VIZIENT OFFICE OF PUBLIC POLICY AND GOVERNMENT RELATIONS

CY 2027 Physician Fee Schedule Proposed Rule Summary

MEDICARE AND MEDICAID PROGRAMS; CY 2027 PAYMENT POLICIES UNDER THE PHYSICIAN FEE SCHEDULE AND OTHER CHANGES TO PART B PAYMENT AND COVERAGE POLICIES; MEDICARE SHARED SAVINGS PROGRAM REQUIREMENTS; AND MEDICARE PRESCRIPTION DRUG INFLATION REBATE PROGRAM

August 4, 2026

BACKGROUND & SUMMARY

On July 14, the Centers for Medicare & Medicaid Services (CMS) issued the annual proposed rule to update the Calendar Year (CY) 2027 Medicare payment and policies for the Physician Fee Schedule (PFS) (hereinafter, "Proposed Rule"). The Proposed Rule revises payment polices under the Medicare PFS, including changes related to practice expense (PE) relative value units (RVUs) calculations and billing of the evaluation and management (E/M) Visit Complexity Add-On Code (HCPCS Code G2211). Also, CMS proposes regulations to implement the Medicare Inflation Rebate Program, Consolidated Appropriations Act of 2026 (e.g., telehealth provisions), and the Working Families Tax Cut (WFTC) legislation's[1] provisions related to limiting Medicare coverage of certain individuals.

In addition, CMS proposes modifications to the Ambulatory Specialty Model (ASM), which is a mandatory payment model that will launch January 1, 2027 (summary of the ASM will be available here in the coming days). CMS also proposes updates the Medicare Shared Savings Program (SSP) and Quality Payment Program (QPP), including the sunset of the traditional Merit-based Incentive Payment Systems (MIPS) where MIPS Value Pathways (MVPs) will be the only reporting option for MIPS beginning with the CY 2029 performance period/2031 MIPS payment year.

Comments are due **September 14, 2026**, and most policies, if finalized, would go into effect January 1, 2027. Vizient looks forward to working with our provider clients to inform our comments to CMS.

PFS UPDATES

CALCULATION OF THE PROPOSED CY 2027 PFS CONVERSION FACTOR

There are three components that must be considered to value each service under the PFS – work, practice expense (PE), and malpractice (MP) relative value units (RVUs). Each component is adjusted by geographic price cost indices (GPCIs), which reflect variations in the costs of furnishing services compared to the national average cost for each component. Then, the RVUs are converted to dollar amounts via the application of a conversion factor (CF), which is calculated by CMS's Office of the Actuary (OACT). Finally, the Medicare PFS payment amount (based on the below formula) for a given service and fee schedule area is calculated based on the previously discussed metrics.

PFS Payment = [(WorkRVU x WorkGPCI) + (PE RVU x PE GPCI) + (MP RVU x MP GPCI)] x CF

Since CY 2026, as required by statute[2], there have been two separate CFs: one for items and services furnished by a qualifying Advanced Alternative Payment Model participant (qualifying APM CF) and another for other items and services furnished by a non-qualifying APM participant (referred to as the nonqualifying APM conversion factor). For CY 2027, the proposed qualifying APM CF is 33.1693 and the proposed non-qualifying APM conversion factor is 32.8409. Both conversion factors are a decrease from the CY 2026 conversion factors. The decrease is largely driven by the expiration of the 2.50 percent statutory boost to the CF,[3] as shown in Tables 1 and 2.[4]

[1] Section 71201 of Public Law 119-21, also referred to as the One Big Beautiful Bill Act
[2] Section 1848(d)(1)(A) of the Social Security Act
[3] https://www.congress.gov/bill/119th-congress/house-bill/1/text
[4] The payment impact of the proposed policies by specialty is shown in Table D-B5 of the Proposed Rule (pg. 44244).

Table 1. Calculation of the CY 2027 PFS Qualifying APM Conversion Factor

Calculation of the Proposed CY 2027 PFS Qualifying APM Conversion Factor		
CY 2026 Conversion Factor		**33.5675**
Conversion factor without one-year 2.5 percent increase		**32.7488**
CY 2027 Qualifying APM Update Factor	0.75 percent (1.0075)	
CY 2027 RVU Budget Neutrality Adjustment	0.53 percent (1.0053)	
CY 2027 Conversion Factor		**33.1693**

Table 2. Calculation of the CY 2027 PFS Non-Qualifying APM Conversion Factor

Calculation of the Proposed CY 2027 PFS Non-Qualifying APM Conversion Factor		
CY 2026 Conversion Factor		**33.4009**
Conversion factor without one-year 2.5 percent increase		**32.5863**
CY 2027 Non-Qualifying APM Update Factor	0.25 percent (1.0025)	
CY 2027 RVU Budget Neutrality Adjustment	0.53 percent (1.0053)	
CY 2027 Conversion Factor		**32.8409**

PRACTICE EXPENSE RELATIVE VALUE UNITS

The PE is the portion of the resources used in furnishing a service that reflects the general categories of physician and practitioner expenses, such as office rent and personnel wages, but excluding MP expenses. Direct expense categories include clinical labor, medical supplies, and medical equipment. Indirect expenses include administrative labor, office expenses, and all other expenses. PE RVUs are developed considering the direct and indirect practice resources involved in furnishing a service.

Indirect Practice Expense Methodology

Allocation

Currently, CMS allocates the indirect costs at the code level based on the direct costs specifically associated with a code and the greater of either the clinical labor costs or the work RVUs. In addition, CMS relies in part on specialty-specific indirect PE per hour (PE/HR) data (e.g., AMA Physician Practice Information Survey (PPIS), supplemental survey data). CMS notes that in recent years the agency has re-examined this approach because the agency believes the policy effectively allocates a larger share of indirect PE RVUs to services that can be reported using technical, professional, and global components, especially when compared to services the can only be reported as a global service.[5] As a result, CMS proposes to allocate indirect PE using both the work RVU and the clinical labor RVU for all services, except for codes with 010- and 090-day global periods.

Phase-Out of the Indirect Practice Cost Index (IPCI)

Several steps of the PE methodology rely on the indirect practice cost index (IPCI) which relates to each specialty's overhead costs and is based on the AMA's 2007 PPIS. CMS proposes to remove the steps of the PE RVU methodology that rely on the IPCI (steps 12-17). CMS believes these steps effectively favor the aggregate specialty-level survey data over the code-level inputs and limit the influence of allocation methodologies. Under this proposal, the total PE RVU, prior to the calculation of the final PE RVUs, would be the sum of Direct Cost PE RVUs (step 5) and Indirect Cost PE RVUs (step 11). CMS proposes to remove steps 12-17 over a two-year period. In the first year, only half of the measured variation in the IPCI will be applied to the indirect allocator. In the second year, the IPCI will no longer be applied. The agency's proposal to phase out the use of the IPCI in the PE methodology will result in significant changes to PE RVUs for services before the stabilization factor (described below) is applied. As a result of changes to the PE RVU, depending on the service, future reimbursement may be less consistent in the coming years.

[5] CMS clarifies that services that can only be reported as a global service depend on the maximum (rather than the sum) of clinical labor and PE RVUs and Physician Work RVUs. CMS refers readers to a RAND Report which addresses approaches to improving the accuracy of the other PFS services relative to services that have a professional and technical component. The report is available at: https://www.rand.org/pubs/research_reports/RRA4720-2.html.

Stabilization Factor

To prevent volatility in PE RVUs, CMS proposes to apply a PE stabilization factor for each code's PE RVU. As a result of the PE stabilization factor, annual changes in code PE RVUs would be capped at 5 percent.[6] CMS clarifies the PE stabilization factor would be applied prior to the phase-in of certain RVU reductions required by statute.[7] This statutory phase-in limits all codes that are not new or revised to a 19 percent decrease in total RVU in an individual calendar year. As a result, a code may be impacted by both the PE stabilization adjustment and statutory phase-in. However, CMS clarifies the PE stabilization factor would not apply to new or revised codes or certain codes that are newly nationally priced since the comparison PE RVU for those codes is unclear. **CMS seeks comments on an approach that would allow the agency to expand the PE stabilization adjustment to new or revised codes and certain codes that are newly nationally priced.**

Information about each of the steps of the indirect PE methodology is available in the Proposed Rule (pgs. 43846-43851).

