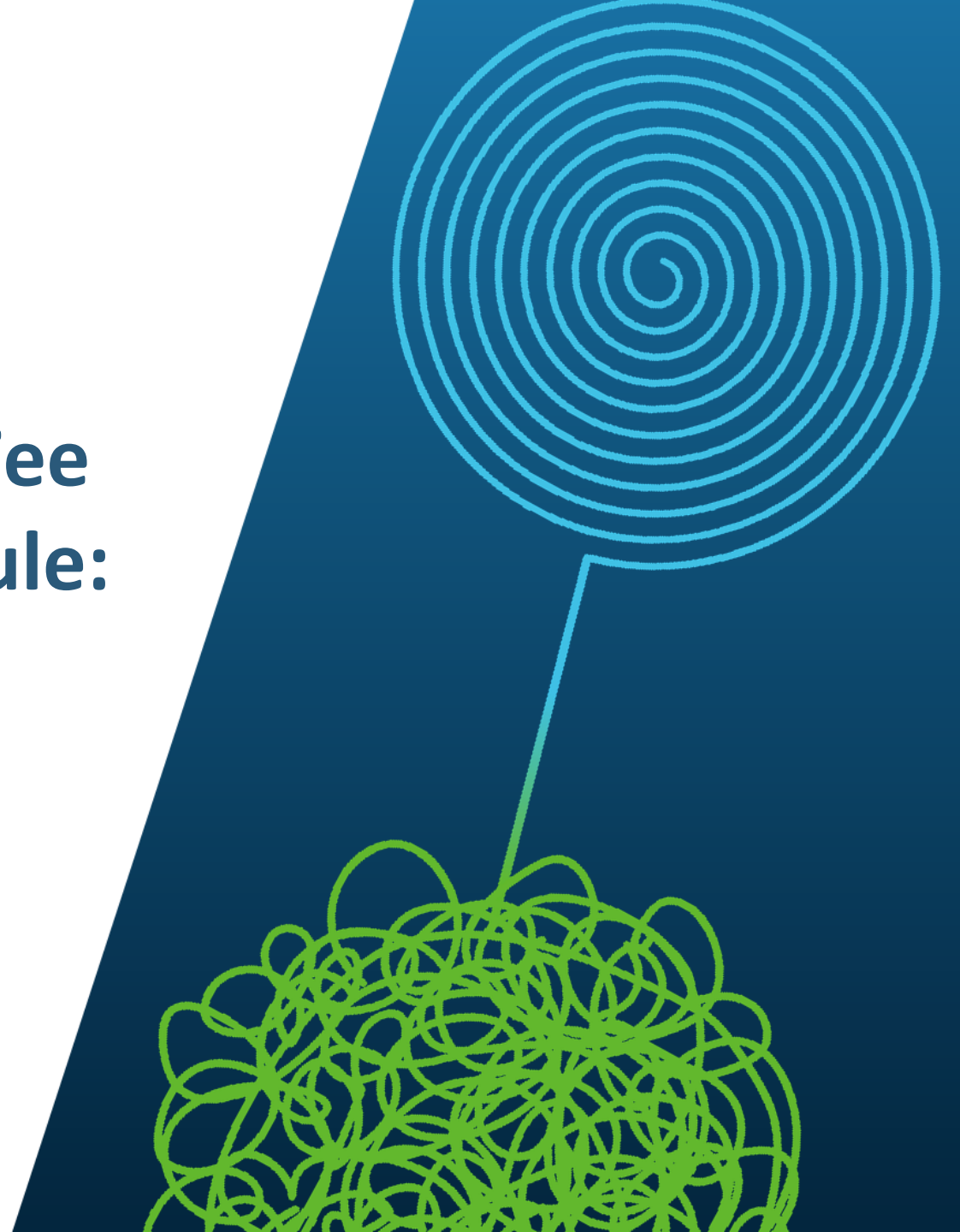
Healthcare Regulatory Roundup #116

CY 2027 Medicare Physician Fee Schedule (MPFS) Proposed Rule:

Key Changes and Strategic Implications

August 12, 2026



Today's Agenda

1. Conversion Factors and Payment Impacts

- CY 2027 proposed conversion factors, specialty and site-of-service exposure, and baseline payment analysis

