AMERICAN OSTEOPATHIC ASSOCIATION

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

On November 4, the Centers for Medicare & Medicaid Services (CMS) issued the CY 2027 Medicare Physician Fee Schedule final rule which includes updates to physician payment policies, Medicare Shared Savings Program, and the Quality Payment Program (QPP). The rule makes critical changes to payment of importance to osteopathic physicians across specialties. The AOA's Public Policy team will continue to review the final rule thoroughly and develop in-depth summary and assessment, which will be available in the coming days. The following highlights the immediate takeaways from the 2,400–page rule.

Consistent with the expiration of the statutory 2.5 percent increase to the Medicare conversion factor in 2026, CMS has reduced the CY 2027 conversion factors accordingly. 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 1.83 percent and the non-APM conversion factor decreasing by 2.31 percent. Relative to the proposed rule, the conversion factors saw further reduction due to budget neutrality requirements. CMS finalized a revised version of its modifier 25 payment reduction while retaining many other originally proposed provisions, which resulted in a slightly higher budget neutrality adjustment. The finalized conversion factors can be found in the table below.

CY 2027 Medicare Conversion Factor Changes

	2026 Conversion Factor	2027 Conversion Factor	Percent Change
APM QP	33.568	32.955	-1.83%
Non-APM QP	33.401	32.629	-2.31%
Anesthesia APM QP	20.600	20.307	-1.42%
Anesthesia Non-APM QP	20.498	20.106	-1.91%

The AOA is deeply disappointed that CMS chose to finalize a payment reduction when office and outpatient (O/O) evaluation and management (E/M) services are furnished on the same date as a 0-day global procedure.

Following extensive advocacy from the AOA emphasizing the harm the modifier 25 payment reduction would cause to patient access and practice sustainability, CMS lowered its payment reduction from 50 to 20 percent and exempted 10- and 90-day global procedures from the policy. However, any payment reduction remains inappropriate. AOA participated in several meetings with CMS, the White House Domestic Policy Council, and Office of Management and Budget to communicate the harm this payment reduction would cause on practices' ability to keep their doors open, as well as the flawed basis upon which CMS proposed the policy. AOA also submitted a joint letter with 67 osteopathic stakeholders opposing the proposed policy. CMS continues to fail to demonstrate meaningful overlap in valuation of distinct services and has arbitrarily finalized the payment reduction. The AOA will continue its advocacy to prevent this policy from going into effect. Outlined below are additional key policy changes across the rule.

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E/M Visit Complexity Add-on Code

CMS is finalizing, as proposed, its policy to transition the G2211 E/M visit complexity add-on code to modifiers that would be appended to E/Ms to adjust payment. CMS would create two modifiers: B1 which would replace the G2211 broadly, and B2 which would be used by Accountable Care Organizations (ACO) participants. The B1 modifier would increase the value of the associated service by 16 percent, 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).

The B2 modifier is 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, as well as "reporting quality measures that can align with providing longitudinal care and care coordination." This modifier would increase payment for the associated E/M by 32 percent 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.

Maternity Care Services

In response to stakeholder feedback, including comments submitted by AOA, CMS is adopting the newly created maternity care service CPT codes and coding framework. The CPT editorial panel revised the maternity care coding framework to better align with modern practice and how care has evolved since the creation of the maternity codes (MMM) global period structure. CMS withdrew its proposal to create a duplicative set of maternity care healthcare common procedure coding system (HCPCS) G-codes mirroring the maternity care bundles under the MMM global structure. AOA expressed concerns that having 2 separate coding frameworks in regulation would bifurcate payment and create administrative complexity for practices. AOA commends CMS for responding to physician concerns.

Merit-Based Incentive Payment System (MIPS)

CMS finalized substantial changes to the Quality Payment Program, including updates to measure inventories and program requirements. Most notably, CMS is finalizing with modification its proposal to sunset traditional MIPS and require participation in MIPS Value Pathways (MVPs). Following concerns raised by stakeholders regarding this transition, including from AOA, CMS is delaying sunset of traditional MIPS to performance year 2031/payment year 2033. AOA recognizes that this may create challenges and unnecessary complexity for many physicians and will continue to work with CMS to preserve the ability to perform under traditional MIPS or MVPs. AOA continues to work with CMS and Congress to enact comprehensive MIPS reform that alleviates unnecessary burden and supports more appropriate payment.

Advanced Alternative Payment Model Participation

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 Tax Identification Number (TIN)/National Provider Identifier (NPI) level, ensuring that financial incentives are directed only to TINs actively participating in Advanced APMs.

The AOA will continue to analyze the final rule and provide resources in the coming days. If you have any questions, please contact Gabriel Miller, Associate Vice President for Public Policy, at gmiller@osteopathic.org.