AMA Alert: Final 2027 Medicare Physician Fee Schedule Released

On November 4, 2026, the Centers for Medicare & Medicaid Services (CMS) released the final rule for the 2027 Medicare physician fee schedule. The rule was mostly finalized as proposed, with a few notable exceptions, including moderation in the original proposals related to Modifier –25, maternity care, arthroplasty and remote monitoring."

AMA staff will circulate a detailed summary of the nearly 2,500-page complete final rule in the coming days. In the interim, we'd like to highlight the following key finalized provisions:

2027 Conversion Factors

For the second year, there are four conversion factors, as outlined below:

Medicare Conversion Factor		Medicare Anesthesia Conversion Factor	
For APM QPs	For non-APM QPs	For APM QPs	For non-APM QPs
$32.9548 (-1.83%)	$32.6286 (-2.31%)	$20.3068 (-1.42%)	$20.1056 (-1.91%)

These conversion factors reflect:

- Expiration of temporary 2.5 percent update for CY 2026 included in H.R. 1
- A negative 0.12 percent budget neutrality adjustment to balance proposed coding and payment policy changes finalized in the rule compared with a positive 0.53 percent in the proposed rule, reflecting CMS' decision to modify the Modifier -25 policy.
- 0.5 percent higher update for Qualified APM Participants (QPs) in Advanced Alternative Payment Models (APMs) under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

Absent congressional action, physicians face a net Medicare payment cut in 2027 even as CMS projects the Medicare Economic Index (MEI) will rise 2.6 percent. The AMA continues to strongly advocate for annual Medicare payment updates that reflect the growth in physician practice costs as measured by the MEI. The AMA strongly supports the bipartisan Patients First Act (H.R. 9693), introduced July 15 by the chairs of the GOP and Democratic Doctors Caucuses, which would establish an annual MEI-based update, reform budget neutrality, replace MIPS, make changes to expand APM opportunities and incentives, and create a new primary care payment pilot outside of budget neutrality. The AMA is urging Congress to act before these cuts take effect on January 1 and will be engaging lawmakers during the lame-duck session.

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

In response to advocacy by the AMA and more than 150 national medical specialty societies, state medical organizations, and other health care organizations in a joint sign-on letter, CMS significantly scaled back its proposal to cut payment when an office/outpatient evaluation and management (E/M) visit is reported with modifier -25 on the same day as a global procedure. CMS had proposed to pay the highest-valued service in full

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and cut payment for every other same-day service by 50 percent for procedures with 0-, 10-, and 90-day global periods. In the final rule, CMS instead:

- limits the policy to 0-day global procedures only, dropping 10- and 90-day global procedures;
- reduces payment for lower-valued same-day service(s) by 20 percent rather than 50 percent;
- applies the policy only to services furnished by the same physician or a physician of the same specialty in the same group practice, so same-day services by physicians of different specialties in the same group are not affected.

The policy applies only to office/outpatient E/M visits and takes effect January 1, 2027. CMS estimates the largest impacts will still fall on dermatology, otolaryngology, and podiatry, though smaller than under the proposed policy (CMS estimates this reduces specialty impacts by about 1 percent). The AMA will continue to explore opportunities in lame duck to secure additional changes.

Modifications to the Practice Expense (PE) Methodology

CMS finalized all four interrelated PE methodology changes as proposed. The AMA had urged CMS to delay the changes until it published specialty-level impacts for each one, and to phase in any changes over four years. CMS declined. It said the policies interact, so publishing their impacts separately would misrepresent their combined effect. CMS also said the new ±5 percent PE cap will phase in changes more gradually than a four-year transition would for many codes.

1. *Indirect PE allocation*

CMS will allocate indirect PE (overhead such as rent and administrative staff) based on the sum of the work and clinical labor RVUs for all services except 10- and 90-day global services. CMS currently uses this methodology only for services with professional and technical components; all others use the greater of the two. CMS excluded 10- and 90-day global services because their bundled valuation does not show how physician work, clinical staff time, and PE each contribute to payment, citing its broader concerns about global surgical valuation.

2. *Elimination of the indirect practice cost indices (IPCIs)*

CMS will phase out the IPCI over two years beginning in 2017. The IPCI rescales indirect PE to specialty-level data from the 2007 AMA Physician Practice Information (PPI) Survey. CMS will continue to use the 2007 data elsewhere in the methodology but reiterated concerns about it and said it may reduce reliance on it in future rulemaking. CMS also declined to use the updated PPI Survey data or to field a new specialty-level survey, citing low response rates and non-random samples. This suggests CMS is unlikely to rely on specialty-specific PE data going forward.

3. *PE stabilization adjustment*

CMS will limit year-to-year changes in a service's PE RVUs to ±5 percent. The cap does not apply to new, revised, revalued, or newly nationally priced codes. It operates separately from the statutory 19 percent limit on annual RVU reductions, so some codes may be subject to both.

4. *Utilization adjustments (setup file)*

CMS will adjust utilization in the PE methodology using the ratio of allowed charges to the national payment amount for each claim line, to account for modifiers, payment rules, and geographic mix. CMS also corrected a

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technical error in its handling of codes billed in multiple units, which had produced large, unexplained drops in estimated allowed charges for certain specialties in the proposed rule.

