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2027 Proposed Physician Fee Schedule Cuts Payments

On July 14, 2026, the Centers for Medicare & Medicaid Services (CMS) released its proposed Medicare Physician Fee Schedule (MPFS) for calendar year (CY) 2027.[1] The proposed rule would decrease both statutory conversion factors used to calculate physician payment, reversing the prior year's increase, while proposing substantial changes to physician payment methodology, accountable care, and quality reporting.[2] According to CMS Administrator Dr. Mehmet Oz, the proposed rule reflects "some of the most significant Medicare reforms in recent years to strengthen primary care, expand accountable care, and modernize physician payment."[3] This Health Capital Topics article discusses the CY 2027 MPFS proposed rule's payment update and significant policy proposals.

Conversion Factor Decreases

The MPFS calculates payments according to Medicare's Resource-Based Relative Value Scale (RBRVS) system, under which relative value units (RVUs) reflecting physician work, practice expense, and malpractice expense are geographically adjusted and multiplied by a conversion factor to yield a payment amount for a given service.[4] As required by statute, CMS calculates two separate conversion factors: one for clinicians who qualify as participants in an Advanced Alternative Payment Model (APM), and one for non-qualifying participants.[5] For 2027, statutory updates under the Medicare Access and CHIP Reauthorization Act (MACRA) are +0.75% for qualifying APM participants and +0.25% for non-qualifying participants.[6] CMS also proposes an estimated +0.53% adjustment to both conversion factors to account for proposed changes in work RVUs.[7] However, these increases are more than offset by the scheduled expiration of a one-time 2.50% conversion factor increase, applicable only to 2026, enacted under the One Big Beautiful Bill Act (OBBBA), which CMS's 2027 rulemaking materials refer to as the Working Families Tax Cut (WFTC) legislation.[8] As a result, CMS proposes a qualifying APM conversion factor of $33.17 for 2027, a decrease of $0.40 (-1.19%) from the current $33.57.[9] The proposed non-qualifying APM conversion factor is $32.84, a decrease of $0.56 (-1.68%) from the current $33.40.[10]

Modernizing Physician Payment

Beyond the annual conversion factor update, CMS proposes several changes to how specific services are valued and paid under the MPFS. For 2027, CMS proposes to reduce payment when a physician furnishes a separately identifiable office or outpatient evaluation and management (E/M) visit on the same day as a procedure with a 0-, 10-, or 90-day global period (the window following a procedure during which related follow-up care is bundled into the procedure's payment rather than billed separately).[11] Under the proposal, the more expensive of the two services would be paid at 100%, and the other would be paid at 50%.[12] CMS states that the current policy likely results in duplicative payment for efficiencies inherent in furnishing both services during the same patient encounter, a rationale the agency previously advanced, without finalizing, in the 2019 MPFS proposed rule.[13]

CMS also proposes to convert HCPCS code G2211, an add-on payment for the inherent complexity of longitudinal, relationship-based E/M visits, from a flat-rate code to a percentage-based modifier that would increase payment for the associated E/M visit by 16%.[14] A second, related modifier would be available only to practitioners participating in a Medicare Shared Savings Program (MSSP) accountable care organization (ACO) or the forthcoming Long-Term Enhanced ACO Design (LEAD) Model, increasing payment for the associated E/M visit by 32% to account for the additional resources required for total cost of care accountability and quality reporting.[15]

Separately, CMS proposes a multi-year overhaul of the methodology used to calculate practice expense (PE) RVUs, which account for a substantial share of most services' total payment.[16] CMS has historically relied on American Medical Association (AMA) physician surveys to estimate direct PE inputs and overall PE, an approach the agency states has been limited by low survey response rates and discrepancies with empirical data where such data exists.[17] CMS states these limitations are especially pronounced for specialty-level PE data, for which collection is burdensome and prone to volatility.[18] Under the proposal, CMS would phase out, over several years, the methodology step that ties the overall number of PE RVUs by specialty to specialty-specific PE-per-hour data dating to 2007 or earlier, replacing it with a "PE stabilizer" intended to limit short-

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term volatility without anchoring PE values to a fixed historical baseline.[19] CMS states the final PE RVUs would continue to be derived from underlying work RVU and direct PE input data, as well as specialty-specific indirect allocators, even as the specialty-level PE-per-hour step is phased out.[20] CMS also proposes to adjust the indirect PE allocation for services furnished to beneficiaries during a Part A skilled nursing facility stay, consistent with the site-of-service payment differential policy finalized in the 2026 PFS final rule.[21]

