CY 2027 Medicare Physician Fee Schedule Proposed Rule

The Most Favorable Provisions Impacting Physicians
July 22, 2026

Executive Overview

The CY 2027 Medicare Physician Fee Schedule proposed rule contains several provisions that could improve payment for physicians, behavioral health providers, and accountable care organizations (ACOs), while also reducing selected reporting and administrative requirements.

An important qualification is that the proposed rule does not provide an across-the-board payment increase. CMS estimates that the 2027 conversion factor would be approximately $33.17 for qualifying alternative payment model participants, a 1.19% decrease, and approximately $32.84 for other clinicians, a 1.68% decrease. The favorable provisions described below may offset some of that pressure for particular practices, specialties, and ACOs, but they will not necessarily produce a net payment increase for every physician.

NOTE: The references below use the numbered pages in the July 2026 public-inspection PDF of CMS-1848-P supplied for this analysis. They do not use the later two-column Federal Register pagination. The conversion-factor impact discussion is on public-inspection PDF p. 1143.

Source: CMS CY 2027 Physician Fee Schedule Proposed Rule Fact Sheet

1. Substantially Higher E/M Payments for ACO and Longitudinal-Care Physician

Proposed rule page reference: *Public-inspection PDF pp. 169-183.*

CMS proposes replacing the separate G2211 complexity add-on code with percentage-based modifiers attached directly to office and outpatient evaluation and management claims.

- MOD1 would increase payment for the associated E/M service by 16% when the visit involves ongoing longitudinal care or management of a serious or complex condition.
- MOD2 would increase payment by 32% when the physician or practitioner participates in the Medicare Shared Savings Program or the LEAD model and satisfies the applicable requirements.

Participating ACO clinicians could use MOD2 for all Medicare beneficiaries they treat, not merely beneficiaries assigned to the ACO. This could create a meaningful new revenue stream for primary care practices and specialists delivering ongoing complex care.

The percentage-based approach may also be fairer than G2211 because payment would rise with the intensity of the underlying E/M service. Attaching a modifier rather than billing a separate claim line could also reduce billing complexity and claim-processing problems.

Source: CMS CY 2027 Physician Fee Schedule Proposed Rule Fact Sheet

2. Increasing the BASIC Track Level E Shared-Savings Rate from 50% to 60%

Proposed rule page reference: *Public-inspection PDF pp. 678-690; CMS's modeled financial-impact estimate appears on p. 687.*

CMS proposes allowing Medicare Shared Savings Program ACOs in BASIC Track Level E to retain as much as 60% of generated savings, rather than the current 50%.

CMS modeled the proposal using 2024 performance data and estimated that it would have increased shared-savings payments by approximately $1.35 million per affected ACO, on average, and approximately $110.6 million in total across 104 Level E ACOs.

The actual future benefit would depend on each ACO's performance, quality scores, and benchmark. Nevertheless, this is one of the clearest and most readily quantifiable financial improvements in the proposed rule. It would also make the BASIC Track more attractive to organizations willing to accept downside risk but not yet prepared to enter the ENHANCED Track.

Source: CY 2027 Physician Fee Schedule Proposed Rule

3. Increasing the ACO Prior-Savings Adjustment from 50% to 75%

Proposed rule page reference: *Public-inspection PDF pp. 702-714; CMS's $1,000 prior-savings example appears on p. 712.*

When an ACO begins a new agreement period, historical success in lowering expenditures can reduce its rebased benchmark and make it more difficult to generate savings again. CMS's prior-savings adjustment is intended to restore part of those previously achieved savings to the new benchmark.

The proposed rule would increase the applicable scaling factor from 50% to 75%. In CMS's simplified example, an ACO with $1,000 in prior savings would receive a $750 adjustment instead of $500, resulting in a benchmark of $9,750 rather than $9,500.

This change would reduce the so-called ratchet effect, under which consistently successful ACOs are effectively penalized through progressively more difficult benchmarks. It could improve long-term ACO participation and provide greater financial stability to organizations with a history of controlling costs.