Remote Monitoring

CMS modified its proposed changes to the direct practice expense inputs for the remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) codes. It finalized the proposed reductions to eight codes, noting that the cuts will be phased in over several years, but did not finalize its proposal to eliminate direct PE inputs for six codes. CMS also stated that it looks forward to reviewing the information from the RUC's review of the codes for future rulemaking. Importantly, it did not finalize its proposal to replace 17 RPM and RTM CPT codes with 4 HCPCS G-codes.

The AMA had also urged CMS to withdraw its plan to restrict delivery of RPM and RTM services to employees of the practice, which could have been highly disruptive and impaired patients' access. In the final rule, CMS states that it is delaying this change for two years, so practices will be able to continue to provide these services through contractual and other arrangements, not just through employees of the practice.

RUC Relative Value Recommendations

CMS accepted 90 percent of the AMA/Specialty Society RVS Update Committee's (RUC's) relative value recommendations for 2027, including for maternity care services, prostate biopsy, and magnetic resonance angiography, head and neck services. CMS had initially proposed to reduce the RUC recommendations for shoulder, hip and knee arthroplasty, but has finalized 2027 work RVUs at the RUC recommended values. CMS also accepted 100 percent of the RUC Health Care Professionals Advisory Committee (HCPAC) Review Board recommendations, including speech-language pathology services, and nearly all of the RUC's direct practice expense recommendations.

Maternity Care Services Codes

The AMA is pleased CMS finalized the revised Maternity Care Services CPT codes, which take effect January 1, 2027. CMS did not finalize an alternative on which it had sought comment: creating HCPCS G-codes to maintain the historical global structure for maternity care. The AMA worked closely with the American College of Gynecologists to urge CMS to adopt the CPT code set without parallel G-codes, noting that two coding structures would create confusion and administrative burden for care teams and patients. The AMA also noted that the new codes, developed over nearly two years by obstetricians, family physicians, and others, reflect modern obstetric practice. They will provide much-needed transparency for patients and more granular data to help physicians and researchers better understand the drivers of maternal mortality. CMS announced that starting January 1, 2027, HHS will not take enforcement action against HIPAA covered entities that use the 2026 CPT maternity care codes for maternity care episodes that began in 2026 and end in 2027, as long as they follow business rules issued by payers and health plans. The enforcement discretion ends December 31, 2027.

Merit-based Incentive Payment System (MIPS)

Following advocacy by the AMA not to increase the MIPS performance threshold, last year CMS finalized policy to maintain the threshold to avoid a MIPS penalty at 75 points through the CY 2028 performance year/2030 MIPS payment year.

In response to AMA advocacy, CMS has modified its proposal to sunset the traditional MIPS reporting option. While CMS proposed to sunset traditional MIPS after the CY 2028 performance period, CMS finalized policy after the CY 2030 performance period—a two-year delay. Beginning with the CY 2031 performance period,

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MVPs will be the only MIPS reporting option for clinicians who don't participate in a MIPS APM. The AMA continues to urge CMS to incentivize, rather than mandate, MVP reporting, and the need to redesign MVPs to focus on the specific health conditions and procedures that an individual physician would treat. The AMA has advocated that CMS not mandate participation in MVPs until fundamental issues are addressed including lack of applicable MVPs for many specialties and subspecialists. In addition, ensuring that rules enable meaningful clinical comparisons and fair and accurate scoring that do not result in artificial scoring discrepancies that have more to do with a physician's specialty than their actual performance. The AMA will continue to work with specialties and CMS to attempt to address these issues and improve MVPs.

CMS also finalized its policy to eliminate the outcome measure requirement for satisfactorily meeting the Quality Category starting with the CY 2027 performance period, which has been a longstanding ask of the AMA. However, instead of reporting on one outcome measure to satisfactorily meet the Quality Category, the policy has been replaced with a core measure requirement, which the AMA feels is an improvement because there has been a shortage of outcome measures, specifically for specialists in the program and the definition of a core measure is more flexible. Small practices will be exempt from this requirement. In our comments, we urged CMS to delay the requirement until CY 2028 MIPS performance period to obtain more input into which measures should initially classify as a core measure and ensure EHR, and registry vendors are ready to support the core measures.

CMS finalized changes that give physicians flexibility to adopt electronic prior authorization for medical items and services. For the 2027 performance period, the measure is optional, offers 10 bonus points for physicians who attest "Yes," and carries no scoring penalty for those who do not report it. This is an AMA win that gives practices additional time to implement and test technology controlled by payers and EHR developers. However, CMS retained mandatory reporting beginning in 2028, declining the AMA's request to extend the voluntary approach.

CMS also finalized three changes that simplify Promoting Interoperability reporting. Beginning with the 2026 performance period, CMS removed the required ONC Direct Review attestation, which could trigger a zero for the entire PI category if omitted, and the optional certification body surveillance attestation. Beginning in 2027, CMS eliminated the Security Risk Analysis measure, removing duplicative reporting and attestation requirements. Physicians must continue conducting applicable security risk analysis and risk management activities under HIPAA.