2. Practice Expense Reform

- Why CMS is reworking the PE methodology and operational implications for providers

3. Payment Policy Updates: G2211 and Modifier -25

- G2211 redesign from add-on code to percentage modifier; global surgery and same-day E/M Modifier -25 risk and revaluation

4. Telehealth and Remote Monitoring

- Telehealth flexibility extensions through CY 2027; RPM/RTM coverage, staffing, and valuation tightening

5. ACO and MIPS Developments

- MSSP/ACO incentive enhancements and BASIC Level E savings rate increase; MIPS sunset and MVP pathway transition

6. Care Model Signals and RFIs

- Care model proposals for chronic disease, behavioral health, ACP, RHC/FQHC; major RFIs on primary care redesign and CPT/RUC process

7. Action Steps and Implementation

- Practical action matrix by industry segment; comment deadline September 14, 2026; final rule expected November 2026

Introductions

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What Changes Most if Finalized?

- CMS proposes reduced CY 2027 conversion factors despite statutory updates because the temporary CY 2026 2.5% increase expires.
- The rule combines rate pressure with redistribution: practice expense reforms, modifier -25/global surgery changes, G2211 redesign, and ACO incentives.
- **Underlying theme: Medicare is pushing payment toward longitudinal, preventive, technology-enabled, and accountable care while constraining payment where CMS believes there may contain overlapping resources.**

Strategic Takeaway

The CY 2027 rule is not just a rate cut — it is a structural redistribution of Medicare payment. Organizations that understand both the immediate dollar impact and the directional policy shift will be better equipped to adapt.

How to Read the Rule:

Immediate Financial Impact vs. Policy Direction

Payment Impact

Executives

- Margin scenarios by service line, CF status, and site of service
- Quantify the 2027 budget delta before the final rule drops

Operational Readiness

Physician / Medical Groups

- Code-level exposure across top CPT/HCPCS families, modifier usage, and workflow changes driven by PE reform and global surgery proposals

Compliance Risk

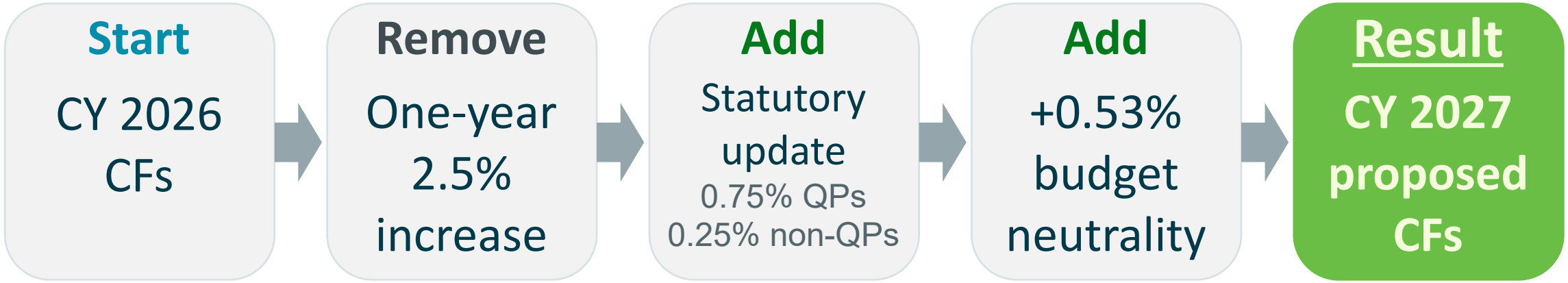
Legal / Compliance Teams

- Documentation standards, billing policy updates, vendor-arrangement review, and contracting implications tied to RPM/RTM, telehealth, and supervision rules

Strategic Takeaway

Each stakeholder in the room needs a different cut of the same rule. Build separate analytical workstreams for finance, operations, and compliance — and connect them through a shared implementation timeline.

How the CY 2027 Conversion Factors Are Built



CMS cannot itself replace the expiring temporary increase; the practical rate story remains linked to Congressional action.

