Health IT, Artificial Intelligence, and Digital-Health Provisions

CY 2027 Medicare Physician Fee Schedule Proposed Rule (CMS-1848-P)

July 23, 2026

This analysis identifies the most consequential provisions in the proposed rule affecting health information technology, artificial intelligence, interoperability, remote monitoring, telehealth, digital quality reporting, and related digital-health operations. It includes both formal policy proposals and requests for information. A request for information signals possible future policy but does not itself establish a binding requirement.

Page-reference convention: Page references use the page count of the 1,592-page public-inspection PDF of the proposed rule.

1. Electronic Prior Authorization as a Central MIPS and Specialty-Model Health IT Requirement

CMS proposes a staged transition for electronic prior authorization that would directly affect EHR functionality, payer application programming interfaces, documentation workflows, identity management, and health care transaction systems.

- For medical items and services, the MIPS measure would be optional for the 2027 performance year. Clinicians could earn 10 bonus points by using certified electronic health record technology (CEHRT) and a payer Prior Authorization API for at least one request.
- Beginning with the 2028 performance year, clinicians generally would have to use CEHRT to obtain coverage requirements, populate documentation templates, submit prior authorization requests, and receive payer responses through the API.
- A clinician who does not attest to meeting the requirement, and who does not qualify for an exclusion, could receive a zero for the entire MIPS Promoting Interoperability performance category.
- CMS also proposes a new electronic prior authorization measure for prescription drugs covered under the pharmacy benefit beginning in 2028. The measure initially would use attestation, with the possibility of future numerator-and-denominator reporting.
- Parallel requirements would apply under the Ambulatory Specialty Model, although the medical-services measure would be optional and unscored in 2027 and required in 2028.

Operational significance: Physician practices, health systems, specialty-model participants, EHR vendors, clearinghouses, and payers would need coordinated technical implementation and testing. The policy could also make API performance and prior authorization integration material to MIPS scoring.

Reference pages: PDF pages 415-418, 977-985, and 999-1002.

2. MIPS Improvement Activity for Responsible Clinical Artificial Intelligence Use

CMS proposes a new MIPS Improvement Activity titled “Clinician Use of Artificial Intelligence to Improve Patient Care.” The activity would allow clinicians to receive MIPS credit for participating in

organizational initiatives involving the responsible and transparent use of AI in clinical or operational workflows.

- Establishing AI evaluation, monitoring, and governance policies.
- Evaluating AI systems for fairness, appropriateness, validity, effectiveness, and ongoing performance.
- Developing or piloting predictive analytics, clinical decision-support tools, and patient risk-stratification systems.
- Using AI-generated clinical notes when the clinician reviews and remains responsible for the final documentation.
- Using AI to identify care gaps, support population-health management, screen patients for clinical-trial eligibility, or draft responses to patient questions.

Operational significance: This proposal would formally incorporate AI governance and use into Medicare clinician performance policy. Organizations could need written oversight procedures, validation protocols, monitoring processes, documentation of clinician review, and evidence that AI-related activities meet the Improvement Activity requirements.

Reference pages: PDF pages 949-951 and 1,499-1,500.

3. Potential Medicare Payment Methodology for AI-Assisted Clinical Care

CMS includes a major request for information concerning whether and how Medicare should pay for clinical technologies and AI used in primary care. CMS is considering whether payment should be tied to demonstrated clinical outcomes rather than treating AI only as another practice expense.

- AI-assisted clinical documentation and clinical decision support.
- The effect of AI on physician time, productivity, service intensity, and practice costs.
- Evidence that AI improves quality, reduces avoidable utilization, or lowers downstream Medicare spending.
- Coding and payment gaps that may discourage adoption of clinically beneficial technology.
- Patient-data privacy, security, and protection concerns.
- Whether Medicare could receive outcome information through electronic or API-based reporting.
- How AI-generated efficiencies should be reflected in physician payment.

