CMS-1848-P | Proposed Rule Analysis

Federal Register public-inspection document 2026-14327

Overview

CMS-1848-P is the proposed CY 2027 Medicare Physician Fee Schedule and Part B rule. Most provisions would take effect January 1, 2027. Comments are due to CMS by September 14, 2026.

A central distinction is that the Physician Fee Schedule primarily determines professional payments to physicians and other practitioners, not hospital IPPS or OPPS facility payments. Hospitals nevertheless have substantial exposure through employed physician groups, provider-based clinics, hospital outreach laboratories, ACOs, 340B operations, and mandatory payment models.

Page-reference convention: References below use the page count in the linked public-inspection PDF, with the cover page counted as page 1.

1. Conversion-Factor Reductions Create a Systemwide Professional-Payment Cut

CMS proposes two CY 2027 conversion factors:

- Qualifying APM participants: $33.17, a 1.19% decrease from CY 2026.
- Nonqualifying APM participants: $32.84, a 1.68% decrease from CY 2026.

Although the underlying statutory updates are positive—0.75% for qualifying APM participants and 0.25% for other clinicians—and CMS estimates a 0.53% budget-neutrality adjustment, these increases do not fully offset the expiration of the temporary 2.5% conversion-factor increase that applied in CY 2026.

The conversion-factor decrease is only the starting point. CMS's specialty-impact table measures the effects of changes in work, practice-expense, and malpractice RVUs, but does not incorporate the separate conversion-factor decline. Consequently, organizations should apply the applicable conversion-factor reduction on top of the specialty-specific RVU impact when estimating actual 2027 Medicare professional revenue.

CMS projects particularly significant RVU-related decreases—before applying the conversion-factor reduction—for:

- Dermatology: approximately 9% overall reduction.
- Otolaryngology: approximately 9% overall, including about 10% in nonfacility settings.
- Colon and rectal surgery: approximately 4% overall, but about 9% in nonfacility settings.
- Podiatry: approximately 4% overall.
- Physician assistants: approximately 3% overall and approximately 5% in nonfacility settings.

Projected RVU gains include approximately 11% for clinical psychologists, 12% for clinical social workers, 3% for physical and occupational therapy, 3% for radiation oncology, and 3% for vascular surgery. These gains, however, would also be reduced by the applicable conversion-factor decline.

Financial significance: Independent practices face a direct reduction in Medicare revenue per service. Hospitals and health systems will see lower professional revenue from employed physicians

and provider-based physician groups, with the largest losses concentrated in procedure-oriented specialties. The hospital facility payment itself generally is not affected by the PFS conversion factor.

Page references: PDF pp. 9 and 1145–1151.

2. Major Practice-Expense Methodology Overhaul Redistributes Payments Among Specialties and Sites of Service

CMS proposes to phase out the Indirect Practice Cost Index, or IPCI, portion of the practice-expense methodology. The IPCI relies heavily on specialty-level cost information originating in surveys from 2007 or earlier and currently rescales code-level practice-expense RVUs to approximate historic specialty-level costs.

Under the proposal:

- In CY 2027, only one-half of the IPCI variation would be applied.
- In the second year, the IPCI would no longer be applied.
- Steps 12 through 17 of the current practice-expense methodology would be eliminated.
- CMS would apply a new practice-expense stabilization adjustment that generally limits annual practice-expense RVU changes to 5% for eligible codes, although other revaluation and statutory adjustments may produce changes greater than 5%.

This change is a major reason for the specialty redistributions described above. CMS attributes much of the projected decline for dermatology, otolaryngology, orthopedic surgery, and hand surgery to the IPCI proposal, together with the same-day E/M reduction discussed in the next section. Behavioral health, therapy, diagnostic testing, and some imaging specialties generally fare better.

Of particular concern to hospitals, CMS also asks whether its current assumption that a hospital-employed physician incurs 50% of the indirect practice expense associated with a service furnished in a facility is accurate. CMS explicitly asks whether the appropriate amount could be less than 50%, potentially even 0%, because some administrative, occupancy, and overhead expenses may already be covered through the hospital's OPPS or other facility payment. This is formally a request for comment rather than a CY 2027 payment proposal, but it signals possible future reductions in facility-based professional payments.