Conversion Factor and Baseline Payment Impacts

- Proposed CY 2027 **qualifying APM conversion factor: $33.17**, down 1.19% from CY 2026.
- Proposed CY 2027 **nonqualifying APM conversion factor: $32.84**, down 1.68% from CY 2026.
- Anesthesia CFs are also proposed to decline**:** **$20.42 for QPs** and **$20.21 for non-QPs**.

Qualifying APM CF
$33.17
▼ 1.19% vs. CY 2026

Non-Qualifying APM CF
$32.84
▼ 1.68% vs. CY 2026

Anesthesia CF (QP/Non-QP)
$20.42/$20.21
▼ Proposed decline

Strategic Takeaway

The CF decline is driven by expiration of a temporary fix, not a new policy penalty. QPM participants receive a slightly more favorable rate — another reason to evaluate ACO and APM participation strategy now.

Specialty and Site-of-Service Exposure

- CMS impact tables should be translated into local service-line and compensation effects, not treated as average national outcomes.
- Largest risks are not only from the CF; PE methodology and global surgery/Modifier -25 proposals create specialty-specific redistribution.

Priority Modeling Areas

- High-volume procedural & office-based services
- Nursing facility & diagnostic code sets
- Care-management codes — PE and site-of-service sensitivity

Strategic Takeaway

National averages mask local exposure. Every organization must run its own code-level and site-of-service impact analysis — the national CF change will not tell you whether your highest-volume service lines win or lose.

Practice Expense Reform:

CMS Is Proposing to Rework the Engine

- CMS proposes:
  - Reducing reliance on older specialty-specific PE/hour data and move toward more objective, routinely updated, auditable cost data
  - Removing the Indirect Practice Cost Index (IPCI) over a two-year transition
  - Revising the indirect PE allocator to use work RVUs plus clinical labor PE RVUs for most services, excluding 010- and 090-day global period codes
  - PE stabilization adjustment that generally caps year-over-year PE RVU increases or decreases at 5% for many existing services

Strategic Takeaway

The PE reform is the most structurally significant piece of this rule. The two-year transition provides a runway, but organizations need to understand which codes are PE-sensitive to plan for significant reimbursement shifts.

Practice Expense Reform: Significant Implications

Call to Action

Hospitals & Health Systems

Assess employed-physician and facility-setting PE assumptions.

CMS seeks comment on how PE costs vary by employment model and site of service.

Physician Groups

Inventory codes where indirect PE is material and compare facility vs. non-facility economics.

Hospital-based also affected by site of service changes.

Rural & Independent Practices

Evaluate whether proposed PE shifts alter service availability, staffing, or outsourcing economics.

Compliance/Legal

Preserve documentation supporting actual practice costs, clinical labor, equipment, and site-of-service assumptions.

Strategic Takeaway

PE reform creates a significant comment opportunity. Organizations with robust cost data should submit comments, CMS has explicitly invited input on employment model and site-of-service PE variation.

Payment Policy Update – G2211 Redesign:

From Add-On Code to Percentage Modifier

- CMS proposes to transition HCPCS G2211 from a separate add-on code to a percentage-based modifier on the underlying office/outpatient E/M service.
- Proposed MOD1 would increase payment for qualifying office/outpatient E/M services by 16%.
- Proposed MOD2 would increase payment by 32% for eligible practitioners in Medicare Shared Savings Program ACOs and LEAD Model ACOs.

MOD1 **All Qualifying E/M**

+16%

Payment increase for qualifying office/outpatient E/M services billed with the modifier.

Eligible: Any qualifying practitioner

MOD2 **ACO-Participating Providers**

+32%

Enhanced payment for practitioners in MSSP ACOs and LEAD Model ACOs furnishing qualifying E/M services.

Eligible: MSSP & LEAD ACO participants

Strategic Takeaway

Monitor physician compensation arrangements tied to G2211. While the proposal may increase practice revenue, physicians could lose the current 0.33 wRVU productivity credit if G2211 is no longer reported as a separate code.

Global Surgery and Same-Day E/M:

Proposed CMS Changes

- CMS proposes to reduce payment when a separately identifiable **office/outpatient E/M visit** is furnished by the same physician or same group on the same day as a **0-, 10-, or 90-day global procedure**.
- Under the proposal, the highest-paid applicable service would be paid at 100%; other applicable surgical procedures or E/M visits would be paid at 50%.
- CMS frames the change as addressing overlap between E/M resources included in global packages and separately billed E/M services.
- Operational risk: scheduling, documentation, and coding behavior may need review to avoid both underpayment and inappropriate visit-splitting.