Operational significance: Although the RFI does not create a payment policy, it could establish the foundation for future Medicare coding, coverage, and reimbursement pathways for clinical AI products. Developers and providers may need to produce stronger clinical evidence, cost data, utilization analyses, and interoperable outcome-reporting capabilities.

Reference pages: PDF pages 252-264, particularly pages 263-264.

4. AI-Augmented Annual Wellness Visits

A related request for information examines the use of technology and AI to enhance the Medicare Annual Wellness Visit before, during, and after the encounter.

- Reviewing medical records and identifying missing preventive services before the visit.
- Producing individualized risk assessments and flagging patients who may need additional evaluation.

- Suggesting follow-up steps for clinician review.
- Personalizing post-visit instructions based on the patient's language and health-literacy level.
- Supporting more individualized preventive-care plans.

Operational significance: CMS indicates that some AI-supported activities may already fit within existing billing rules, while seeking input on whether additional payment, coding, quality, or documentation policies are needed. This could expand opportunities for AI-enabled preventive-care platforms, provided that clinician oversight, documentation integrity, privacy, and clinical validity are adequately addressed.

Reference pages: PDF pages 264-266.

5. Transition to FHIR-Based Digital Quality Reporting

CMS describes a policy direction under which clinician, hospital, and ACO quality reporting would migrate from current clinical quality measure, electronic clinical quality measure, and QRDA-based processes to Fast Healthcare Interoperability Resources (FHIR)-based digital quality measures.

- 2028: Initial FHIR-based reporting options would become available for selected measures while existing submission mechanisms remain available.
- 2029: Parallel reporting would continue, with CMS encouraging broader FHIR adoption.
- 2030: FHIR-based reporting would become required for measures that have transitioned to FHIR specifications. For MIPS, this generally corresponds to the 2032 payment year.
- For Shared Savings Program ACOs, CMS similarly anticipates a two-year transition beginning in performance year 2028, followed by mandatory FHIR reporting in 2030 for APP Plus measures with available FHIR specifications.

Operational significance: The transition could require major changes to EHR systems, data aggregators, registries, ACO data warehouses, quality-measure engines, API endpoints, and data-validation processes. Organizations would need to address patient matching, data completeness, terminology mapping, measure logic, and cross-vendor testing.

Reference pages: PDF pages 585-587 and 909-913.

6. Simplified CEHRT Compliance Options for Shared Savings Program ACOs

CMS proposes to replace the current requirement that all ACO participants report the full set of MIPS Promoting Interoperability measures with more flexible ACO-level options beginning in performance year 2027.

- An ACO could use standardized data obtained through a certified FHIR API to support complete reporting of at least one APP Plus measure.
- Alternatively, an ACO could attest that it satisfies at least one of three ACO-level CEHRT metrics: electronic prescribing; bidirectional health-information exchange; or provider-to-patient electronic exchange.
- The provider-to-patient option would require timely electronic access and the ability for patients to access information through an application of their choice using the certified EHR's API.

Operational significance: The proposal could substantially reduce ACO reporting burden while increasing the importance of practical interoperability, patient-facing APIs, and reliable electronic

exchange. ACOs would still need controls to demonstrate data completeness, participant compliance, and successful use of certified technology.

Reference pages: PDF pages 639-672, particularly pages 652-656 and 661.

7. Revisions to Remote Physiologic and Remote Therapeutic Monitoring

CMS proposes several changes affecting remote physiologic monitoring (RPM), remote therapeutic monitoring (RTM), digital monitoring platforms, and third-party service vendors.

- RTM, like RPM, generally would be limited to established patients.
- A separately billable initiating visit would be required when RPM or RTM begins, whether conducted in person or, when otherwise permitted, through telehealth.
- Clinical-staff time could count only when the staff are direct employees of the billing practitioner or practice. Medicare billing generally would no longer permit clinical monitoring work to be contracted entirely to an outside third-party company.
- Clinical staff could still work remotely under general supervision and would not have to be physically located in the physician's office.
- CMS addresses newer codes covering 2-15 days of device data and the first 10 minutes of treatment-management services.

