Fact Sheet

Calendar Year (CY) 2027 Medicare Physician Fee Schedule Proposed Rule

CY 2027 PFS Rate Setting and Conversion Factor

As required by statute, beginning in CY 2026, there are two separate conversion factors: one for qualifying alternative payment model (APM) participants (QPs) and one for physicians and practitioners who are not QPs. By statute, QPs are those that meet certain thresholds for participation in an Advanced APM, which means generally that the payment model has features to ensure accountability for quality and cost of care. The update to the qualifying APM conversion factor for CY 2027 is +0.75% while the update to the non-qualifying APM conversion factor for CY 2027 is +0.25%. The changes to the PFS conversion factors for CY 2027 include these updates as required by statute and an estimated +0.53% adjustment necessary to account for proposed changes in work RVUs for some services. However, Public Law 119-21, which CMS refers to as the Working Families Tax Cut (WFTC) legislation, provided a one-year PFS conversion factor increase of 2.50% for CY 2026, which will no longer be in effect for CY 2027. This effectively means that current law requires -2.50% reduction in Medicare payment under the PFS compared to CY 2026. The proposed CY 2027 qualifying APM conversion factor of $33.17 represents a projected decrease of $0.40 (-1.19%) from the current conversion factor of $33.57. Similarly, the proposed CY 2027 nonqualifying APM conversion factor of $32.84 represents a projected decrease of $0.56 (-1.68%) from the current conversion factor of $33.40.

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

For CY 2027, we are proposing to reduce payment when a separately identifiable office/outpatient evaluation and management (E/M) visit is furnished by the same physician (or a physician in the same practice) on the same day as a 0-, 10-, or 90-day global procedure. The most expensive service (either surgical or E/M visit) would be paid at 100% and all other surgical procedure(s) or E/M visit(s) furnished on the same day would be paid at 50%.

This proposed policy is like a proposal in the CY 2019 PFS proposed rule, made in the context of a broader proposal that would have modified the payment structure of E/M visits. While we did not finalize the proposal at that time, we noted that we continued to believe that there are efficiencies when the same physician (or a physician in the same group practice) provides an E/M service for the same patient in conjunction with a procedure with a global period and that we are likely duplicating payment under the current payment methodology. The current proposal would address that overvaluation.

E/M Visit Complexity Add-On (HCPCS code G2211)

In the CY 2021 PFS final rule, we finalized separate payment for the office/outpatient evaluation and management (O/O E/M) visit complexity add-on code, HCPCS code G2211. Policy implementation was temporarily delayed by statute but implemented for CY 2025.

For CY 2027, we are proposing two changes. We are proposing to transition HCPCS code G2211 to a modifier that can be appended to the associated E/M base code (placeholder modifier MOD1 will be replaced with a two-digit HCPCS modifier if finalized). This modifier would increase the payment of the associated E/M code by 16%, instead of a flat rate, maintaining an equal percentage increase across all levels of E/M codes. We are also proposing to recognize additional resource costs incurred by practitioners in Accountable Care Organizations (ACOs) when providing longitudinal care, such as maintaining total cost of care accountability and reporting quality measures that can align with providing longitudinal care and care coordination. This modifier (placeholder modifier MOD2) would be available only for practitioners participating in a Shared Savings Program ACO or Participant Providers in a Long-term Enhanced ACO Design (LEAD) Model ACO and would increase payment of the associated E/M visit by 32%. Under the Shared Savings Program, use of the MOD2 modifier would be voluntary and available to be billed for all beneficiaries to whom an ACO participant or provider furnishes services, not limited only to Shared Savings Program-assigned beneficiaries. The MOD2 modifier would also be voluntary for the LEAD Model and could be billed for all beneficiaries to whom the Participant Provider furnishes services, not limited only to LEAD aligned beneficiaries. Claims submitted with MOD2 would be included in beneficiary assignment calculations, historical benchmark expenditures, and performance year expenditures for the Shared Savings Program.

Practice Expense

CMS has historically relied on the American Medical Association (AMA) surveys to estimate physician work, direct practice expense (PE) inputs, and overall PE for calculating payment rates. These recommendations have been limited by several factors, especially from a reliance on resource-intensive but ultimately unreliable surveys with low response rates asking for expert estimates that present significant discrepancies with alternative empirical data sources, in the cases where empirical data exists.