Source: CY 2027 Physician Fee Schedule Proposed Rule

4. Risk-Adjusting the 5% Cap on Favorable ACO Benchmark Adjustments

Proposed rule page reference: *Public-inspection PDF pp. 714-732.*

CMS proposes applying the existing 5% cap on positive benchmark adjustments on a risk-adjusted basis. The change would apply to favorable regional adjustments, prior-savings adjustments, and population adjustments.

The current fixed cap may not fully recognize ACOs whose patient populations become clinically more complex. Under the proposal, the permitted adjustment would better reflect changes in beneficiary risk and disease burden.

This is particularly positive for ACOs serving older, medically complex, disabled, or high-needs populations. It should reduce the risk that an ACO's benchmark fails to keep pace with legitimate increases in expected patient costs.

Source: CY 2027 Physician Fee Schedule Proposed Rule

5. New ACO Growth Adjustment for Adding Clinicians and Beneficiaries

Proposed rule page reference: *Public-inspection PDF pp. 732-756; CMS's illustrative $174.02 growth adjustment and $299.02 combined adjustment appear on p. 753.*

CMS proposes a new benchmark adjustment intended to reward ACOs that expand by recruiting clinicians who are relatively new to value-based care and by bringing additional beneficiaries into accountable-care arrangements.

The growth adjustment could be added to the most favorable existing benchmark adjustment, subject to the risk-adjusted cap. CMS provides a hypothetical example in which the growth adjustment adds approximately $174 per beneficiary to an existing $125 adjustment, producing a total adjustment of approximately $299.

This could make expansion financially more viable, particularly for ACOs recruiting independent primary care practices, rural physicians, or clinicians who have not previously participated in Medicare value-based payment models. It also addresses a longstanding concern that adding new physicians and patients can disrupt an ACO's benchmark and expose it to financial risk before care-management improvements take effect.

Source: CY 2027 Physician Fee Schedule Proposed Rule

6. Proposed ACPT Reforms Could Protect ACO Benchmarks and Improve Cohort Fairness

Proposed rule page reference: *Public-inspection PDF pp. 756-783; performance-year-specific rates, pp. 762-766; guardrails for agreement periods beginning in 2027 or later, pp. 766-771; retroactive lower-bound guardrail for 2024-2026 agreement cohorts, pp. 771-778; PY 2025 reconciliation timing, pp. 778-779.*

The Accountable Care Prospective Trend (ACPT) is the prospectively projected component of the three-way factor used to update an ACO's historical benchmark. The ACPT generally receives a one-third weight, while the national-regional expenditure trend receives a two-thirds weight. Because the resulting update directly affects the benchmark against which an ACO's expenditures are measured, an ACPT projection that is materially too low can reduce shared savings or increase shared losses.

For agreement periods beginning on or after January 1, 2027, CMS proposes replacing the current fixed five-year schedule of modified United States Per Capita Cost (USPCC) annualized growth rates with performance-year-specific rates. CMS would publish the rate for each performance year in the late spring or early summer of the preceding year. All ACO agreement-period cohorts being reconciled for the same performance year would use the same underlying modified USPCC annualized growth rates.

CMS also proposes the following guardrails for agreement periods beginning in 2027 or later:

- Lower guardrail: If the modified USPCC cumulative growth rate is more than 1.0 percentage point below the corresponding observed cumulative growth in national assignable expenditures, CMS would recompute the ACPT using a growth rate equal to observed growth minus 1.0 percentage point.
- Upper guardrail: If the modified USPCC cumulative growth rate is more than 1.5 percentage points above observed cumulative growth, CMS would recompute the ACPT using a growth rate equal to observed growth plus 1.5 percentage points.
- The guardrail would be evaluated independently at reconciliation for each performance year. An adjustment in one year would affect that year's benchmark and shared-savings or shared-loss calculation, but it would not automatically carry forward to a later year.

For ACOs whose agreement periods began in 2024, 2025, or 2026, CMS proposes a retroactive lower-bound guardrail beginning with performance year 2025 and continuing through the remaining years of those agreements. These ACOs would receive protection when the modified USPCC cumulative growth rate is more than 1.0 percentage point below actual national expenditure growth, but they would not be subject to the proposed 1.5-percentage-point upper guardrail. CMS states that the retroactive policy would either benefit an affected ACO or leave it financially unchanged. For two-sided-risk ACOs, CMS would also calculate the loss-recoupment limit using the lesser of the benchmark amounts calculated before and after the retroactive adjustment, so that the policy would not increase an ACO's maximum loss liability.