Payment Impact

Highest-paid service	**100%**
Other same-day services	**50%**

Applies to same-day E/M + global surgery (0-, 10-, or 90-day periods) by same physician or group

Action Required

Audit O/O E/M w/ applicable global day procedure usage and same-day scheduling patterns. Revenue cycle and compliance both have a stake in the outcome.

Strategic Takeaway

The 50% reduction for same-day E/M and global surgery services could materially affect proceduralists. Model O/O E/M and 0, 10, 90-day global usage and ignore the modifier (modifier 24 and 25 will be impacted).

Global Surgery Data and Future Revaluation

- CMS proposes to pause additional post-operative visit data collection while seeking comment on strategies to improve global package valuation.
- CMS also discusses transparency challenges where bundled global payments obscure pre-, intra-, and post-operative components.
- Strategic implication: surgical services should expect continued scrutiny of global period assumptions, post-op visit frequency, and empirical data.

Strategic Takeaway

The pause in data collection is not a retreat — CMS is signaling it wants better data before the next global surgery revaluation. Surgical specialties should participate in comments and be prepared to submit utilization data that supports fair valuation.

Telehealth Updates and Communications Technology

- CMS proposes:
  - Conforming changes to implement statutory telehealth flexibility extensions through CY 2027
  - Adding selected HCPCS G-codes to the Medicare Telehealth Services List, including clinical staff advance care planning, shared medical appointments, pediatric speech-language pathology, and vaccine adverse-effect evaluation codes
  - Revised descriptors for telehealth critical care consultation codes G0508 and G0509
  - New informational telehealth modifiers (BB/BC), including modifiers to identify services furnished through certain virtual platform arrangements.

Originating Site Facility Fee

$32.65 Proposed CY 2027 telehealth originating site rate

Key Codes Revised

G0508
G0509

Telehealth critical care consultation code descriptors updated

Strategic Takeaway

Telehealth flexibilities are extended but not made permanent. Organizations should not assume current telehealth operations will remain unchanged beyond CY 2027 — longer-term program design should account for potential reversion.

RPM/RTM: Coverage, Staffing, and Valuation Tightening

- CMS proposes:
  - That RTM services be furnished only to established patients, aligning with the RPM established-patient policy
  - A separately reportable face-to-face initiating visit, in person or telehealth, at the onset of RPM or RTM services
  - To count RPM/RTM clinical staff time only when the staff are direct employees of the billing practitioner or practice and furnishing services under general supervision
  - Valuation changes and seeks comment on consolidating 17 RPM/RTM codes into four HCPCS G-codes

Strategic Takeaway

The RPM/RTM proposals are a significant program integrity tightening. Organizations using vendor-staffed remote monitoring models should submit comments while also assessing how they will modify their delivery model to meet the new direct-employment and supervision requirements if these proposals are finalized.

MSSP/ACO Enhancements:

Incentives, Benchmarks, Engagement

- CMS proposes:
  - To increase the BASIC Track Level E shared savings rate from 50% to 60% for agreement periods beginning on or after January 1, 2027
  - Multiple benchmark and financial methodology refinements, including prior-savings adjustment, regional adjustment, growth adjustment, and Accountable Care Prospective Trend changes
  - Allowing eligible ACOs to reduce or eliminate Part B cost sharing for assigned beneficiaries, subject to CMS approval and clinical-goal requirements
  - CEHRT simplification pathways and beneficiary-assignment refinements intended to support accountable care participation

Shared Savings Rate

50% → 60%

BASIC Track Level E increase for agreement periods starting Jan 1, 2027

MOD2 Bonus

+32%

E/M payment increase for MSSP ACO participants under the G2211 redesign

Beneficiary Benefit

Part B

Eligible ACOs may reduce or eliminate Part B cost sharing for assigned beneficiaries

Strategic Takeaway

The BASIC Level E savings rate increase from 50% to 60%, combined with MOD2 eligibility, makes MSSP participation significantly more attractive. Organizations on the fence should model the updated economics before the final rule.