These dynamics are particularly problematic for specialty-level practice expense data. In these cases, data collection is particularly burdensome and subject to volatility based on low response rates and significant incongruities in collection methodologies between physician groups and other entities paid under the PFS. We are engaged in a multi-year

effort to transition the PE methodology away from reliance on the AMA's data and toward an approach that relies on more objective, routinely updated and auditable cost data. We believe this change will lead to PFS payments being more sensitive to market pressures, open broader possibilities for right-sizing payments across outpatient care settings and make payments more transparent for practitioners and beneficiaries.

As part of reforming the way PE RVUs are assigned to specific services, we are proposing to reduce reliance on outdated specialty-specific practice expense per hour (PE/HR) data. Specifically, we are proposing to phase out part of the methodology that ensures the overall number of PE RVUs by specialty is consistent with the old PE/HR data from 2007 or earlier. Under the proposed methodology, the final PE RVUs would still be derived from the input data (including both work RVUs and direct PE inputs, as well as specialty-specific indirect allocators). However, the existing final step would be phased out over several years and replaced with a PE stabilizer that mitigates short term volatility without anchoring overall values to a specific point in time. Based on feedback from interested parties, we also are proposing to adjust the indirect PE allocation for visits furnished to beneficiaries in a Part A stay in a skilled nursing facility consistent with our site of service payment differential policy finalized in the CY 2026 PFS final rule. We also are seeking comments on whether the site of service payment differential between Facility and Non-facility is still appropriate, or whether we should consider an alternative approach to improving assumptions about indirect practice costs, particularly for physicians employed by a hospital, health system, or other entity.

Comment Solicitation on Strategies for Improving Global Surgery Payment Accuracy

For CY 2027, as part of an iterative process to improve global surgical service valuation and payment accuracy, we are proposing to pause the data collection required by section 523 of the Medicare Access and CHIP Reauthorization Act (MACRA). We can continue to assess how best to use the data and what we can do to improve this data collection going forward. We currently have several years of data showing that the post-operative visits during the global period are not occurring, yet providers are still being paid for these visits under the current global payment policy. Additionally, we believe that current data collection requirements may be causing undue burden to providers and that pausing the data collection will help reduce the burden for practitioners. We are soliciting public comments on expanding our data collection as well as other data sources we might consider to more accurately value payments for global surgical services. Additionally, we are posting a public use file with this proposed rule to display the imputed RVUs associated with both the 10-and 90-day post-operative visits based on a purely arithmetic approach to understand the valuation of the services based on the analyzed data. We also

welcome comments on potential revaluation strategies that we may consider through future rulemaking.

Supporting Beneficiaries Planning for Future Medical Decisions

We are proposing to create two new HCPCS codes to describe advance care planning (ACP) services furnished by clinical staff under the direct supervision of the billing physician or other practitioner. These new codes will more accurately distinguish and value the work done by billing practitioners from time spent by their clinical staff providing ACP services. We are further proposing that the existing ACP CPT codes 99497 and 99498 would only be used to report time personally spent by the billing practitioner.

Limiting Medicare Coverage of Certain Individuals

We are proposing rules to implement the statutory changes made by section 71201 of Public Law 119-21, which CMS refers to as the "Working Families Tax Cut" (WFTC) legislation, which amended Title XVIII of the Social Security Act and limits Medicare eligibility to individuals in the following four groups:

1. A citizen or national of the United States;
2. An alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act;
3. An alien who has been granted the status of Cuban and Haitian entrant; or
4. An individual who lawfully resides in the United States in accordance with a Compact of Free Association.

CMS is proposing to implement the WFTC legislation and is proposing amendments to current Medicare regulations to incorporate the newly specified groups of individuals who may be eligible for Medicare, procedures for termination and applicable appeal rights for those found ineligible, and enrollment options for individuals who later gain or regain eligibility.

Request for Information (RFI) on Duplicate Laboratory Testing, Imaging, and Result Sharing and Interoperability

Diagnostic imaging and laboratory test results are frequently siloed within acquiring electronic health record systems, leaving treating healthcare providers unaware of their existence and unable to access them across care settings. This inaccessibility leads to incomplete or delayed care management, duplicative testing, increased program costs, and unnecessary radiation exposure to patients. We are issuing a RFI to gather input from stakeholders, including clinicians, laboratories, imaging healthcare providers, health

systems, payers, health IT developers, and other interested parties, to inform potential actions aimed at addressing these interoperability and duplicate testing concerns.