CMS's performance year 2025 illustration indicates that the proposed lower-bound protection could be especially important for some existing ACOs. For ACOs with agreements beginning in 2024, the proposed ACPT would be 15.3% for ESRD beneficiaries and 14.7% for Aged/Disabled beneficiaries, compared with

unadjusted values of 13.0% and 10.6%, respectively. For ACOs with agreements beginning in 2025, the proposed values would be 7.7% and 5.7%, compared with unadjusted values of 7.5% and 5.6%.

What this could mean for an ACO: The lower guardrail is a meaningful financial protection. When the prospective trend materially understates actual national expenditure growth, the recalculated ACPT would produce a higher updated benchmark than the unadjusted methodology. That could increase the amount of shared savings earned, help an ACO cross its minimum savings threshold, or reduce shared losses. Using a common annual growth rate for all ACO cohorts should also reduce differences caused solely by the year in which an ACO entered its agreement.

The proposal also creates trade-offs. ACOs beginning new agreements in 2027 or later would lose the five-year ACPT predictability available under the current methodology and would need to update benchmark, reserve, and participant-distribution forecasts annually. The upper guardrail could reduce an otherwise favorable benchmark when the prospective trend substantially exceeds actual national expenditure growth. The practical result is greater protection against major forecast errors, but less certainty over the full five-year agreement period.

The retroactive proposal will also delay performance year 2025 reconciliation. CMS plans to issue performance year 2025 financial results in November 2026 and distribute shared savings payments in December 2026. ACOs expecting a payment should account for this delay in cash-flow planning, participant distributions, and reserves.

ACO leadership should therefore treat the ACPT as an annually refreshed benchmark input, model the lower and upper guardrails separately by Medicare enrollment category, and reforecast expected shared savings or losses after CMS publishes each performance-year rate.

Source: CY 2027 Physician Fee Schedule Proposed Rule

7. Significant Payment Increases for Psychiatric Collaborative Care and Behavioral-Health Integration

Proposed rule page reference: *Public-inspection PDF pp. 163-169.*

CMS proposes substantial increases in work relative value units for several Psychiatric Collaborative Care Model and behavioral-health integration services.

- CPT 99492: 1.88 to 2.75 work RVUs - approximately a 46% increase.
- CPT 99493: 2.05 to 2.26 work RVUs - approximately a 10% increase.
- CPT 99494: 0.82 to 1.13 work RVUs - approximately a 38% increase.
- HCPCS G2214: 0.77 to 1.13 work RVUs - approximately a 47% increase.
- HCPCS G0568: 1.88 to 2.75 work RVUs - approximately a 46% increase.

CMS also proposes increasing the clinical-labor rate assigned to behavioral-health care managers from $0.57 to $0.70 per minute, an increase of nearly 23%.

These revisions would improve reimbursement for primary care practices, psychiatric practices, and health systems that integrate behavioral-health care managers and psychiatric consultants into medical care. They may make collaborative-care programs financially feasible for more physician groups.

Source: CY 2027 Physician Fee Schedule Proposed Rule

8. A 19.1% Work-RVU Increase for Tobacco Cessation and Substance-Use Screening Services

Proposed rule page reference: *Public-inspection PDF pp. 161-163.*

CMS proposes a uniform 19.1% increase in work RVUs for tobacco-cessation counseling and Screening, Brief Intervention and Referral to Treatment services.

- CPT 99406: 0.24 to 0.29 work RVUs.
- CPT 99407: 0.50 to 0.60 work RVUs.
- HCPCS G2011: 0.33 to 0.39 work RVUs.
- HCPCS G0396: 0.65 to 0.77 work RVUs.
- HCPCS G0397: 1.30 to 1.55 work RVUs.

Although the dollar increase per service would be modest, these are frequently furnished preventive and behavioral-health services. The cumulative benefit could be meaningful for primary care, pulmonary, cardiology, oncology, and behavioral-health practices with significant tobacco- or substance-use populations.