Updates to the PE Methodology – Site of Service Payment Differential

In the CY 2026 PFS Final Rule, CMS finalized policy to allocate half the amount of indirect PE RVUs per work RVU for services furnished in the facility setting compared to those allocated to services furnished in the non-facility setting. As a result of the 2026 policy, there has been a significant payment differential for physician visits (certain E/M visits) in nursing facility settings because whether a visit is furnished in the facility or non-facility setting depends on whether the beneficiary's stay is covered under Part A. For purposes of PFS payment, a service furnished to a patient in a skilled nursing facility during a Part A hospital stay (place of service 31) is considered to be in the ''facility'' setting, while a service furnished to a patient in the same setting but covered by Part B (place of service 32) is considered to be in the ''non-facility'' setting.[8] Meaning, billing and reimbursement was based on the beneficiary's status only (i.e. Part A versus Part B stay) in that setting, rather than the setting of care itself. To address this issue where reimbursement for certain physician visits in the same site of care is different for CY 2027, CMS proposes to equalize the rate for nursing facility visits without regard to the beneficiary's status by setting the facility PE RVU equal to the non-facility PE RVU for certain nursing facility related CPT codes.[9]

In addition, CMS indicates that certain parties have stated that the facility PE reductions have had a disparate effect on hospital medicine groups and hospitalists, particularly those that operate independently from their hospital or health systems. **As a result, CMS seeks comment on how PE costs vary for physicians and other professionals, not only based on whether they practice in part or exclusively in a facility setting but also based on how their costs vary when they are employed by health systems, hospitals, or other entities.**

Also, CMS seeks comment on the amount of indirect PE hospital-employed physicians incur when they furnish care within a facility (e.g., For these physicians, is the 50 percent indirect PE allocation accurate or could it possibly be less than 50 percent, such as 0 percent?). CMS requests comment on whether a new HCPCS modifier for employed physicians would be a reasonable way to identify and reduce facility PE from the services they perform in the facility setting, or whether there are other methods CMS could consider. Additional questions related to this topic are in the Proposed Rule (pg. 43861).

Strategies to Improve Payment Transparency, Accuracy, and Congruency Across Payment Systems

Professional and Technical Components

Most PFS services are valued at two amounts considering the site of service (i.e., non-facility setting and facility setting). However, other codes (e.g., diagnostic and imaging services) may be billed with a professional component (PC) modifier and technical component (TC) modifier, or without modifiers (global codes) that are paid for the complete global service. CMS

---

[6] CMS clarifies the 5 percent cap would apply after the cognitive services floor and other code-level adjustments.

[7] Section 1848(c)(7) of the Act, which was add in 2014, specifies that for services that are not new or revised codes, if the total RVUs for a service for a year would otherwise be decreased by an estimated 20 percent or more as compared to the total RVUs for the previous year, the applicable adjustments in work, PE, and MP RVUs must be phased in over a 2- year period. In implementing the phase-in, CMS considers a 19 percent reduction as the maximum 1-year reduction for any service not described by a new or revised code. This approach limits the year 1 reduction for the service to the maximum allowed amount (that is, 19 percent), and then phases in the remainder of the reduction. A detailed description of the phase-in methodology is provided in the CY 2016 PFS Final Rule.

[8] For purposes of PFS payment, a service furnished to a patient in a skilled nursing facility during a Part A hospital stay (place of service 31) is considered to be in the "facility'' setting, while a service furnished to a patient in a Part B stay (place of service 32) is considered to be in the "non-facility'' setting, per the Medicare Claims Processing Manual (MCPM), Chapter 12, Section 20.4.2

[9] CPT Codes 99304-99310 and 99315-99316

indicates that these differences in how payments are constructed and displayed can make it difficult for the agency to evaluate relative payment rates, underlying resource costs, and value across settings of care. CMS believes these challenges are compounded by differences across Medicare payment systems in how similar services are defined, bundled, and paid.[10]

To facilitate more consistent comparisons across services and settings, CMS has developed a public use file that displays, for services that are not currently billable with TC/26 modifiers, RVU amounts that reflect the relative resources involved in furnishing professional and technical aspects of the services, which is available on the CMS website.[11] CMS indicates this file is intended to improve transparency regarding how PFS payments may be conceptually divided between physician professional and technical components of the services.

CMS emphasizes that in making the public use file available, the agency is not proposing changes to existing payment or billing at this time but that the file provides a foundation for future rulemaking. **CMS seeks comment on the utility of displaying RVUs associated with professional and technical aspects of services that are not currently billable with TC/26 modifiers, including how they may use this information to assess payment differences across settings. Also, CMS seeks comment on potential approaches CMS could consider in future rulemaking to improve transparency for services currently paid as globals. Specifically, CMS is interested in feedback on how the agency could develop methodologies to more clearly identify and, where appropriate, disaggregate the underlying components of these services.** Additional questions related to this topic are in the Proposed Rule (pg. 43862).

Global Surgical Packages

In the CY 2015 PFS Final Rule, CMS finalized a policy to transition all 10-day and 90-day globals to 0-day globals, allowing any post-operative visits furnished after the day of the procedure to be billed as a standalone visit. However, CMS was prohibited from implementing this policy based on requirements in the Medicare Access and CHIP Reauthorization Act (MACRA) and was required to collect data on how to best value globals. In the Proposed Rule, CMS outlines various data collection efforts since MACRA became law. CMS proposes to pause the data collection required by MACRA to reduce burden and questions whether a more robust data collection effort would be more appropriate.[12] **CMS also seeks input on whether the agency should require all providers to report CPT code 99024 (postoperative follow-up visit) and other data sources the agency might consider to more accurately value global surgical packages. CMS welcomes comments on potential reevaluation strategies that the agency may consider through future rulemaking.**

MEDICARE TELEHEALTH SERVICES

Proposals to Modify the Medicare Telehealth Services List

For CY 2027, CMS did not receive any requests to add or remove services from the Medicare Telehealth Services List but proposes to add five new HCPCS G-codes to the Medicare Telehealth Services List.[13] If finalized, these services would be paid under the PFS when furnished via telehealth. The proposed codes include:

- GACP1 and GACP2 – Advance care planning.
- GSMAS – Group-based medical sessions for patients with common medical conditions.
- GSLPP – Pediatric speech, language, voice, communication, and auditory processing disorder treatment.
- GADV1 – Evaluation and management services related to vaccine adverse effects.

---

[10] In the Proposed Rule, CMS provides, "For example, some payment systems incorporate technical inputs and facility resources into a single payment. This variation can obscure meaningful comparisons across sites of care and may complicate efforts to advance site-neutral payment policies aimed at reducing incentives for hospitals to acquire physician practices and limit site-of-care decisions based on financial considerations."

[11] Not all services are included in the file. For example, CMS has excluded 010- and 090-day global surgery services from display in this public use file since there are numerous ways to consider how the structure of payment for those codes may be best understood.

[12] CMS is also posting a public use file 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 data that was analyzed. This public use file shows the current work RVUs, the number of postoperative visits that are reported to CMS using no-pay HCPCS code 99024, and the work RVUs remaining if all postoperative visits are removed.

[13] These codes are outlined in the Proposed Rule (pgs. 43901-43902).

Proposal Implementing Consolidated Appropriations Act, 2026 Telehealth Flexibilities

The Consolidated Appropriations Act, 2026 (CAA, 2026)[14] extended existing telehealth flexibilities by temporarily (until December 31, 2027) removing geographic restrictions, allowing a broad range of originating sites, and permitting different types of practitioners to furnish Medicare telehealth services. In addition, the law delays in-person visit requirements for mental health services furnished through telehealth and extends flexibilities to allow audio-only Medicare telehealth services to January 1, 2028. In the Proposed Rule, CMS proposes Medicare regulations to implement the CAA, 2026's telehealth policies that extend existing flexibilities.

The CAA, 2026 also requires CMS to establish new telehealth billing modifiers to identify telehealth services furnished through certain virtual telehealth platform arrangements and telehealth services furnished incident to a physician's or practitioner's professional service. To implement this policy, CMS proposes creating modifiers BB and BC, effective January 1, 2027. These modifiers are for claims reporting purposes only and do not affect payment. CMS will issue implementation instructions through the agency's website and may provide updates to this policy through future subregulatory guidance.[15]

Telehealth Critical Care Consultations

In the CY 2026 PFS Final Rule, CMS permanently removed the limitation of one telehealth critical care consultation per day. Following this policy change, CMS received questions about whether the terms "initial" and "subsequent" in the critical care consultation code descriptors continued to imply frequency restrictions. To clarify billing requirements, CMS proposes revising the descriptors to align with time-based critical care coding conventions, with G0508 describing the first 30 to 74 minutes of a telehealth critical care consultation and G0509 describing each additional 30 minutes. **CMS requests comments on this proposal.**

Changes to Teaching Physicians' Billing for Services Involving Residents or Teaching Physicians with Virtual Presence

For CY 2027, CMS is proposing a modification to previously finalized policy that allows teaching physicians to have a virtual presence in teaching settings during three-way telehealth visits. Under the proposal, teaching physicians would be permitted to bill for telehealth services involving residents when either the teaching physician or the resident is physically present with the patient, rather than requiring the teaching physician, resident, and patient to all be in separate locations. CMS clarifies this policy would only be applicable to services that are on the Medicare Telehealth Services List.