Financial significance: The immediate proposal redistributes billions of dollars of PFS allowed charges among specialties. The longer-term hospital risk is more substantial: CMS is questioning whether professional payments to hospital-employed physicians should continue to include the current level of indirect overhead when the hospital separately receives a facility payment.

Page references: PDF pp. 26–28, 53, and 1146–1151.

3. Fifty-Percent Reduction for Same-Day E/M Visits and Global Procedures

CMS proposes to reduce payment when the same physician—or another physician in the same group—reports a separately identifiable office or outpatient E/M visit on the same day as a procedure with a 0-, 10-, or 90-day global period.

Under the proposed multiple-service methodology:

- The most expensive service, whether the E/M visit or the procedure, would be paid at 100%.
- Each additional E/M service or global procedure furnished that day would be paid at 50%.

- The policy would apply even when the E/M service appropriately qualifies for modifier -25 as a significant, separately identifiable service.

CMS argues that efficiencies occur when an E/M visit and a procedure are furnished by the same practice on the same day and that current payments duplicate certain clinical labor and practice expenses.

CMS estimates that the largest negative effects would fall on:

- Otolaryngology.
- Dermatology.
- Podiatry.
- Hand surgery.
- Physician assistants.
- Colon and rectal surgery.

These specialties frequently perform an examination, make a clinical decision, and complete a minor procedure during the same encounter.

Financial significance: This is a direct utilization-driven payment reduction rather than a general conversion-factor cut. Practices should identify all 2025 and 2026 claims containing modifier -25 and a same-day global procedure and model a 50% reduction on the lower-valued service. Hospital-owned specialty practices and provider-based clinics could experience significant professional-revenue reductions, although the associated hospital outpatient facility payment is not directly reduced by this proposal.

The policy could also create pressure to schedule the procedure on a different day, increasing patient inconvenience, billing complexity, and potentially total program spending.

Page references: PDF pp. 199–203 and 1151–1152.

4. G2211 Would Be Replaced by Percentage-Based Modifiers, Including a Larger ACO Payment

CMS proposes to replace the current fixed-dollar G2211 office/outpatient E/M complexity add-on with two percentage-based modifiers.

MOD1

MOD1 would replace G2211 for longitudinal or otherwise complex office/outpatient E/M care. It would increase payment for the underlying E/M service by 16%. Unlike the current fixed-dollar add-on, the payment would increase with the level of the base E/M code.

MOD2

MOD2 would increase the underlying E/M payment by 32% and would be available only to:

- Practitioners participating through a Medicare Shared Savings Program ACO.
- Participant providers in the Long-term Enhanced ACO Design, or LEAD, Model.

Use would be voluntary. Qualifying practitioners could report MOD2 for services furnished to all of their Medicare beneficiaries, not only beneficiaries assigned or aligned to the ACO. Claims carrying MOD2 would nevertheless be included in Shared Savings Program assignment calculations, historical benchmarks, and performance-year expenditures.

Financial significance: MOD2 could materially increase fee-for-service revenue for primary care physicians and other clinicians furnishing substantial volumes of longitudinal E/M services. It creates a new direct financial advantage for joining or remaining in a qualifying ACO.

For hospital-led ACOs, however, the increase is not entirely "free money." The additional professional payments would be counted in the ACO's expenditures. Thus, higher physician revenue could be partially offset by lower shared savings or increased shared-loss exposure. Hospital systems will need to model the MOD2 revenue at the employed-practice level and its corresponding effect on the ACO benchmark.

MOD1 is likely to redistribute payments among E/M levels because a percentage methodology produces lower additions for lower-level visits and larger additions for higher-level visits than a flat-dollar code.

Page references: PDF pp. 171–184 and 1152.

5. Remote Patient and Therapeutic Monitoring Would Face Tighter Billing and Staffing Restrictions

CMS proposes several major changes to remote physiologic monitoring and remote therapeutic monitoring:

- RTM would be limited to established patients.
- A practitioner beginning RPM or RTM would have to furnish a separately reportable initiating visit.
- Clinical-staff time could be counted only when the staff are direct employees of the billing practitioner or practice.
- Practices could no longer bill Medicare for clinical-staff monitoring work performed by a third-party contractor.
- CMS proposes valuation changes based on evidence that remote-monitoring devices may now cost less than assumed in the original code valuations.
- CMS is considering replacing the existing 17 RPM and RTM codes with four bundled G-codes covering setup, equipment, data transmission, and treatment management.