Expanding Accountable Care

The proposed rule also includes a series of changes to the MSSP, the largest Medicare value-based payment program, which has generated savings for the Medicare Trust Funds for eight consecutive performance years.[22] In performance year 2024, 75% of the 476 participating MSSP accountable care organizations (ACOs) earned shared savings payments totaling $4.1 billion, generating approximately $2.5 billion in net savings compared to projected spending benchmarks.[23] For 2027, CMS proposes to increase the shared savings rate for Level E of the BASIC track (the highest risk level within the BASIC track, just below the ENHANCED track) from 50% to 60%, narrowing the gap with the ENHANCED track's 75% sharing rate, while also reducing a regional adjustment that has favored ENHANCED track ACOs.[24] CMS states the combination is intended to rebalance financial incentives across tracks and encourage ACOs to select a participation track based on their actual capacity to generate savings, rather than differences embedded in track design.[25] CMS further proposes to increase the scaling factor applied to the prior savings adjustment from 50% to 75%, to risk-adjust the 5% cap on upward adjustments to an ACO's historical spending benchmark, and to establish a new growth adjustment to reward ACOs that recruit clinicians and beneficiaries new to value-based care.[26] Beginning April 1, 2027, ACOs with an approved implementation plan could reduce or eliminate beneficiary cost-sharing for Part B items and services other than durable medical equipment, prosthetics, orthotics, and supplies, and prescription drugs.[27] Separately, CMS proposes technical refinements to the Ambulatory Specialty Model (ASM), the mandatory, two-sided risk payment model for specialists treating heart failure and low back pain scheduled to launch January 1, 2027, including new participant exceptions for tax identification number changes and heart failure-related specialty redesignations, additional quality-reporting flexibility for small practices, and a new low back pain imaging measure.[28]

Sunsetting Traditional MIPS

The Merit-based Incentive Payment System (MIPS) is one of two tracks under Medicare's Quality Payment Program, established under MACRA, through which most Medicare clinicians who are not qualifying APM participants report quality, cost, and technology-use data that adjusts their MPFS payment up or down based on performance.[29] CMS has stated that MIPS was designed, when it launched in 2017, to move Medicare away from a fragmented fee-for-service system and toward one that rewards quality, outcomes, and value.[30] MIPS Value Pathways (MVPs) are subsets of measures and activities tailored to a specific specialty, condition, or care setting, intended to replace MIPS's traditionally broad menu of reporting options with a more clinically cohesive set of measures.[31] CMS also proposes to sunset traditional MIPS reporting beginning with the 2029 performance period, leaving MVPs as the primary MIPS reporting option for clinicians who do not participate in an Advanced APM.[32] MIPS eligible clinicians would have until the end of the 2028 performance period to transition to an applicable MVP, unless they participate in a MIPS APM and report the APM Performance Pathway.[33] CMS proposes three new MVPs for 2027, focused on diabetes, hypertension, and hospital-based care, which the agency estimates would provide a relevant reporting option for approximately 98% of specialties.[34] Beginning in 2027, MIPS eligible clinicians reporting under either traditional MIPS or an MVP would be required to report at least one newly designated "MIPS Core Measure" specific to their specialty, though small practices would be exempt from the requirement.[35]

Stakeholder Reactions

Industry analysts project the proposed rule's provisions would have disparate effects across specialties. Reported estimates show double-digit increases in projected allowed charges for clinical social work (12%) and clinical psychology (11%), and smaller increases for diagnostic testing facilities and geriatrics (4%).[36] By contrast, dermatology (-9%), otolaryngology (-9%), orthopedic surgery (-7%), and hand surgery (-5%) are projected to see some of the largest reductions.[37]

Provider groups swiftly criticized the proposed payment reduction. Jerry Penso, M.D., president and CEO of AMGA, stated that the proposed conversion factors "fall well short of what it actually costs our members to deliver care," adding that "the underlying erosion of physician payment reasserted itself" once the temporary 2026 increase expired.[38] Penso reiterated AMGA's call for Congress to tie the annual physician payment update to the Medicare Economic Index (MEI), the inflation-adjustment mechanism already used to update payments for hospitals and skilled nursing facilities, rather than continuing to rely on temporary, one-year legislative fixes.[39] Premier, a health system-owned performance improvement alliance, offered a more favorable view of the rule's accountable care provisions. John Knapp, Premier's vice president of advocacy, stated that the proposed Shared Savings Program changes "reflect a clear commitment to strengthening value-based care" by improving financial predictability and reducing reporting burden for participating ACOs.[40] Stakeholders may submit comments on the proposed rule through September 14, 2026.[41]

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Conclusion

The proposed rule's net payment reduction arrives amid renewed congressional attention to physician payment reform, including bipartisan legislation introduced the day after the rule's release that would tie the annual conversion factor update to an inflation-based index, an approach that the Medicare Payment Advisory Commission (MedPAC) and physician organizations across specialties have advocated for several years.[42] Whether Congress again enacts a temporary, one-year override (as it did for 2026), or instead moves toward a structural fix tied to practice cost growth, the underlying statutory mechanism continues to produce the same annual pattern: modest relief followed by its expiration. For those working with physician practices, the more consequential question may not be whether Congress intervenes again this year, but whether it addresses the budget-neutral formula that makes such intervention necessary in the first place.

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