MATERNITY CARE SERVICES

Historically, global maternity payment assumed 12 prenatal visits; updated American College of Obstetricians and Gynecologists (ACOG) guidance[16] recommends a more individualized approach, with approximately 8 visits for average-risk pregnancies and 13 visits for higher-risk pregnancies, plus additional visits as needed. The American Medical Association (AMA) and ACOG worked collaboratively to develop new maternity CPT codes. The AMA Relative Value Scale Update Committee (RUC) reviewed the new maternity codes, which assumed 12 prenatal visits in its utilization calculations. CMS believes that assumption overstates the typical number of prenatal visits and, as a result, undervalues the work associated with labor and delivery services. CMS proposes removing four prenatal evaluation and management (E/M) visits from the utilization estimate used in the crosswalk calculation and reallocating those relative value units (RVUs) to the new labor and delivery codes (CPT codes 59XX1-59XX8). This proposal results in a 15% increase in work RVUs for each labor and delivery code. CMS Table A-D2 in the Proposed Rule (pg. 43881) shows the RUC-recommended and CMS proposed work RVUs for the CPT codes.

In the Proposed Rule, CMS expresses concern that the new codes may be disruptive to how the existing coding structure accounted for clinical practice patterns. **CMS seeks comment on whether the agency should delay adoption of the new CPT maternity care codes and, as an alternative, create 15 new Medicare HCPCS G-codes that would preserve the**

[14] https://www.congress.gov/bill/119th-congress/house-bill/7148/text
[15] CMS did not specify a date for release of guidance.
[16] https://www.acog.org/news/news-releases/2025/04/new-acog-guidance-recommends-transformation-to-us-prenatal-care-delivery

current global maternity payment structure.[17] Also, CMS is seeking feedback on whether maintaining the current structure through G-codes would be preferable while the agency continues to assess how changes to maternity care coding and payment could affect maternal health outcomes.

REMOTE THERAPEUTIC MONITORING (RTM) AND REMOTE PHYSIOLOGIC MONITORING (RPM)

CMS proposes that, beginning in CY 2027, Remote Therapeutic Monitoring services may only be furnished to established patients, consistent with the policy that already applies to Remote Physiologic Monitoring services.[18] Under this proposal, practitioners would need to have an existing clinical relationship with a patient before billing Medicare for RTM services. CMS is proposing this change due to concerns about program integrity. Also, CMS seeks to ensure that remote monitoring services are provided within an established course of care.

CMS also proposes that, beginning in CY 2027, RPM and RTM services must be started through a separate initiating visit with the billing practitioner. The purpose of the visit is to ensure the practitioner evaluates whether remote monitoring is clinically appropriate for the patient, discusses the service, obtains the patient's consent, and establishes the care plan needed for effective monitoring. The initiating visit must be a face-to-face encounter, which can be in-person or via telehealth, and cannot be a service that is not separately billable under Medicare. CMS also clarifies that the visit can only serve as the initiating visit if RPM or RTM is actually discussed with the patient during that encounter. The initiating visit may be billed separately from the remote monitoring services themselves.

In addition, CMS proposes to eliminate Medicare payment for RPM and RTM services that are outsourced to third-party companies and instead require that these services be provided by clinical staff employed by the billing practitioner's practice. Under the proposal, beginning January 1, 2027, the time used to bill RPM or RTM services could count only if it is performed by clinical staff who are direct employees of the practitioner or the practitioner's practice and are working under the practitioner's general supervision. **CMS seeks comment on how common third-party contracting is today and whether this policy could affect patient access to remote monitoring services**.

Valuation of Codes

CMS proposes reducing Medicare payment for certain RPM and RTM device-related services because the agency is concerned that the current practice expense (PE) inputs may overstate the actual costs of the monitoring equipment. For RPM and RTM set-up and patient education codes (99453 and 98975), CMS proposes crosswalks to those used for self-measured blood pressure training services (CPT 99473). For RPM and RTM device supply codes (CPT 99454, 98976, 98977, 98978, 98984, 98985, and 98986), CMS proposes crosswalks to other existing monitoring services that CMS believes more accurately reflect the resources used in practice. **CMS seeks detailed information about the actual devices used, typical costs, pricing arrangements, and whether those costs include hardware, software, or both before finalizing any changes.**

In addition, CMS proposes removing the PE inputs from the RPM and RTM treatment management codes (CPT 99457, 99458, 98979, 98980, and 98981, and 99470), as the agency believes the costs of furnishing these services are already reflected in the physician work RVUs. CMS proposes maintaining the current work RVUs and physician work times for these codes while eliminating the associated PE inputs. CMS does not believe these services typically require additional clinical staff time or other practice expenses beyond the professional work involved in reviewing data, managing treatment, and communicating with patients. **CMS is seeking input from stakeholders on whether this assumption accurately reflects the typical clinical workflow for RPM and RTM treatment management services.**

---

[17] The proposed G codes are detailed in Table A–D3 in the Proposed Rule (pg. 43882).

[18] RPM represents the remote monitoring of parameters such as weight, blood pressure, and pulse oximetry to monitor a patient's condition and inform their management. The remote physiologic monitoring code set currently includes CPT codes 99091, 99445, 99453, 99454, 99457, 99458, 99470, 99473, and 99474. For RTM, there are distinct device supply codes for three types of therapeutic monitoring: respiratory system, cognitive behavioral therapy, and musculoskeletal system monitoring. The remote therapeutic monitoring code set currently includes CPT codes 98975, 98976, 98977, 98978, 98979, 98980, 98981, 98984, and 98985 (code descriptors in Table A-D6). There are three components of RPM and RTM services: education and setup, device supply, and treatment management.

SIMPLICATION OF RPM AND RTM BILLING CODES

CMS is considering updates to simplify the RPM and RTM billing codes and help ensure patients receive the full remote monitoring service. CMS is considering replacing the current 17 RPM and RTM billing codes with four new HCPCS G-codes to simplify billing, reduce administrative burden, and ensure patients receive all required components of remote monitoring services. These HCPCS G-codes would adopt all current conditions of payment for the remote therapeutic and remote physiologic codes finalized in prior rulemaking, as well as the proposed established patient, initiating visit, or supervision requirements, if finalized. The proposed G-codes would include:

- GRPM1- (RPM initial setup and patient education)
- GRPM2 - (Remote monitoring of physiologic parameters)
- GRTM1 - (RTM initial setup and patient education)
- GRTM2 - (Remote monitoring of physiologic parameters)

CMS is concerned that the growing number of RPM and RTM billing codes has made the system overly complex and administratively burdensome and that the current code structure may not adequately address concerns raised by the Department of Health and Human Services' (HHS) Office of Inspector General (OIG), including findings that many beneficiaries do not receive all of the required components of remote monitoring services**. CMS seeks comment on the proposed HCPCS G-codes and on any other revisions needed to the code descriptors to reflect the necessary service elements for this code family. CMS is also seeking feedback on how these new G-codes would be implemented in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). CMS also requests comment on how to value the proposed new G-codes.**[19]

EVALUATION AND MANAGEMENT (E/M)

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

In CY 2026, the payment rate for the G2211 add-on code ranged between $17-$20 depending on geographic location.[20] However, CMS now believes the code is better reflected as a component of the underlying E/M visit rather than as a separate add-on visit. As a result, for CY 2027, CMS proposes to replace HCPCS code G2211 with two new billing modifiers (MOD1 and MOD2).

CMS proposes creating MOD1 for providers to append to the E/M code instead of submitting G2211 as a separate claim line. CMS proposes MOD1 will be valued at 16% of the underlying E/M service rather than maintaining a flat add-on payment. CMS notes that the proposed 16% adjustment is derived from G2211 utilization and modified to maintain budget neutrality.[21]

CMS also proposes creating a second modifier (MOD2) for clinicians practicing in Accountable Care Organizations (ACOs).[22] Like MOD1, instead of billing G2211, eligible ACO participants could voluntarily append MOD2 to qualifying office/outpatient or home/residence E/M visits that involve increased longitudinal care complexity. MOD2 would be valued at 32% of the associated E/M visit to recognize the additional resources required for care coordination, integrated care, and accountability for quality and total cost of care within an ACO.