The increase also better recognizes the counseling time, clinical judgment, and behavioral-change work involved.

Source: CY 2027 Physician Fee Schedule Proposed Rule

Positive Administrative Benefits

9. Elimination of Several MIPS Promoting Interoperability Reporting Requirements

Proposed rule page reference: *Policy discussion: public-inspection PDF pp. 968-976; quantified annual burden and cost estimate: p. 1127.*

CMS proposes removing the MIPS Security Risk Analysis measure and two separate attestations associated with Office of the National Coordinator health-information technology requirements.

CMS estimates that these changes would eliminate approximately 41,228 reporting hours annually and save clinicians approximately $4.54 million per year. The Security Risk Analysis reporting removal accounts for most of the projected savings.

This proposal would eliminate the need to submit a MIPS attestation demonstrating completion of the analysis. However, it would not eliminate the underlying HIPAA Security Rule obligation for covered entities to perform required security risk assessments. The benefit is therefore a reduction in duplicative CMS reporting rather than relief from cybersecurity or HIPAA compliance itself.

Source: CY 2027 Physician Fee Schedule Proposed Rule

10. Broad Simplification of ACO Quality Reporting

Proposed rule page reference: *MIPS CQM availability and incentive, pp. 581-590; 95% beneficiary-representation threshold, pp. 609-617; Medicare eCQM option, pp. 617-628; APP Plus reduction to eight measures, pp. 635-639; CEHRT and electronic-reporting provisions, pp. 648-652.*

CMS proposes several related changes that could substantially reduce quality-reporting burdens for Shared Savings Program ACOs.

- Continue permitting ACOs to report MIPS clinical quality measures, rather than forcing an immediate transition to a more technically demanding collection method.
- Allow certain participant tax-identification numbers to be excluded from quality reporting, provided that the remaining participants represent at least 95% of the ACO's assigned beneficiaries.
- Create a Medicare electronic clinical quality measure collection type based on assigned Medicare beneficiaries, rather than requiring reporting across all patients and payers.
- Reduce the APP Plus measure set to eight measures by removing two measures.
- Provide incentives for ACOs that voluntarily move toward electronic reporting.

These changes address one of the most persistent ACO complaints: obtaining standardized data from every participating physician practice, electronic health-record system, and patient population is disproportionately expensive and technically difficult.

The Medicare eCQM option may be especially helpful because it narrows the required population to the beneficiaries for whom the ACO is actually accountable.

Source: CMS Shared Savings Program Proposals in the CY 2027 PFS Rule

11. Pausing the Global-Surgery Data-Collection Requirement

Proposed rule page reference: *Public-inspection PDF pp. 57-59.*

CMS proposes pausing the MACRA-mandated collection of data on postoperative visits furnished during global surgical periods.

CMS acknowledges that the current data-collection process imposes an undue reporting burden and that pausing it would provide immediate relief while the agency reconsiders how best to obtain reliable information concerning global surgical services.

This is particularly beneficial for surgeons, multispecialty groups, and health systems that must identify and report postoperative encounters that ordinarily generate no separate Medicare payment. The proposal would remove a reporting obligation that consumes staff and physician time without directly improving reimbursement or patient care.

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Overall Assessment

The strongest potential financial winners appear to be:

- Physicians eligible for the proposed 16% or 32% E/M modifiers.
- BASIC Track Level E ACOs receiving a larger share of savings.
- Successful or expanding ACOs benefiting from improved benchmark methodology.
- ACOs protected by the proposed ACPT lower-bound guardrail when projected growth materially understates actual national Medicare expenditure growth.
- Practices providing psychiatric collaborative care, behavioral-health integration, tobacco-cessation counseling, and substance-use screening.

The most concrete administrative improvement is the removal of selected MIPS Promoting Interoperability requirements, for which CMS has quantified more than $4.5 million in annual savings. The ACO reporting changes could ultimately produce an even larger operational benefit, although CMS has not provided an equally clear aggregate dollar estimate.

Comments on the proposed rule are due September 14, 2026.