The direct-employment proposal would not require staff to be physically present in the office, but they would have to be employed by the billing practice and satisfy applicable incident-to and general-supervision requirements.

Financial significance: Many remote-monitoring programs currently depend on outside vendors that provide equipment, monitoring staff, patient outreach, documentation, and billing support. Under the proposal, a practice could continue using vendors for technology or administrative services, but could not count contractor clinical-staff time toward the Medicare time-based codes.

Hospital-owned practices would have to:

- Bring monitoring nurses or other clinical personnel onto the hospital or medical-group payroll.
- Restructure vendor contracts.
- Accept lower monitoring capacity.
- Or discontinue billing for affected services.

Bundling could simplify claims but may reduce revenue for organizations that now legitimately bill multiple component codes. The final effect cannot be calculated until CMS establishes final code descriptors and RVUs.

Page references: PDF pp. 149–160.

6. Mandatory Ambulatory Specialty Model Places Broad Professional Revenue at Risk

The Ambulatory Specialty Model was finalized in the CY 2026 rule; this proposed rule makes technical, scoring, quality-measure, rural, and collaborative-care refinements before the model begins on January 1, 2027.

ASM is a mandatory five-year model, running from 2027 through 2031, for selected specialists located in designated geographic areas. It targets:

- Heart failure, principally involving cardiologists.
- Low back pain, involving anesthesiology, interventional pain management, pain management, neurosurgery, orthopedic surgery, and physical medicine and rehabilitation.

Participation is determined at the individual TIN/NPI level using specialty, historical episode volume, and location.

Participants are scored on quality, cost, improvement activities, and promoting interoperability. The resulting adjustment applies two years later to all Medicare Part B covered professional services billed by the participant, not merely claims associated with heart failure or low back pain.

Payment adjustments range from:

- Negative 9% to positive 9% during the first two ASM payment years.
- Gradually increasing to negative 12% to positive 12% in the final payment year.

Financial significance: A hospital-employed cardiologist or orthopedic surgeon selected for ASM could have the adjustment applied to the clinician's entire Medicare professional book of business. The adjustment is clinician-specific, so two physicians in the same hospital group could receive materially different payment multipliers.

Hospital facility payments are not directly adjusted. Nevertheless, the model is intended to reduce avoidable hospitalizations, imaging, and low-value procedures, creating possible reductions in downstream inpatient and outpatient volume. The rule's proposed refinements to collaborative care arrangements may allow hospitals, physician groups, and other parties to structure financial relationships around model performance, subject to documentation and compliance requirements.

Page references: PDF pp. 345–430; core financial-model provisions at pp. 345–353.

7. Extensive Shared Savings Program Changes Alter Hospital and Physician ACO Economics

The rule contains several interrelated proposals affecting ACO benchmarks, sharing rates, and cash flow.

Higher BASIC Level E Sharing Rate

For agreement periods beginning on or after January 1, 2027, CMS would increase the maximum BASIC Level E sharing rate from 50% to 60%. Using 2024 results, CMS estimates that applying a 60% rate to 104 Level E ACOs would have increased shared-savings payments by approximately

$110.6 million, or approximately $1.35 million per ACO on average. This is an illustration using historical performance, not a guaranteed future increase.

Less Favorable Regional Adjustment for Some ENHANCED ACOs

CMS would reduce the maximum positive regional-adjustment weight for lower-spending ACOs in the ENHANCED track from 50% to 35%. Efficient ACOs whose spending is already below their regional market could receive a lower benchmark and therefore have less room to earn shared savings.

Greater Recognition of Prior Savings

The prior-savings-adjustment scaling factor would increase from 50% to 75%, helping ACOs retain more recognition for savings generated during earlier agreement periods and partially mitigating the "ratchet effect" when benchmarks are rebased. CMS also proposes to risk-adjust the existing 5% cap on certain positive benchmark adjustments.