---

[19] For GRPM1 and GRTM1, CMS is considering basing payment on direct PE inputs from CPT code 99473 (Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration). For GRPM2, CMS suggests crosswalks to the work RVU input of 0.61 RVUs from CPT code 99457 and the direct PE inputs from CPT code 99474.[19] For GRTM2, CMS is considering a crosswalk to the work RVU input of 0.62 RVUs from CPT code 98980 and the direct PE inputs from CPT code 93270.[19] CMS believes these crosswalks may better reflect the resources required to furnish remote monitoring services and is requesting information about typical workflows, devices, and costs before making final payment determinations.

[20] https://www.cms.gov/medicare/physician-fee-schedule/search?Y=0&T=4&P=1&HT=0&CT=3&H1=G2211&M=5

[21] CMS explains that G2211 was originally valued by crosswalking it to CPT code 90785, resulting in a fixed payment regardless of the complexity of the E/M visit. However, CMS believes a flat add-on results in a disproportionately larger payment increase for lower-level E/M visits than for higher-level visits.

[22] New proposed modifier descriptor: Visit complexity inherent to new or established office/outpatient or home or residence evaluation and management service, associated with medical care services furnished by a participant or practitioner participating in a Medicare accountable care organization. Services must serve as the continuing focal point for all needed health care services and/or be part of ongoing care related to a patient's single, serious condition or complex condition.

CMS proposes that clinicians determine whether to bill MOD1, MOD2, or no modifier based on the complexity of the visit and would allow MOD2 to be used for all beneficiaries treated by participating ACO providers, regardless of whether the beneficiary is assigned or attributed to the ACO.

CMS proposes to maintain the current billing limitations for the proposed MOD1 and MOD2 modifiers when an office/outpatient (O/O) E/M visit is billed with Modifier -25.[23] Under the existing policy, payment is allowed only when the E/M visit is furnished on the same day as an annual wellness visit (AWV), vaccine administration, or another Medicare Part B preventive service. **CMS seeks comment on this proposal and whether the agency should expand the proposed policy to allow MOD1 or MOD2 to be billed with Modifier -25 when the E/M visit occurs on the same day as a 0-, 10-, or 90-day global surgical procedure.**

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

CMS proposes to reduce payment when a separately identifiable O/O E/M visit is furnished by the same physician, or another physician in the same group practice, on the same day as a 0-, 10-, or 90-day global surgical procedure. Under the proposal, the highest-paid service would continue to be paid at 100%, while all other same-day E/M visits and procedures would be paid at 50%, consistent with Medicare's existing multiple procedure payment reduction (MPPR) policy. **CMS is seeking comment on the proposed 50% reduction, whether a 25% reduction would be more appropriate, and whether the policy should apply to other E/M services, such as inpatient visits.**

Vaccine Adverse Effects Management (HCPCS Code GADV1)

CMS proposes a new add-on billing code, GADV1, to pay physicians and other qualified practitioners for an additional 15 minutes of work involved with evaluating and managing suspected vaccine adverse reactions that requires effort beyond what is typically captured in an E/M visit.[24] CMS proposes that GADV1 could be billed in addition to an office, outpatient, or home/residence E/M visit when the clinician documents a relationship between the vaccination and the patient's symptoms, performs an appropriate evaluation to exclude other causes, and develops a treatment plan. CMS proposes valuing GADV1 by crosswalking it to HCPCS code G2212 (15 minutes of prolonged E/M services), assigning 0.61 work RVUs, and adding this code to the Medicare Telehealth Services List. **CMS is requesting comment on whether to create a separate standalone code for visits focused solely on vaccine-related concerns, rather than using an add-on code.**

SHARED MEDICAL APPOINTMENT (HCPCS CODE GSMAS)[25]

CMS proposes to establish a new HCPCS code (GSMAS) for Shared Medical Appointments (SMAs), which are voluntary group visits where patients with a common chronic condition receive medical care, education, and peer support. SMAs would be limited to conditions that can be improved through lifestyle changes, such as diabetes, obesity, hypertension, and hyperlipidemia. CMS proposes allowing SMAs to be furnished in person or via telehealth. Sessions would be 60 minutes, limited to 10 patients, led and billed by a physician or qualified nonphysician practitioner, and require an established patient relationship, patient consent, and individualized documentation.[26] **CMS seeks comment on safeguards to prevent fraud, waste, and abuse, such as requiring evidence-based protocols, trained interventionists, and outcome tracking.**

CMS proposes that HCPCS code GSMAS would be billed once per patient, per session and clarifies that if a patient also receives a separate E/M visit on the same day, the same physician work and time cannot be counted twice. CMS proposes valuing the new HCPCS code GSMAS using a building block methodology based on an established patient level 3 E/M visit and a group behavior management service, resulting in a proposed work RVU of 1.73. CMS also proposes adding HCPCS code

---

[23] Modifier -25 is used to indicate that an E/M visit was a significant, separately identifiable service performed on the same day as another procedure/service.
[24] Gdv1: Office or other outpatient evaluation and management service(s) for the diagnosis and treatment of vaccine adverse effects, new or established patient; each 15 minutes personally performed by the physician or qualified healthcare professional
[25] CMS proposes the following descriptor for SMAs: HCPCS code GSMAS: Voluntary, group-based medical session involving multiple patients with common medical condition(s), receiving medical care in a group setting; billed and led by a physician or qualified nonphysician practitioner and may include services provided by other qualified healthcare professionals, clinical staff, or auxiliary personnel under the direction of the supervising physician or other practitioner. Session integrates group education, counseling, and peer support with individualized patient clinical assessment and care, 2-10 patients, billed once per patient, per session.
[26] CMS proposes that each SMA include: 1) an individualized E/M assessment documented in each patient's medical record; 2) evidence-based education, counseling, and discussion of self-care and disease management; and 3) lifestyle and behavior change counseling, with medication management when clinically appropriate.

GSMAS to the Medicare Telehealth List. **CMS is seeking comments on the proposed code, required SMA components, valuation, work RVUs, physician time, and practice expense inputs.**

SOFTWARE AS A MEDICAL SERVICE (SAMS)

Payment for Software as a Medical Service

Historically, CMS has referred to artificial intelligence (AI) and algorithm-based clinical decision-making technologies as Software as a Service (SaaS) when these technologies assist providers with clinical assessments or diagnoses. In other industries, SaaS is used to describe general cloud-based computing service models outside of a health care context. To clarify this distinction, CMS proposes to change the terminology from Software as a Service to Software as a Medical Service (SaMS) to refer to software-based technologies that support clinical decision making through algorithmic analysis, including those that provide clinical or diagnostic functionality. This proposal reflects a similar proposal in the CY 2027 Outpatient Prospective Payment (OPPS) Proposed Rule, **CMS welcomes comments on the proposed change in terminology.**

SaMS Analyses Performed on Laboratory Tests

For CY 2027, CMS proposes to remove payment for 10 HCPCS codes describing SaMS analyses performed on laboratory tests from the Clinical Laboratory Fee Schedule (CLFS) and instead have these codes contractor priced under the PFS.[27] CMS believes these services are software-based diagnostic tools rather than laboratory tests. In addition, for CY 2027 and subsequent years, CMS proposes to assign any new codes that describe SaMS analysis performed on laboratory tests for payment under the PFS. CMS explains the agency may finalize a policy that includes such payment for additional HCPCS codes in the PFS final rule based on public comment. **CMS requests comment on these proposals and on additional HCPCS codes that should be designated as SaMS analysis performed on laboratory tests and paid under the PFS.**

ADVANCE CARE PLANNING (ACP) SERVICES (HCPCS CODES GACP1 AND GACP2)

CMS has separately paid for ACP services using CPT codes 99497 and 99498 since CY 2016, including when furnished with an Annual Wellness Visit (AWV) or most E/M visits.[28] For CY 2027, CMS proposes to create two new HCPCS codes, GACP1 and GACP2, for clinical staff under the direct supervision of a physician or qualified practitioner to bill for ACP services. Under the proposal, the existing CPT codes 99497 and 99498 would be reserved for ACP services personally performed by the billing physician or practitioner. CMS proposes that CPT codes 99497 and 99498 and GACP1 and GACP2 may be billed incident to a physician's or qualified practitioner's services. To bill these services, the physician or practitioner must have previously furnished a professional service, such as an E/M visit or ACP, and remain actively involved in managing the patient's ongoing course of treatment. CMS proposes to value the new codes by crosswalking them to existing chronic care management codes that describe 20-minute increments of clinical staff time. **CMS requests comment on whether the new ACP G-codes should combine the time of the billing practitioner and clinical staff into a single code rather than billing them separately.**

NATIONAL PAYMENT FOR NON-SHEET FORM SKIN SUBSTITUTES

For CY 2027, CMS proposes to replace contractor pricing for non-sheet skin substitute products with national pricing using the same payment methodology established for sheet-form skin substitutes in the CY 2026 PFS Final Rule.[29] CMS proposes to pay non-sheet skin substitutes using the same nationally standardized methodology based on the wound surface area treated

---

[27] Table A-D8 in the Proposed Rule (pg. 43912) shows the list of currently payable SaMS analysis performed on laboratory tests under the CLFS that we are proposing to contractor price under the PFS.

