claims Quality Measures (page 373)

ADDITIONAL RESOURCES

- Proposed 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.