CY 2027 Medicare Physician Fee Schedule Final Rule

Executive Summary | November 4, 2026

Effective January 1, 2027, except where otherwise specified. This memorandum prioritizes the principal payment and policy changes and compares the final rule with the July proposed rule.

Final rule: https://www.federalregister.gov/d/2026-22743

Final rule PDF: https://public-inspection.federalregister.gov/2026-22743.pdf

1. Physician Payment: Larger Reductions Than Proposed

CMS finalized lower CY 2027 conversion factors than originally proposed, principally reflecting expiration of the temporary 2.5% increase for 2026 and a final negative budget-neutrality adjustment. The statutory updates remain 0.75% for qualifying Advanced APM participants and 0.25% for others.

Payment category	Proposed	Final	Change vs. 2026
Qualifying APM practitioners	$33.17	$32.95	−1.83%
Other practitioners	$32.84	$32.63	−2.31%

Compared with the proposed positive 0.53% budget-neutrality adjustment, CMS finalized a negative 0.12% adjustment. Specialty-level results will differ according to changes in relative value units and practice-expense allocations. For hospital-employed medical groups, the headline conversion-factor change does not represent the full revenue impact.

2. Same-Day E/M and Procedures: Proposed Cuts Narrowed

The proposed rule would have paid the highest-valued service at 100% and reduced other separately billed same-day E/M or procedural services to 50%, for procedures with 0-, 10-, and 90-day global periods. The final rule instead applies a smaller 20% reduction (80% payment) only to eligible services associated with 0-day global procedures; 10- and 90-day procedures are excluded from this new reduction.

This is one of the most material revisions from the proposal and substantially limits potential losses for surgical and outpatient procedural practices.

3. Practice Expense RVUs: Reform Retained With Transition

CMS retains its reform of indirect practice-expense calculations, including movement away from the specialty-specific indirect practice cost index based on older expense data. The final rule establishes a two-year transition for phaseout of that index and updates indirect expense allocation, including treatment of services in skilled nursing facilities.

These changes may materially redistribute reimbursement among specialties and sites of service, even where conversion factors change uniformly. Hospital systems should review the final specialty-level impact tables rather than assume proportional payment reductions.

4. Primary Care: New 16% and 32% Complexity Adjustments

CMS finalized replacement of the separate office/outpatient E/M complexity add-on, G2211, with two modifiers: B1 increases qualifying E/M payment by 16%, while B2 increases payment by 32% for qualifying practitioners in Medicare Shared Savings Program ACOs or the Long-term Enhanced ACO Design (LEAD) Model. Eligible ACO practitioners may use B2 for Medicare beneficiaries beyond those assigned to the ACO, subject to the rule's conditions.

Comparison: The percentages and overall policy were retained substantially as proposed; the proposed placeholder modifiers were designated B1 and B2 in the final rule. The change increases the economic significance of eligible ACO participation for integrated primary care groups.

5. Remote Patient and Therapeutic Monitoring: Staffing Rule Delayed

CMS finalized new limitations on remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM), including established-patient and separately reportable initiating-visit requirements, as applicable, and valuation changes. However, CMS deferred the proposal requiring monitoring clinical staff to be employed by the billing practice rather than supplied under contract.

Comparison: The proposed staffing requirement would have begun in 2027; the final rule delays implementation to January 1, 2029. CMS also did not adopt the proposed broad conversion of existing monitoring CPT codes into four replacement HCPCS codes. This provides significant additional time for health systems using contracted monitoring vendors.

6. Accountable Care Organizations: Stronger Incentives

CMS finalizes additional Medicare Shared Savings Program incentives, including opportunities for approved ACOs to reduce or eliminate Part B cost sharing on certain services to assigned beneficiaries beginning April 1, 2027; increased shared-savings opportunities for eligible ACOs; changes to benchmark predictability; and reduced administrative burdens.

Comparison: CMS largely retained the proposed expansion with refinements. Combined with the 32% B2 modifier, these policies increase incentives for health systems to consider eligible accountable care arrangements, while retaining the financial and quality-accountability obligations of those models.

7. MIPS: Traditional Reporting Continued Through 2030

CMS finalized a move away from traditional Merit-based Incentive Payment System (MIPS) reporting toward MIPS Value Pathways (MVPs) and Advanced APM arrangements. The final rule extends traditional MIPS reporting through performance year 2030, with discontinuation beginning in 2031—two years later than proposed. New MVPs cover diabetes, hypertension, and hospitalists; specialty-specific core-measure reporting begins in 2027.

Comparison: The transition date is deferred two years, giving large employed physician organizations additional time to update reporting systems and workflows.

8. 340B Part D Reporting: Start Date Retained, Deadline Deferred

Beginning with covered Part D prescriptions dispensed January 1, 2027, 340B covered entities must capture and report specified data needed for administration of the Part D Drug Inflation Rebate Program and prevention of duplicate discounts, including applicable contract-pharmacy prescriptions.

Comparison: CMS maintained the substantive reporting requirement but moved the first quarterly submission, for January–March 2027 dispensing, to September 30, 2027. Thus, hospitals must capture data beginning January 1 even though the initial reporting deadline is delayed.

9. Expanded Preventive, Behavioral Health and Rural Services

CMS finalized additional separate reimbursement for shared medical appointments, including an extended-time code, as well as higher payment valuations for smoking cessation, substance-use screening and brief intervention, and psychiatric collaborative care. It also adds separate qualifying Rural Health Clinic visits for diabetes self-management training and medical nutrition therapy. New HCPCS codes G0572 and G0573 support advance-care-planning services furnished by clinical staff under direct supervision.

Comparison: These expansions were largely finalized as proposed, with refinements to shared medical appointment coding. They support physician and hospital programs addressing chronic disease, nutrition, behavioral health and longitudinal care.

10. Other Provisions

CMS pauses existing global-surgery postoperative visit data collection, addresses statutory RHC/FQHC telehealth extensions through December 31, 2027, implements statutory clinical laboratory payment protections, refines the Ambulatory Specialty Model for heart failure and low back pain, and implements statutory eligibility limitations affecting certain noncitizens.

Principal Changes From the Proposed Rule

Issue	**Final disposition**
Conversion factors	Worse than proposed: −1.83% / −2.31%
Same-day procedure/E/M	20% cut vs. proposed 50%; limited to 0-day procedures
RPM/RTM staffing	Contracted-staff restriction delayed to 2029
Traditional MIPS	Transition delayed to 2031
340B Part D reporting	First quarterly submission delayed to Sept. 30, 2027
Primary care / ACOs	16% and 32% E/M modifiers largely finalized as proposed