[28] These codes are valued based on physician or qualified practitioner time, CMS has long allowed clinical staff time to count toward the service when the billing practitioner provides direct supervision and meaningfully participates in the discussion. CMS now believes that this team-based approach is not well reflected in the current coding and payment structure and suggests that new coding may better distinguish and value the work performed by the billing practitioner versus clinical staff during ACP services. Under this proposal, the new G codes and CPT codes 99497 and 99498 could be reported together, if time thresholds by the billing practitioner and clinical staff were each met with these respective code sets.

[29] In the CY 2026 PFS Final Rule, CMS did not establish national pricing for non-sheet products. Instead, the agency finalized contractor pricing, meaning each Medicare Administrative Contractor (MAC) determined payment because CMS believed those products were too difficult to standardize nationally.

(cm^2), rather than allowing Medicare Administrative Contractors to determine payment. CMS explains that recent analysis and stakeholder feedback indicate the resource costs for non-sheet products are comparable to sheet-form products.

REQUEST FOR INFORMATION (RFI): REDESIGNING PRIMARY CARE TO MAKE AMERICA HEALTHY AGAIN AND OTHER TOPICS

CMS seeks comment on methods to update payment for primary care services to reflect changes in how primary care is delivered due to advances in technology, including artificial intelligence (AI). Specifically, CMS is interested in feedback on how to better value primary care services, adapt payment to reflect technology and AI in primary care, the influence of the American Medical Association (AMA) on CPT coding, and expand prospective primary care payment within the Medicare Shared Savings Program (MSSP) and potentially across Medicare as outlined in Table 3. CMS is also considering first implementing prospective primary care payment (PPCP) permanently within the MSSP before potentially expanding it across Medicare, while seeking input on appropriate safeguards to prevent fraud, waste, and abuse.

Table 3. Summary of primary care and other requests for information included in the Proposed Rule.

Subject	CMS Viewpoint	CMS Feedback Request
Reconsidering Relative Primary Care Payment	CMS is considering creating separate categories of E/M visits in future rulemaking to better align payment with the purpose and complexity of the care provided with these services.	The agency asks whether longitudinal, acute, and consultative visits should be valued differently and on additional approaches to improve payment for primary care services.[30]
Care Management Code 'Family'	CMS created several separate billing codes to pay for care coordination and between-visit management activities, including Transitional Care Management (TCM), Chronic Care Management (CCM), Principal Care Management (PCM), and Advanced Primary Care Management (APCM). However, use of these codes has remained lower than CMS expected.	Whether a different payment structure would be more effective, how the care management code family could be simplified, and whether supervision requirements should be updated to reflect technology-enabled care models.[31]
Payment Implications of Technology Enablement of Primary Care	Technology-enabled care, including AI tools used in primary care and other clinical settings, are becoming more common, particularly technologies that reduce documentation burden and support clinical decision-making.	How to develop a consistent payment approach for technology-enabled care, how to account for the costs and benefits of these tools, and whether payment should be tied more directly to demonstrated clinical outcomes.[32]
Technology and AI-Augmentation in Primary Care via the Medicare Annual Wellness Visit (AWV)	Evidence on the impact of AWVs has been mixed and is exploring whether technology-enabled approaches could improve both beneficiary participation and health outcomes.	Whether current Medicare requirements create barriers to innovative AWV delivery models that incorporate AI tools developed or operated by technology companies in partnership with Medicare-enrolled providers.[33]
Developing Prospective Payment in the Shared Savings Program	CMS believes predictable monthly payments (e.g., capitated payment) would give providers more flexibility to deliver care in ways that are not tied to office visits, such as care coordination, telehealth, and electronic communication.	CMS requests feedback on potential primary care capitated payment arrangements in the SSP.[34]
Current Procedural	The Current Procedural Terminology (CPT®) coding system is owned and copyrighted by the AMA and CMS uses CPT® under a licensing agreement with the	The influence of the CPT coding system and AMA process on physician payment

[30] Specific questions are in the Proposed Rule (pgs. 43937-43938).
[31] Specific questions are in the Proposed Rule (pgs. 43938-43939).
[32] Specific questions are in the Proposed Rule (pgs. 43939-43940).
[33] Specific questions are in the Proposed Rule (pgs. 43940-43941).
[34] Specific questions are in the Proposed Rule (pgs. 43944-43946).

Terminology (CPT) RFI	AMA. There has been longstanding concern over the Federal reliance on a private organization with "such an obvious conflict of interest" in providing information on the time and resource requirements to conduct physician services when this information may influence their own payment.	policy as part of the Make America Health Again priorities.[35]
Community-based Palliative Care	CMS is interested in whether additional Medicare services are needed to support beneficiaries with serious illness.[36]	CMS is requesting feedback on how Medicare should define, deliver, and pay for community-based palliative care and serious illness care outside of the hospice benefit. In addition, CMS asks for input on several issues, including eligibility, advanced primary care management, quality measurement and fraud, waste, and abuse
Intensive Lifestyle Interventions to Slow Progression of Alzheimer's Disease	CMS's current payment system may not adequately support these types of comprehensive preventive services and growing evidence suggests multi-domain interventions, such as physical activity, nutrition, sleep improvement, stress management, and other lifestyle changes, may be more effective than single interventions.	CMS is requesting input on whether Medicare should develop and reimburse for intensive lifestyle interventions (ILIs) aimed at reducing the risk of Alzheimer's disease and related dementias (AD/ADRD) and slowing cognitive decline.
Duplicate Laboratory Testing, Imaging, and Result Sharing and Interoperability	CMS is considering approaches including promoting broader use of standardized data exchange technologies, participation in national interoperability networks, and clarification of billing and operational requirements to support seamless information sharing.	CMS is seeking stakeholder feedback on methods to improve interoperability for diagnostic imaging and laboratory results to reduce duplicate testing, improve care coordination, and allow for greater access to patient information.

LIMITING MEDICARE COVERAGE OF CERTAIN INDIVIDUALS

CMS proposes to implement Section 71201 of the Working Families Tax Cut (WFTC) legislation,[37] which limits Medicare enrollment to individuals who are: (1) citizens or nationals of the United States; (2) aliens lawfully admitted for permanent residence under the Immigration and Nationality Act (INA) (lawful permanent resident); (3) aliens granted the status of Cuban and Haitian entrant (CHE); or (4) individuals lawfully residing in the United States. Prior to the WFTC legislation, Medicare eligibility for noncitizens depended on whether the individual was lawfully present in the United States, allowing for a broader range of immigration categories to qualify for Medicare.[38] As a result, CMS proposes to update regulations for Medicare, Medicare Advantage (MA), Medicare Part D, and Medicare Cost Plan to reflect the new eligibility rules established by the WFTC legislation.[39]

CMS proposes to add a new definition of "eligible noncitizen" to Medicare regulations and, consistent with the WFTC legislation, would require that only individuals who are U.S. citizens, U.S. nationals, or eligible noncitizens will qualify for Medicare beginning July 4, 2025. CMS indicates that individuals already enrolled in Medicare as of July 4, 2025, who fall outside the newly authorized eligibility categories may temporarily keep coverage for an 18-month grace period, after which

[35] Specific questions are in the Proposed Rule (pgs. 43952-43953).
[36] Specific questions are in the Proposed Rule (pgs. 43949-43950).
[37] CMS refers to Public Law 119-21 as the "Working Families Tax Cut" (WFTC) legislation. This law is also known as the One Big Beautiful Bill Act (OBBBA). https://www.congress.gov/bill/119th-congress/house-bill/1/text
[38] Before the WFTC changes, CMS generally relied on the Social Security Administration's (SSA's) lawful presence verification framework to determine whether a noncitizen could receive Medicare benefits. Under that framework, SSA verified whether an individual was a U.S. citizen or otherwise "lawfully present" in the United States. SSA used policies contained in its Program Operations Manual System (POMS) and the immigration categories listed in 8 CFR § 1.3(a). The "lawfully present" standard included a broad range of immigration categories, such as: Lawful permanent residents (green card holders); Refugees; Asylees; Certain parolees admitted for at least one year; Cuban and Haitian entrants; and COFA migrants.
[39] CMS is not proposing to change the existing rule that lawful permanent residents must have continuously resided in the United States for at least five years to qualify for premium Part A or Part B. Those beneficiaries would remain eligible if they meet the current requirements.

the individuals would no longer be eligible for Medicare unless they can demonstrate that they meet one of the eligibility categories established by the WFTC legislation.