New Growth Adjustment

CMS proposes an additional benchmark adjustment for ACOs that recruit clinicians and beneficiaries who are inexperienced with Shared Savings Program or similar accountable-care arrangements. The growth adjustment would be combined with other positive adjustments but would remain subject to the applicable 5% cap.

Part B Cost-Sharing Support

Beginning as early as April 1, 2027, CMS-approved ACOs could enter voluntary agreements with ACO participants to reduce or eliminate deductibles and coinsurance for selected Part B services. Prescription drugs and DMEPOS would be excluded. The ACO would have to reimburse participating providers from its own funds under written agreements.

Prepaid Shared Savings Sunset

CMS proposes one final 2027 cohort and would stop distributing prepaid shared-savings payments after December 31, 2027. Existing repayment and reporting obligations would continue.

Financial significance: Physician-led BASIC Level E ACOs generally receive the clearest upside. Some established, low-spending hospital-led ENHANCED ACOs could lose benchmark headroom because of the reduced regional adjustment. Cost-sharing support may improve adherence and utilization of high-value care but requires the ACO to fund the waived amounts. Each ACO will need a beneficiary-level benchmark simulation rather than relying on the rule's national averages.

Page references: PDF pp. 684–689, 693–723, 750–770, and 790–806.

8. New 340B Requirements Create Mandatory Part D Reporting and Medicare-Enrollment Exposure

The proposed rule contains two major 340B changes. Neither proposal establishes a new reduction in the Medicare Part B payment rate for 340B drugs. The changes concern Part D inflation-rebate identification and covered-entity reporting.

A. Mandatory Medicare Part D Claims Data 340B Repository

Beginning with Part D claims dated January 1, 2027 or later, every covered entity subject to the proposal would have to submit information for Part D prescriptions identified as 340B, including prescriptions dispensed by:

- The entity's in-house pharmacy.
- Contract pharmacies.
- Other contractors or third-party administrators.
- Retrospective replenishment arrangements.

For each claim, the covered entity would submit:

1. Date of service or fill date.
2. Prescription or service reference number.
3. Fill number.
4. Dispensing pharmacy NPI.
5. Eleven-digit NDC.
6. The covered entity's 340B ID and name as shown in OPAIS.

Submissions would be due quarterly, no later than the end of the following calendar quarter. Every submission would require certification that:

- The submitted claims are verified 340B claims.
- The submission includes all known Part D 340B claims for the period.
- The submitter is authorized to act for the covered entity.

A TPA may make the submission, but the covered entity remains responsible for completeness and accuracy. CMS proposes to connect the reporting obligation to Medicare enrollment requirements and states that failure to comply could support revocation of the provider's Medicare enrollment and associated provider agreement.

CMS estimates approximately:

- 14,000 affected 340B providers.
- Four submissions per provider annually.
- Eight labor hours per submission plus a one-time registration hour.
- 462,000 aggregate annual labor hours.
- $52.37 million in aggregate estimated labor costs.

That equals roughly $3,740 per covered entity using CMS's aggregate assumptions, but it likely understates expenses for entities that must modify split-billing systems, pharmacy data feeds, contract-pharmacy agreements, and TPA contracts.

CMS says the repository data would initially be used for testing and validation, not for calculating inflation rebates. A future decision to use repository data in rebate calculations would require separate notice-and-comment rulemaking. CMS also states that repository data would not be made available to manufacturers or Part D plans.

B. New ADAP 340B Identification Methodology

CMS also proposes to treat all Part D prescription-drug-event records for beneficiaries identified as having AIDS Drug Assistance Program supplemental coverage as 340B-eligible, subject to

protections against double counting. These units would be removed from Part D inflation-rebate calculations.

CMS acknowledges that the methodology could overestimate 340B use because ADAP formularies and purchasing structures differ by state. CMS nevertheless found that the change would meaningfully increase the identification of 340B units for antiretroviral drugs while having minimal effects on most other drug classes. The change would apply to the rebate period beginning October 1, 2025.

Financial significance: The ADAP change generally reduces manufacturer inflation-rebate exposure by excluding more 340B units. For hospitals and other covered entities, the dominant financial issue is the mandatory repository: new IT, pharmacy, TPA, certification, and compliance expenses, coupled with an unusually significant potential sanction—Medicare enrollment revocation.