Operational significance: The proposed employee requirement could materially disrupt outsourced RPM and RTM business models. Physician organizations may need to reconsider employment structures, contracting arrangements, supervision, platform design, documentation, and billing controls.

Reference pages: PDF pages 149-155, with code valuations also discussed on pages 222-223.

8. Alignment of the CEHRT Definition with ONC HTI-5 Certification Changes

CMS proposes to revise the MIPS definition of Certified Electronic Health Record Technology to align with Office of the National Coordinator for Health Information Technology proposals that remove, revise, or replace several certification criteria.

- Family health history.
- Patient health-information capture.
- Automated numerator recording and automated measure calculation.
- Certain clinical-quality-measure certification functions.
- Several criteria supporting patient access, information exchange, referral-loop closure, public-health reporting, and standardized APIs.

Operational significance: Many functions would remain supported through revised or replacement certification criteria, but EHR vendors and provider compliance teams would need to map the new ONC certification structure to MIPS requirements beginning in 2027. Organizations should evaluate whether product upgrades, recertification, workflow changes, or revised compliance documentation will be required.

Reference pages: PDF pages 956-964, with detailed certification tables on pages 958-961 and 1,022-1,023.

9. Telehealth, Audio-Only Care, Virtual-Platform Claims, and Virtual Teaching

The proposed rule incorporates and implements several policies affecting digitally delivered care, telehealth platforms, audio-only services, claims configuration, and graduate medical education workflows.

- Geographic restrictions and originating-site limits would remain relaxed through December 31, 2027.
- The in-person requirement for tele-mental-health services would be delayed until January 1, 2028.
- Audio-only Medicare telehealth would remain available through January 1, 2028.
- New modifiers BB and BC would identify services delivered through certain contracted virtual platforms and telehealth services furnished incident to a practitioner's professional service.
- CMS proposes to permit a teaching physician's virtual participation when either the resident or the teaching physician is physically with the beneficiary, rather than limiting the policy to three-way visits in which all three individuals are in separate locations.
- CMS proposes to add new clinical-staff advance-care-planning codes to the Medicare telehealth list.
- The proposed 2027 originating-site facility fee is $32.65.

Operational significance: Providers and technology vendors would need to update platform contracting, claims edits, modifier use, documentation, audio-only workflows, resident supervision processes, and telehealth compliance protocols.

Reference pages: PDF pages 60-67; the advance-care-planning telehealth addition is also discussed on page 294.

10. National Laboratory and Imaging Interoperability and Duplicate-Testing Policies

CMS issues a request for information concerning the inability of clinicians to obtain prior laboratory results and diagnostic images from other organizations and the resulting potential for unnecessary duplicate testing.

- Standards needed for nationwide laboratory and imaging exchange.
- Technical conformance testing and certification.
- EHR access to outside laboratory results and diagnostic images.
- Responsibility when a test must be repeated because prior information is inaccessible.
- Potential payment denials, reduced payments, recoupments, claims edits, or frequency limits for duplicate tests.
- Mechanisms through which clinicians could document a legitimate clinical reason for repeat testing.

Operational significance: Although this is an RFI, it could lead to new interoperability standards, participation requirements, quality measures, or payment consequences for providers that cannot electronically exchange diagnostic information. It could also create significant obligations for imaging networks, laboratories, health information exchanges, and EHR vendors.

Reference pages: PDF pages 867-872.

Additional Health IT Compliance Provision

Removal of Certain MIPS Security and ONC Attestations

CMS proposes to remove the MIPS Security Risk Analysis measure beginning with the 2027 performance year and to eliminate the ONC Direct Review and ONC-Authorized Certification Body Surveillance attestations.

Operational significance: The change would reduce duplicative MIPS reporting, but it would not eliminate HIPAA security risk analysis, risk-management, or cybersecurity obligations. Physician practices and health systems would remain responsible for complying with the underlying privacy and security requirements even though the specific MIPS attestation would be removed.

Reference pages: PDF pages 969-976.

Source

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Source PDF: https://public-inspection.federalregister.gov/2026-14327.pdf