AMERICAN OSTEOPATHIC ASSOCIATION

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CY 2027 Medicare Physician Fee Schedule and Quality Payment Program Proposed Rule

Overview

On July 14, 2026, the Centers for Medicare & Medicaid Services (CMS) issued the CY 2027 Medicare Physician Fee Schedule proposed rule which includes updates to physician payment policies, the Quality Payment Program (QPP), and the Medicare Shared Savings Program. The AOA will advocate across all avenues to protect patient access to care and appropriate physician payment. Key takeaways include the following.

- As of CY26, physicians who are qualifying participants in advanced alternative payment models (AAPMs) under the Quality Payment Program (QPP) are subject to a different conversion factor than physicians who are not qualifying participants (i.e. MIPS participants). Both conversion factors will see a decrease in 2027, with the APM conversion factor decreasing by 1.19% and the non-APM conversion factor decreasing by 1.68%.
- The agency is proposing substantial payment reductions when a separately identifiable office/outpatient (O/O) evaluation/management (E/M) is furnished on the same date as a 0-, 10-, or 90- day global procedure.
- CMS is proposing to transition how the G2211 visit complexity add-on code is billed from a standalone code to a modifier, and CMS will create an additional modifier to account for the resources associated with providing care as part of an accountable care organization (ACO).
- In regard to the Quality Payment Program, CMS proposes to sunset traditional MIPS starting in the CY 2029 performance year and fully transition to MIPS Value Pathways (MVPs). CMS also proposes to create new core measure designations for the quality performance category, in addition to measure inventory and reporting changes across performance categories.

Outlined below is an initial summary of this year's proposed rule. The AOA will share more details as it continues to review the proposed rule in detail and will submit comments to CMS on its proposals ahead of the September comment deadline.

Physician Fee Schedule

Conversion Factor

Fee-for-service payments under the Medicare program are determined by multiplying the relative value units (RVUs) for work, practice expense, and malpractice for a given service by the fee schedule conversion factor. These values are then adjusted based on geographic practice cost indices (GPCIs). As of January 2026, physicians who are qualifying participants (QP) in advanced alternative payment models (AAPMs) under the Quality Payment Program (QPP) are subject to a different conversion factor than physicians who are not qualifying participants (i.e. MIPS participants).

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Due to the expiration of the 1-year conversion factor increase enacted under the One Big Beautiful Bill Act, which was secured through extensive AOA advocacy, CMS has proposed to reduce conversion factors for CY27. For 2027, conversion factors will be as follows:

Clinician Classification	2027 Conversion Factor (CF)	Percent Change from 2026
APM QP	33.169	-1.19%
Non-APM QP	32.841	-1.68%
Anesthesia APM QP	20.417	-0.89%
Anesthesia Non-APM QP	20.214	-1.39%

The AOA will continue to work with Congress to prevent the proposed reductions and enact long-term physician payment reform to ensure sustainable payment that reflects the rising cost of practicing medicine.

Payment Reduction for E/M Services Furnished with Procedures

Beginning in 2027, CMS is proposing to reduce payment when separately identifiable E/M services are appended with a modifier -25 and furnished with another 0-. 10-, or 90- day procedure on the same date. Under the proposal, the most expensive service would be paid at 100% while payment for all other services furnished would be reduced by 50%. This payment reduction would impact the delivery of thousands of services commonly provided on the same day as an E/M, including osteopathic manipulative treatment (OMT). CMS had previously proposed implementing this policy in 2019 but did not finalize the provisions following advocacy from AOA. CMS claims that this policy is intended to account for efficiencies when services are provided on the same date, and potentially duplicative payment, but this rationale reflects a misunderstanding of the RBRVS Update Committee (RUC) process for service valuation. The AOA will advocate to prevent this policy from going into effect.

E/M Visit Complexity Add-on Code

CMS is proposing substantial changes to how the G2211 visit complexity add-on code is billed and paid. First, CMS proposes to transition G2211 from a code to a modifier that would be used to append an E/M base code. CMS proposes that this modifier would be used to increase the value of the associated service by 16%, rather than establishing a flat rate through a single code. For higher level E/M visits (99214 and 99215), this change would result in a modest increase in payment relative to the current methodology. However, it would result in a slight reduction compared to current payment when appended to lower level E/M codes (99212 and 99213).

Second, CMS will create a second modifier that would be intended to recognize the resource costs incurred by ACOs in providing longitudinal care. Examples of costs CMS cites include the work and resources associated with maintaining total cost of care accountability for a patient, work associated with coordinating needed care for a patient, as well as “reporting quality measures that can align with providing longitudinal care and care coordination.” CMS proposes to value this modifier as increasing payment for the associated E/M by 32%. when performed by Shared Savings Program ACO participants, ACO professionals, and ACO providers/suppliers, as well as Participant Providers in the Long-term Enhanced ACO Design (LEAD) Model. CMS outlines specific rules for how ACO participants would use this modifier, and the overall intent is to account for the work these clinicians perform.

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Telehealth

Following AOA advocacy on the Consolidated Appropriations Act (CAA) of 2026, congress extended telehealth flexibilities enabling payment for telehealth services provided to patients in their homes through December 2027. CMS proposes several changes related to telehealth policy. First, CMS is implementing provisions of the CAA, including creating modifiers for claims for telehealth services furnished by physicians or practitioners that contract with or have payment arrangements with the telehealth virtual platform used to provide the services, and for telehealth services furnished incident to a physician's or practitioner's service. Second, CMS proposes creating greater flexibility in billing of telehealth services involving residents, allowing teaching physicians to bill for services involving residents when either the teaching physician or resident is in the same physical location as the beneficiary.

Expansion of Teaching Physician Policy Related to the Primary Care Exception

CMS is expanding its primary care exception policy and proposing to allow payment for all levels of an O/O E/M service provided in primary care centers without the presence of a teaching physician. The service must meet the requirements of the primary care exception, and be provided under direct supervision of the teaching physician, in such cases where the teaching physician must believe such care is clinically appropriate.

Quality Payment Program

CMS proposes substantial changes to the Quality Payment Program, including updates to measure inventories and program requirements. Most notably, CMS is proposing to sunset traditional MIPS and require participation in MIPS Value Pathways (MVPs) beginning in CY 2029. AOA recognizes that this may create challenges and unnecessary complexity for many physicians and will work with CMS to preserve the ability to perform under traditional MIPS or MVPs. To support broad participation in MVPs, CMS proposes to add 3 additional pathways in 2027: diabetic disease, hypertension, and hospitalist.

For physicians who participate in Advanced Alternative Payment Models (AAPMs), beginning in CY27, CMS proposes to apply qualifying participant (QP) and Partial QP determinations at the TIN/NPI level, ensuring that financial incentives are directed only to TINs actively participating in Advanced APMs. Additionally, it is important to note that QP thresholds will once again increase to 75% of Medicare payments or 50% of Medicare patients through an APM for full QP status, or 50% of payments and 35% of patients through an APM for partial QP status.

AOA continues to work with CMS and Congress to enact comprehensive MIPS reform that alleviates unnecessary burden and supports more appropriate payment.

Conclusion

The AOA will continue its detailed review of the CY2026 Medicare Physician Fee Schedule and will share resources with members as they are developed. In the meantime, if you have any questions, please contact Gabriel Miller, Associate Vice President of Public Policy, at gmiller@osteopathic.org.