Page references: PDF pp. 492–511 and 1101–1103.

9. Clinical Laboratory Fee Schedule Reductions Could Affect Hospital Outreach and Physician-Office Laboratories

The rule implements statutory changes to the Clinical Laboratory Fee Schedule reporting cycle:

- The applicable private-payer data-collection period is January 1 through June 30, 2025.
- The corresponding reporting period is May 1 through July 31, 2026.
- Revised private-payer-based rates would apply beginning in 2027.
- Individual test rates could be reduced by as much as 15% per year in 2027, 2028, and 2029, compared with the preceding year's payment.

Because the maximum reduction is applied annually, a test subjected to the full permitted decrease in each of the three years could be paid approximately 39% less in 2029 than in 2026 on a compounded basis.

Financial significance: The most direct exposure falls on:

- Independent laboratories.
- Physician-office laboratories.
- Hospital outreach laboratories and other hospital laboratory services billed separately under the CLFS.
- Certain laboratory joint ventures and management arrangements.

The reduction does not automatically apply to every test; each test's rate will depend on the weighted median of reported private-payer rates. Nevertheless, laboratory organizations should model high-volume tests against multiple reduction scenarios.

CMS notes that independent laboratories receive approximately 83% of their Medicare revenue under the CLFS. Hospitals may have a more diversified laboratory payment mix, but outreach programs with narrow margins could face significant reductions.

Page references: PDF pp. 337–341 and 1157.

10. MIPS Would Move Toward Mandatory Specialty-Specific Reporting, Affecting Future Professional Payments

CMS proposes to sunset traditional MIPS reporting for most clinicians and require reporting through a MIPS Value Pathway, or MVP, beginning with the CY 2029 performance period, affecting CY 2031 payments. Clinicians reporting through the APM Performance Pathway would be excepted. Virtual groups would also become eligible for MVP reporting.

For the 2027 performance period, CMS proposes three new MVPs:

- Diabetic Disease.
- Hypertension.
- Hospitalist.

The Hospitalist MVP would apply to physicians and nonphysician practitioners who furnish hospitalist services and would include measures relating to heart-failure medication, advance-care planning, and other hospital-care outcomes.

The proposal would also:

- Make the electronic prior-authorization measure optional, with bonus points, for the 2027 performance period.
- Move mandatory electronic prior-authorization reporting to the 2028 performance period.
- Modify quality-measure benchmarking, topped-out measure scoring, and improvement activities.
- Continue applying MIPS adjustments to all covered Part B professional services in the applicable payment year.

Financial significance: Although the full MVP mandate would not affect payments until 2031, hospitals must prepare now because employed physicians frequently report MIPS as groups or subgroups using health-system EHR and quality infrastructure. The new Hospitalist MVP creates particular implications for hospital-employed hospitalists, nurse practitioners, physician assistants, and clinical nurse specialists.

Failure to align EHR workflows, clinician attribution, measure collection, and group/subgroup reporting could place a health system's entire employed professional revenue stream at risk for negative MIPS adjustments. Conversely, specialty-specific reporting may produce more favorable scores for groups whose performance is not well represented under traditional MIPS.

Page references: PDF pp. 875–896, 1000–1002, and 1118–1120.

Overall Financial Assessment

The most immediate negative financial provisions are:

1. The 1.19% or 1.68% conversion-factor decrease.

2. The modifier -25 same-day payment reduction.

3. Practice-expense redistribution away from several procedure-oriented specialties.

4. New staffing and billing restrictions for remote monitoring.

5. Potential CLFS reductions beginning in 2027.

The largest potential opportunities are:

- The 32% MOD2 E/M adjustment for qualifying ACO practitioners.
- The 60% BASIC Level E shared-savings rate.
- Higher payments for certain behavioral health, therapy, diagnostic, and radiation-oncology services.
- Potential positive ASM adjustments for high-performing specialists.

For hospitals, the most important strategic concern is that CMS is increasingly linking physician professional revenue to site of service, total cost of care, ACO participation, and specialty-specific performance, while simultaneously questioning the amount of indirect practice expense that should be paid to hospital-employed physicians.

Primary Sources

Proposed rule: Federal Register public-inspection PDF (2026-14327)