CMS proposes that the Social Security Administration (SSA) will review current Medicare beneficiaries to identify individuals who no longer meet the new Medicare eligibility requirements. Beneficiaries who appear ineligible would receive a notice and an opportunity to provide documentation showing they remain eligible for Medicare. CMS proposes that the SSA would send termination notices beginning in December 2026 explaining that the individual does not meet the eligibility criteria and will no longer receive Medicare coverage. Unless the individual successfully demonstrates eligibility, Medicare enrollment would terminate effective February 1, 2027. The notice would also explain the individual's right to appeal the determination through existing Medicare and Social Security appeals processes.

CMS also proposes a permanent process for terminating Medicare coverage for individuals who do not meet the new eligibility requirements established by the WFTC legislation. In addition to the 18-month grace period for certain beneficiaries enrolled as of July 4, 2025, CMS would prospectively terminate Medicare entitlement for individuals later determined to be ineligible. Coverage would terminate at the end of the month following the month in which the notice is issued. Before coverage is terminated, affected individuals would receive notice, an opportunity to provide evidence of eligibility, and information about their appeal rights.

CMS recognizes that there will be a gap between the enactment of the WFTC legislation on July 4, 2025, and the implementation of SSA's new Medicare eligibility screening process, which is expected in 2026. Individuals who enroll in Medicare during this period are not eligible for the 18-month grace period, as they were not enrolled on the date the law was enacted. If CMS or SSA later determines that these individuals do not meet the new Medicare eligibility requirements, their Medicare coverage could be prospectively terminated under the standard termination procedures proposed by CMS, after notice and appeal rights are provided.

CMS proposes creating a new Special Enrollment Period (SEP) for individuals who become eligible for Medicare after a change in their citizenship, nationality, or immigration status or who previously lost Medicare eligibility and later regain it. The SEP would begin when an individual provides the SSA with documentation showing they meet the new eligibility requirements and would remain open for six months. If the individual enrolls during this SEP, Medicare coverage would begin prospectively on the first day of the month after enrollment, rather than retroactively. CMS estimates that about 32,000 individuals will lose Medicare coverage beginning in 2027 as a result of the new Medicare eligibility restrictions.[40]

MEDICARE PRESCRIPTION DRUG INFLATION REBATE PROGRAM

The Inflation Reduction Act (IRA) established requirements under which drug manufacturers must pay inflation rebates if they raise their prices for certain drugs payable under Part B and/or covered under Part D faster than the rate of inflation. The IRA also provides for an adjustment to the beneficiary coinsurance amount in cases where the price of a Part B rebatable drug increases faster than the rate of inflation such that the beneficiary coinsurance is calculated based on the lower inflation-adjusted payment amount instead of the applicable payment amount. While regulations to implement the Medicare Prescription Drug Inflation Rebate Program were established in prior rulemaking, CMS proposes limited modifications to those regulations (e.g., clarifying the definition of “first marketed date”, modify the skin substitutes excluded product category, the inflation data used to determine the benchmark, and methodology to account for 340B eligible units) and to mandate covered entity submissions to a 340B repository, as detailed below.

340B REPOSITORY

In the CY 2026 PFS Final Rule, CMS established policy for a 340B repository to receive voluntary submissions from covered entities of certain data elements associated with Part D claims for which the covered entity dispensed (directly or indirectly, including via retrospective replenishment and contract pharmacy arrangements) units of a drug for which a manufacturer provides a discount under the 340B Program (“Part D 340B claims’’). In the Proposed Rule, CMS indicates that the agency is

[40] Because CMS is also proposing a new SEP for individuals who later become eligible after a change in their citizenship, nationality, or immigration status, the agency assumes that about 10% of those losing coverage (3,200 individuals annually) will use the SEP to re-enroll in Medicare. CMS emphasizes that this is only a placeholder estimate because there is no historical experience with this new enrollment pathway.

working to operationalize the 340B repository, which is expected to launch in Fall 2026 for voluntary reporting. Most relevant to covered entities, CMS proposes to require the submission of Part D 340B data to the 340B repository beginning with claims with a date of service on or after January 1, 2027. CMS clarifies that such reporting would fulfill a 340B provider's obligation to provide access to documentation relating to covered Part D drugs written or ordered by such 340B provider to maintain enrollment in Medicare.[41]

In addition, CMS proposes to require that a provider or supplier that is also a covered entity[42] must submit the following data elements associated with each claim for units of a covered Part D drug billed to Medicare by such covered entity or its contractor (e.g., contract pharmacies):

1. Date of Service (that is, the date the prescription was filled by the pharmacy);
2. Prescription or Service Reference Number;
3. Fill Number (that is, the code indicating whether the prescription is an original or a refill; if a refill, the code indicates the refill number);
4. Dispensing Pharmacy National Provide Identifier (NPI); and
5. National Drug Code (NDC)–11.

CMS proposes to require that 340B providers submit data on a quarterly basis (at minimum) within 1 calendar quarter following the close of the relevant calendar quarter.[43] CMS also notes that the agency is issuing a revised collection of information[44] alongside the Proposed Rule to reflect the burden associated with a mandatory submission to the 340B repository. In addition, CMS proposes, as part of every submission, to require 340B providers (or an individual or contractor with the delegated authority as an authorized representative of the 340B provider to perform the certification) to certify that the data elements from all claims submitted to the 340B repository are from verified 340B claims and, to the best of the 340B provider's knowledge, its submissions include all Part D 340B claims for the 340B provider at the time of submission for the relevant period.[45] CMS also proposes a process for revisions. **CMS seeks comments on this proposal, including comments on the documentation and timing requirements.**

CMS clarifies that under this current proposal, the data submitted to the 340B repository would not be used to calculate inflation rebates. CMS will continue to use the previously finalized Prescriber-Pharmacy Methodology to remove 340B units from Part D inflation rebate calculations. Any future proposal to use the data reported to the 340B repository to remove 340B units from Part D inflation rebate calculations would undergo notice-and-comment rulemaking.

MEDICARE SHARED SAVINGS PROGRAM (SSP)

Eligible groups of providers and suppliers, including physicians, hospitals, and other healthcare providers, may participate in the SSP by forming or joining an ACO. Under the SSP, providers and suppliers that participate in an ACO continue to receive traditional Medicare fee-for-service (FFS) payments, and the ACO may be eligible to receive a shared savings payment if the ACO meets specific quality and cost performance requirements. Depending on its participation track, an ACO may also be required to repay a portion of losses if spending exceeds established benchmarks. The SSP offers two participation tracks (e.g., BASIC[46] or ENHANCED[47]) which provide different levels of financial risk. As of January 1, 2026, the

[41] In the Proposed Rule, CMS indicates that if this proposal is finalized, CMS would reserve the right to revoke, in accordance with existing §424.535(a)(10), a currently enrolled provider or supplier's Medicare enrollment and any corresponding provider agreement or supplier agreement for failure to comply with the requirements for maintaining and providing access to documentation specified in proposed §424.516(f)(4).

[42] CMS also proposes to require that the provider or supplier that is a covered entity also submit its 340B ID and name as designated in the 340B OPAIS database.

[43] For example, for claims with dates of service between October 1, 2027, through December 31, 2027, 340B providers would submit the data elements from Part D 340B claims to the 340B repository no later than March 31, 2028.

[44] Information Collection Request (ICR) for the Medicare Prescription Drug Inflation Rebate Program under sections 11101 and 11102 of the Inflation Reduction Act (IRA)'' (CMS–10930, OMB 0938–1485)

[45] CMS proposes that 340B providers could arrange for TPAs or other vendors to submit the required data elements to the 340B repository on their behalf. 340B providers would ultimately be responsible for the accuracy of the data submitted to the 340B repository, even if a 340B provider has an arrangement with a vendor to submit on its behalf.