MIPS, MVPs, and Advanced APM Developments

- CMS proposes:
  - Sunsetting traditional MIPS reporting beginning with the CY 2029 performance period, moving clinicians toward MVPs unless they report through an APM pathway
  - Three new MVPs for CY 2027: diabetic disease, hypertension, and hospitalist
  - Modifying existing MVPs and introducing MIPS core measure requirements
  - Assigning QP status at the TIN/NPI combination level, limiting APM benefits to the participating TIN/NPI relationship

Strategic Takeaway

Traditional MIPS has a sunset date. Organizations still relying on traditional MIPS reporting should begin mapping to MVPs or APM pathways now — the 2029 deadline is closer than it appears in implementation terms.

Traditional MIPS Sunset:
CY 2029
performance period

Other Care-Model Signals:

Chronic Disease, Behavioral Health, ACP, RHC/FQHC

- Shared medical appointments (SMAs)
  - CMS proposes separate coding and payment for shared medical appointments for patients with common chronic conditions.
- Behavioral health valuation
  - CMS proposes increased work RVUs for smoking/tobacco cessation and SBIRT services as part of behavioral health valuation updates.
- Advance Care Planning (ACP)
  - CMS proposes new advance care planning G-codes for clinical staff time directed by a treating practitioner.
- RHC/FQHC updates
  - CMS proposes recognizing DSMT and MNT as stand-alone billable RHC visits and updating FQHC PPS base rate methodology.

CMS Policy Direction

- **Chronic disease management rewarded**
- **Behavioral health integration valued**
- **Community-based care investment**
- **Coding readiness is a prerequisite**

Strategic Takeaway

CMS is sending consistent signals that chronic disease management, behavioral health integration, and community-based care will be rewarded. Organizations not yet billing these services should assess coding readiness and clinical workflow implications.

Major RFIs: What CMS Is Testing for Future Rulemaking

- Primary Care redesign
  - CMS seeks comment on improving primary care valuation, technology-enabled care, and prospective/capitated primary care payment.
- CPT/RUC process
  - CMS seeks comment on the influence of CPT and RUC processes on physician payment policy and possible alternatives.
- Duplicate testing, imaging, and interoperability
  - CMS seeks input on payment, documentation, frequency, and data-sharing approaches for duplicate laboratory testing, imaging, and interoperability.
- QPP and future-looking topics
  - QPP RFIs include digital quality reporting, MVP scoring, and public reporting methodology; other topics include palliative care, Alzheimer's disease prevention, and clinical trial counseling.

Strategic Takeaway

RFIs are CMS's policy laboratory. The primary care capitation and CPT/RUC process RFIs in particular signal potentially transformative changes to how physician payment is structured. Responding to RFIs is an opportunity to shape future rules — not just react to them.

Practical Action Matrix Before the Final Rule

Audience Segment	Priority Actions
Hospitals/health systems	Model employed-physician, HOPD, nursing facility, and procedural service-line impacts; test PE and E/M exposure; review ACO and care-management strategy.
Physician groups	Run top-code payment simulations; review G2211/MOD1/MOD2 assumptions; examine modifier -25/-24 and global-period documentation; assess RPM/RTM staffing model.
Rural providers	Evaluate whether PE, telehealth, RHC/FQHC, RPM/RTM, and workforce assumptions affect access; prepare comments with access-specific data.
ACOs	Reassess BASIC Level E vs. ENHANCED strategy, benchmark changes, beneficiary cost-sharing options, CEHRT pathways, and QPP reporting readiness.
Compliance/Legal	Review vendor agreements, incident-to/general-supervision assumptions, documentation policies, beneficiary consent, billing edits, and final-rule implementation governance.

Strategic Takeaway

Every organization has distinct action items. Use this matrix to assign owners and deadlines — the comment period closes September 14, 2026, and the final rule typically drops in November.

Action Trigger

Comment deadline: September 14, 2026.
Final rule expected: November 2026.

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Wednesday, August 26 11 am – 12 pm ET

FY 2027 Medicare Final Rules: Inpatient, SNF, Rehab, Psych, and Hospice Updates

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