Medicare Shared Savings Program

CMS finalized several changes as proposed to Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), including a higher shared savings rate (60 percent, up from 50 percent) for ACOs in Level E of the BASIC track; new financial incentives for first time participants; several benchmarking, patient assignment, and quality reporting changes; and the option to reduce or eliminate beneficiary out-of-pocket costs for certain items and services.

- **Eliminating blanket PI reporting:** Beginning in 2027, CMS replaces the MSSP requirement to report all MIPS PI measures with three flexible ways to demonstrate certified EHR use, including credit for existing electronic quality reporting without a separate attestation.

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- **Reducing requirements across ACO practices:** For ACOs choosing the EHR activity attestation pathway, CMS requires only one provider or supplier in each participating practice to perform the selected activity, with exclusions for qualifying practices facing hardships or meeting specified special statuses, including rural practices.

- **Simplifying public reporting:** Beginning in 2027, CMS eliminates the requirement to calculate and publicly report counts of participants earning PI scores. ACOs instead identify which certified EHR use pathway they selected.

Advanced Alternative Payment Model (APM) Determinations

Despite AMA opposition, CMS generally finalized its proposal to determine Advanced APM Qualifying Participant (QP) status at the TIN/NPI combination level rather than the NPI level. That means, beginning with the 2027 performance/2029 payment year, APM incentive payments and the higher QP conversion factor will apply only to claims billed under a qualifying clinician's APM-participating TINs, rather than all their TINs. CMS did make one slight modification that it would apply partial QP status to all of a clinician's TINs if the clinician qualified as an individual. CMS says this will prevent a "windfall" of APM incentive payments to non-APM participating TINs and estimated in the proposed rule that it would reduce payments to APM participants by $2.38 billion over the next decade. However, this number is anticipated to grow exponentially in the future due to the cumulative impact of 0.5 percentage point higher CF for APM QPs every year. The AMA had urged CMS not to finalize the change, which we believe exceeds CMS' authority under MACRA, will result in unnecessary operational complexity, and will discourage APM participation, particularly among specialty, small, rural, and independent practices. The AMA will continue to push back against this policy.

Ambulatory Specialty Model (ASM)

Although CMS finalized ASM regulations during the 2026 rulemaking cycle, the model is scheduled to start in 2027 and it proposed several modifications in this year's proposed rule concerning changes to physician specialty designations and TINs, as well as Quality and Promoting Interoperability measures. AMA comments recommended several changes to these proposed policies and reiterated the need for important changes to the policies adopted last year. Recently, the AMA joined several other national organizations in a joint letter calling for the initial launch of ASM to be delayed until all operational and technical infrastructure is available, tested, and ready, as well as for holding participants harmless from downside risk in the first year if the launch is not delayed. In the final rule, CMS generally finalized the changes as proposed, but it did adopt AMA recommendations that participants not have to notify CMS of specialty or TIN changes and that cardiology subspecialists should not need to be board certified in their subspecialty to be exempt from ASM. CMS did not propose more fundamental changes to the policies adopted in last year's rule, however, and reiterated that it still plans to launch the model in January 2027.

CPT Request for Information

CMS included a request for information (RFI) on the CPT code set, CPT licensing, the CPT code development process, and the RUC. The RFI questioned the AMA's role and sought input on alternatives to CPT as the national code set for physician services, including paying for physician services using ICD-10-PCS or other bundled approaches. In its comments, the AMA explained that CPT is a clinically grounded national standard, maintained for 60 years, that CMS uses at no cost. It clarified that the CPT Editorial Panel creates codes and the RUC recommends resource inputs, while CMS alone determines payment. It also cautioned that replacing CPT

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or introducing competing code sets would add cost and disrupt claims processing, quality measurement, and interoperability. In the final rule, CMS did not propose changes and noted that commenters broadly supported a single national coding standard and opposed alternative code sets to CPT. CMS noted that the Agency "highly value[s] the expertise of volunteer groups of physicians who submit relative resource recommendations" and reaffirmed "the crucial role for physicians to provide input to the federal government based on firsthand expertise," noting that "It is in both CMS and the public's interest to consider input from doctors and front-line medical health professionals about the medical services they perform in their daily patient care, and we reiterate that CMS considering the relative resource costs associated with services in accordance with 42 USC 1395w-4(c) when setting payment for physician services. CMS reiterates the RUC or other organizations may submit data to support valuation of physician services, and we encourage all organizations to do so." However, CMS acknowledged comments focused on the RUC and that it is "considering a number of potential avenues for improving this process," citing commenters' recommendations on transparency, data sources, and committee composition.. CMS also stated a desire for additional empiric data and reporting expected clinical outcomes and may establish this additional information as a requirement in future rulemaking.

Additional Resources:

- CMS Press Release
- Physician Payment Schedule Fact Sheet
- Medicare Shared Savings Program Fact Sheet
- Quality Payment Program (QPP) Fact Sheet

This summary is a result of a quick review of the rule in the first 24 hours. Stay tuned for AMA's detailed summary. Reach out to AMA.advocacy@ama-assn.org with any immediate questions.

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