[46] Currently, the BASIC track offers a glide path for eligible ACOs to transition from a one-sided shared savings-only model to progressively higher increments of financial risk and potential reward under two-sided shared savings (otherwise referred to as performance-based risk) and shared losses models within a single 5-year agreement period.

[47] Currently, the ENHANCED track offers ACOs the opportunity to accept greater financial risk for their assigned beneficiaries in exchange for potentially higher financial rewards.

SSP included 511 ACOs, representing over 700,000 healthcare providers and organizations providing care to over 12.6 million assigned beneficiaries. For CY 2027, CMS proposes a series of updates to the SSP intended to strengthen financial incentives for ACOs, including changes to beneficiary assignment, quality reporting, financial methodologies, and Certified Electronic Health Record Technology (CEHRT) requirements, as outlined below.[48]

PROPOSED MODIFICATIONS TO THE SSP BENEFICIARY ASSIGNMENT METHODOLOGY

Proposal To Exclude From Assignment Calculations Allowed Charges for Primary Care Services Billed Through a Non-ACO TIN by an ACO Professional Used in Assignment

To increase participation in accountable care, CMS proposes changes to the beneficiary assignment methodology beginning in performance year (PY) 2028. CMS proposes that primary care services furnished by an ACO clinician but billed through a non-ACO billing TIN would no longer be counted in assignment calculations when determining which provider furnished the plurality of a beneficiary's primary care services. Under current policy, beneficiaries may fail to be assigned to an ACO when an ACO clinician furnishes services through both ACO and non-ACO entities because services billed under the non-ACO TIN can shift the plurality assignment calculation away from the ACO. As a result, beneficiaries who primarily receive care from ACO clinicians may not be assigned to the ACO. CMS estimates that the assignment-related proposals could increase ACO assignment by approximately 0.5 to 1.0 million beneficiaries annually. **CMS requests comment on the proposal to apply this approach in determining SSP assignment for the PY starting on January 1, 2028, and subsequent PYs.**

Proposal To Modify Assignment Eligibility Criteria and Prospective Assignment Exclusion Criteria Based on Medicare Enrollment Status

Under current policy, beneficiaries generally cannot be assigned to an ACO if, at any point during the assignment window, they are enrolled only in Medicare Part A, only in Medicare Part B, or in MA or another private Medicare plan. CMS proposes, beginning in PY 2028, to expand beneficiary assignment eligibility by allowing Medicare beneficiaries to be assigned to an ACO if they have at least one month of both Medicare Part A and Part B enrollment and are not enrolled in MA or other private Medicare plan enrollment during that same month within the 12-month assignment window.

Proposed Revisions to the Definition of Primary Care Services Used in Shared Savings Program Beneficiary Assignment

Currently, CMS determines beneficiary assignment based on a specific list of CPT and HCPCS codes that the agency defines as primary care services and periodically updates that list to reflect evolving Medicare payment policies. CMS proposes to update the SSP definition of "primary care services" beginning in PY 2027 by including new codes for Screening, Brief Intervention and Referral to Treatment; Vaccine Adverse Effects Management; and ACP as primary care services.[49] CMS also proposes a technical update to clarify that the current primary care service definition applies only through PY 2026, while the revised definition, including the new automatic replacement-code policy, would apply beginning in PY 2027 and subsequent years. CMS also proposes that if CMS later replaces a CPT or HCPCS code that is currently designated as a primary care service for beneficiary assignment purposes, the replacement code would automatically be treated as a primary care service without requiring additional rulemaking. **CMS is seeking feedback on its proposal to update the list of primary care services and whether there are other existing or newly proposed CPT or HCPCS codes that should be considered primary care services for beneficiary assignment purposes in future rulemaking.**

PROPOSED REVISIONS TO BASIC TRACK LEVEL E

CMS proposes several changes to the SSP financial methodology to encourage greater participation in BASIC track Level E, which is the highest level of the BASIC track. In the Proposed Rule, CMS explains that participation in BASIC Level E has trailed behind participation in the ENHANCED track and is concerned that the current payment structure may encourage some ACOs to move into the ENHANCED track before they are prepared to assume the higher level of financial risk. As a

[48] In the Proposed Rule CMS recognizes that ACOs applying to participate in the Medicare Shared Savings Program beginning January 1, 2027, may need to choose between the BASIC and ENHANCED tracks before the CY 2027 PFS rule is finalized. Because proposed MSSP financial methodology changes could affect that decision, CMS expects to give eligible ACO applicants a limited opportunity to revise their track selection after the final rule is issued. CMS also notes that organizations that do not apply for a January 1, 2027, start date may instead apply for participation beginning January 1, 2028.
[49] A full list of codes can be found in the Proposed Rule (pgs. 44035-44036)

result, CMS proposes that ACOs entering new agreement periods on or after January 1, 2027, would be eligible to keep 60% of shared savings generated under BASIC Track Level E, compared with the current 50% rate. The proposed increase would apply only to ACOs entering new agreement periods on or after January 1, 2027. ACOs participating in existing agreement periods that began between 2022 and 2026 would continue to receive the current 50% shared savings rate through the remainder of the existing agreement periods. CMS estimates the proposal would increase shared savings payments by an average of about $1.35 million per BASIC Level E ACO, resulting in approximately $110.6 million in additional shared savings payments across affected ACOs. **CMS requests comment on this proposal.**

PROPOSAL TO REDUCE THE MAXIMUM WEIGHT ON THE REGIONAL ADJUSTMENT FOR ACOS UNDER THE ENHANCED TRACK

For PY 2027, CMS proposes reducing the positive regional adjustment for certain ENHANCED Track ACOs.[50] Specifically, for ENHANCED Track ACOs whose spending is below their regional average, CMS would reduce the weight used to calculate the positive regional adjustment from 50% to 35%. CMS explains that some low-spending ACOs receive large benchmark increases through the regional adjustment, making it easier to earn shared savings, while higher-spending ACOs may face benchmark disadvantages that discourage participation. **CMS requests comment on this proposal.**

CMS believes some low-spending ACOs receive large benchmark increases through the regional adjustment, making it easier to earn shared savings, while higher-spending ACOs may face benchmark disadvantages that discourage participation. The proposal would not change the regional adjustment methodology for ACOs with spending above the regional average.

PROPOSAL TO INCREASE THE PRIOR SAVINGS ADJUSTMENT BY INCREASING THE SCALING FACTOR

Under current policy, eligible ACOs can receive a prior savings adjustment, which is capped at 5 percent of benchmark year 3 national assignable expenditures. CMS uses a 50% scaling factor to determine the prior savings adjustment. CMS proposes to increase the prior savings adjustment scaling factor from 50% to 75%, beginning in PY 2027, because the agency believes the current adjustment does not adequately reward ACOs that successfully reduce Medicare spending in prior agreement periods and sustain those savings over time. By increasing the adjustment to 75%, CMS expects more ACOs to benefit from their past savings, helping to offset the effects of benchmark rebasing and encouraging continued participation in the SSP. **CMS requests comment on this proposal.**

PROPOSAL TO RISK ADJUST THE 5 PERCENT CAP ON UPWARD ADJUSTMENTS TO THE HISTORICAL BENCHMARK

CMS proposes, beginning January 1, 2027, and for subsequent years, to risk-adjust the current 5% cap, based on beneficiary risk, on positive benchmark adjustments so that ACOs serving more medically complex beneficiaries may receive larger benchmark increases.[51] Currently, an ACO may qualify for a regional adjustment, prior savings adjustment, or population adjustment and CMS applies the most favorable adjustment for which the ACO is eligible. However, the value of these positive adjustments is capped at 5% of national per-capita Medicare spending, regardless of the health status of the ACO's assigned beneficiaries. [52] **CMS requests comment on the proposal to risk-adjust the 5% caps on positive regional adjustment amounts, applicable for agreement periods beginning on January 1, 2027, and for subsequent years.**

---

[50] The regional adjustment compares an ACO's spending to average Medicare spending in its geographic region. ACOs with spending below the regional average generally receive a positive benchmark adjustment, while ACOs with spending above the regional average may receive a negative adjustment. CMS first adopted the regional adjustment in PY 2017 and expanded it in PY 2019 to apply beginning with an ACO's first agreement period. At that time, CMS also reduced the maximum adjustment weight from 70% to 50% out of concern that the policy was becoming overly favorable to some low-spending ACOs.
[51] CMS outlines to proposed methodology to risk adjust the 5 percent cap in the Proposed Rule (pg. 44083-44090).
[52] The methodology for calculating the adjustment to apply when establishing benchmarks for ACOs entering an agreement period beginning on January 1, 2025, and in subsequent years is outlined in the Proposed Rule (pgs. 44091-44092).

PROPOSED NEW GROWTH ADJUSTMENT

CMS proposes a new growth adjustment beginning on January 1, 2027, that would provide an additional increase to an ACO's benchmark if the ACO successfully recruits providers and beneficiaries who are inexperienced with value-based care.[53] CMS would calculate the growth adjustment based on the number of new beneficiaries brought into accountable care by inexperienced providers. The adjustment would reward ACOs for recruiting clinicians who have not participated in a shared savings initiative during the previous five years and beneficiaries who have not previously been assigned to an SSP ACO or another CMS shared savings initiative. Eligible ACOs could receive an additional benchmark increase, subject to a proposed risk-adjusted 5% cap. **CMS is seeking comment on the proposal.**

CMS estimates the proposal would increase Medicare spending by approximately $1.67 billion over 10 years.[54] CMS outlines the proposed calculation of the new growth adjustment and the incentive factor in the Proposed Rule (pgs. 44095-44099).[55] **CMS requests comment on these proposals.**

CMS proposes to allow eligible ACOs, with CMS approval, to reduce or waive Medicare Part B cost sharing for certain beneficiaries and services. ACOs would have flexibility in designing the program and would be prohibited from promoting the benefit as a replacement for supplemental insurance or encouraging beneficiaries to drop their existing coverage. CMS proposes requiring detailed recordkeeping, CMS oversight, audit authority, compliance monitoring, and adherence to fraud and abuse safeguards. **CMS requests comment on these proposals.**

PROPOSAL TO DISCONTINUE AVAILABILITY OF THE OPTION FOR PREPAID SHARED SAVINGS

CMS proposes to eliminate the prepaid shared savings option from the SSP, with the last opportunity for ACOs to elect participation occurring for PY 2027, due to lower-than-expected participation. CMS clarifies existing participants would continue under current program rules through the end of their eligible payment period, but CMS proposes to discontinue the option for future years because it no longer views it as an efficient use of program resources. **CMS requests comment on this proposal.**

PROPOSAL TO MODIFY THE METHODOLOGY AND USE DESCRIPTION FOR ADVANCE INVESTMENT PAYMENTS (AIPS)

CMS proposes to modify the methodology in calculating Advance Investment Payments, which are quarterly payments available to certain new, low-revenue ACOs that are inexperienced with performance-based risk and new to the SSP beginning on January 1, 2028. CMS currently uses the Area Deprivation Index (ADI) to identify rural populations and is proposing to replace the ADI component of the AIP methodology with a new rural residency adjustment to encourage participation by low-revenue, risk-inexperienced ACOs, particularly those serving rural communities.[56] CMS proposes adding the rural component to the payment amount calculation for determining quarterly advance investment payments. Under the proposal, CMS would determine rural status using beneficiaries' mailing addresses and county classifications using federal Census and Office of Management and Budget (OMB) data. Beneficiaries living in micropolitan or non-core counties would be considered rural for purposes of the calculation. CMS would then incorporate the number of assigned rural beneficiaries into the formula used to determine an ACO's maximum quarterly AIP.[57] **CMS requests comment on this proposal.**

---

[53] CMS explains that new growth means the number of beneficiaries (in person year terms) that are new to the SSP that are brought into the program by ACO professionals who are inexperienced in shared savings initiatives. To identify the ACO's new growth, CMS will first identify the ACO professionals who are inexperienced in shared savings initiatives. Then CMS will determine the number of beneficiaries (in person year terms) that are new to the SSP that are brought into the program by these inexperienced ACO professionals. CMS would define an "inexperienced" ACO professional as a clinician who has not participated in MSSP, an Innovation Center ACO model (such as ACO REACH), or another CMS-designated shared savings initiative during any of the previous five years. CMS would also identify "inexperienced" beneficiaries as beneficiaries who were not assigned to an MSSP ACO or another CMS shared savings initiative during the comparison period.

[54] The annual and 10-year total projections for these provisions are detailed in Table D–B9 in the Proposed Rule (pg. 44256)

[55] Table B-G31 in the Proposed Rule (pgs. 44102-44103) outlines a hypothetical growth adjustment calculation for PY 1.

[56] Under this proposal, ACOs would receive $45 per beneficiary per quarter for beneficiaries who are enrolled in the Low-Income Subsidy (LIS), are dually eligible for Medicare and Medicaid, or live in a rural area. For all other beneficiaries, ACOs would receive $25 per beneficiary per quarter

[57] CMS would determine rural status using beneficiaries' mailing addresses and county classifications from federal Census and Office of Management and Budget data, with beneficiaries living in micropolitan or noncore counties considered rural.

IDENTIFYING ACOS EXPERIENCED WITH PERFORMANCE-BASED RISK MEDICARE ACO INITIATIVES

Under current policy, a TIN may be counted as having prior risk experience if it was included in financial reconciliation for a two-sided risk model during the previous five years, even if it never formally participated in the model. CMS proposes, beginning January 1, 2027, to exclude participant TINs that did not have a written agreement to participate in a performance-based risk Medicare ACO initiative when determining whether an ACO is experienced or inexperienced with risk. Under the proposal, only TINs with a formal written participation agreement would count toward an ACO's risk experience, which could allow more ACOs to qualify as inexperienced and remain eligible for participation options available to newer organizations, such as the BASIC track glide path.

RFI: Specialty Care In The Shared Savings Program

CMS is asking for feedback on how to better involve specialists in ACOs and improve coordination between primary care and specialty care. While ACOs have generally improved quality and reduced costs, CMS notes that most accountable care efforts are focused on primary care, even though specialty care accounts for most Medicare physician spending. CMS is seeking ideas on policies that could strengthen specialist participation, improve care coordination, reduce unnecessary spending, and help both physician-led and hospital-led ACOs achieve better outcomes for beneficiaries.[58]

UPDATES TO THE QUALITY PAYMENT PROGRAM (QPP)

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established the QPP for eligible clinicians. Under the QPP, MIPS eligible clinicians can participate via one of two tracks – the MIPS (reporting via traditional MIPS or MIPS Value Pathways (MVPs)) and APMs. Generally, the Proposed Rule sets forth changes to the QPP starting January 1, 2027. Notably, CMS proposes sunsetting the traditional MIPS reporting option, leaving MVPs as the only reporting options for MIPS beginning with the CY 2029 performance period/2031 MIPS payment year.[59] Under this proposal, traditional MIPS would continue to be an available reporting option until the CY 2029 performance period/2031 MIPS payment year, when sunsetting occurs. Among several other highlights and proposals, CMS proposes adding three new MVPs regarding the following topics: Diabetic Disease, Hypertension, and Hospitalist. In addition, CMS proposes updating all MVPs to include MIPS core measures. **CMS seeks comment on a range of issues related to the QPP, including the timeline to sunset traditional MIPS and future scoring methodology.**

Additional information regarding the QPP is available in the Proposed Rule (pgs. 44141-44274 and 44304-44557) and in a CMS summary.

WHAT'S NEXT?

CMS typically publishes the PFS final rule by early November, with effective dates of most policies being January 1, 2027. The comment period closes on September 14, 2026. Vizient's Office of Public Policy and Government Relations looks forward to hearing continued member feedback on this proposed rule. Stakeholder input plays a major role in shaping future changes to policy. We encourage you to reach out to our office if you have any questions or regarding any aspects of this proposed regulation – both positive reactions and provisions that cause you concern. Please direct your feedback to Jenna Stern Vice President, Regulatory Affairs and Public Policy, in Vizient's Washington, D.C. office.

---

[58] Questions related to this RFI can be found in the Proposed Rule (pgs. 44129-44134). CMS is requesting feedback on the following topics: Meaningful engagement; CMS-delivered tools and support; Attribution or assignment modifications; Benchmarking; Specialist performance measurement; Waiver flexibilities; and ACO and provider burden.

[59] CMS clarifies that beginning in the CY 2029 performance period/2031 MIPS payment year, eligible clinicians participating in MIPS, and not reporting the APM Performance Pathway (APP), would be required to report the measures and activities in a selected MVP for MIPS. CMS also proposes including virtual groups in MVP reporting to ensure all eligible clinicians can report MVPs.

TO LEARN MORE, CONTACT:
Vizient's Office of Public Policy & Government Relations
at (202) 354-2600 or VizientGR@vizientinc.com