Summary of the CY 2027 Medicare Physician Fee Schedule Proposed Rule

On Tuesday, July 14, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year 2027 Medicare Physician Fee Schedule and Quality Payment Program proposed rule. CMS also posted a press release, MPFS Fact Sheet, QPP fact sheet, and MSSP fact sheet. The AAFP is reviewing the proposed rule and will provide comments to CMS on matters of importance to family physicians by the due date of September 14, 2026. The final rule will be released around November 1, 2026, and will take effect on January 1, 2027, except where specified otherwise in the final rule.

2027 Conversion Factor and Impact on Family Medicine

As statutorily required, 2027 MPFS will again feature two conversion factors: one for qualifying alternative payment model participants (the APM CF) and one for all other clinicians (the non-APM CF). The CY 2027 APM CF of $33.1693 represents a decrease of $0.40 (-1.19 percent). Similarly, the CY 2027 nonqualifying APM CF represents a projected decrease of $0.56 (-1.68 percent). The reduction to both conversion factors is driven by the expiration of the temporary 2.5 percent physician payment increase enacted by Congress. CMS' valuation updates helped mitigate what otherwise would have been a more severe reduction. Despite the conversion factor reductions, CMS estimates that the impact on total allowed charges by family physicians will be a positive one percent total in 2027 due to a number of more positive changes to specific services frequently delivered by family physicians.

Determination of Practice Expense Relative Value Units (PE RVUs)

CMS proposes multiple refinements to its PE RVU methodology and pricing of specific supply and equipment items and supply packs. Among the PE RVU methodology refinements, CMS proposes to:

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- Calculate indirect PE based on both work RVUs and clinical labor RVUs for all services except 010- and 090-day global period codes, rather than using the greater of work RVUs or clinical labor RVUs as it does now for most codes;
- Remove steps in the methodology that rely on the indirect practice cost index (over a 2-year transition period);
- Apply a new stabilization adjustment to the PE RVUs;
- Use a new approach to account for payment modifiers and other special payment rules.

CMS also proposes to continue using current PE/hour and 2006-based Medicare Economic Index (MEI) cost shares in its methodology rather than transitioning to 2019-based MEI cost shares. Further, CMS proposes to equalize the payment rate for nursing facility visits without regard to the beneficiary's Part A or Part B status by setting the facility PE RVU equal to the non-facility PE RVU for CPT codes 99304-99310 and 99315-99316.

Lastly, CMS proposes to pause the data collection related to how to best value global surgical services as required by the Medicare Access and CHIP Reauthorization Act. In conjunction with this proposal, CMS asks whether all physicians should be required to report code 99024 (Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management (E/M) service was performed during a postoperative period for a reason(s) related to the original procedure) when providing a postoperative follow-up visit otherwise included in a global surgical service.

In addition to its proposals, CMS seeks comments on various issues related to PE RVUs, including:

- How PE costs vary among physicians and to what extent indirect PE are incurred when physicians are employed by a hospital or primarily practice in the hospital;
- Whether a HCPCS modifier should be established for employed physicians;
- How to address the problem that the current structure of global surgery services has effectively obscured how the components of care are individually valued and limited CMS' ability to disaggregate them;
- The utility of displaying RVUs associated with the professional and technical aspects of services that are not currently reportable with modifiers distinguishing the professional and technical components and potential approaches to improving the transparency of such services.

Telehealth Services under the MPFS

CMS proposes adding five new HCPCS codes to the Medicare Telehealth Services List:

- GACP1: Advance care planning services furnished under the direction of a treating physician or other qualified health care professional (first 20 minutes);
- GACP2: Advance care planning services (each additional 20 minutes; add-on code to GACP1);
- GSMAS: Shared medical appointment for 2 to 10 patients with a common medical condition that integrates group education, counseling, peer support, and individualized clinical care; led by a physician or qualified nonphysician practitioner and billed once per patient, per session;
- GSLPP: Individual treatment of speech, language, voice, communication, and/or auditory processing disorders for pediatric patients;
- GADV1: Evaluation and treatment of vaccine adverse effects (each additional 15 minutes; add-on code billed with specified office/outpatient and home-based E/M services).

CMS is also updating its regulations to reflect the telehealth extensions through 2028 enacted by the Consolidated Appropriations Act in 2026. These extensions include the delay of the in-person visit requirement for mental health services delivered via telehealth and the continuation of coverage for certain audio-only telehealth services.

CMS also proposes to replace the current "initial" and "subsequent" language in HCPCS telehealth critical care consultation codes G0508 and G0509 with time-based billing, with G0508 covering the first 30 to 74 minutes and G0509 covering each additional 30 minutes.

Further, CMS seeks to modify its current teaching physician policy for telehealth services involving residents. Under the current policy, billing requires the teaching physician, resident, and patient to each be in separate locations during a three-way telehealth visit. In CY 2027, CMS proposes allowing billing for telehealth services on the Medicare Telehealth Services List when the resident is physically present with the beneficiary and the teaching physician participates virtually, or the teaching physician is physically present with the beneficiary and the resident participates virtually. CMS indicates it generally interprets physical presence as being in the same room as the beneficiary and seeks comment on other scenarios.

Additionally, CMS is proposing to update payment for HCPCS Q3014 (Telehealth Originating Site Facility Fee) based on the projected 2.5 percent MEI increase, from $31.85 in 2026 to $32.65 in 2027.

Valuation of Specific Codes

As usual, CMS offers a multitude of proposals for valuation of specific codes under the fee schedule. For 2027, those of interest to family physicians include:

Maternity Care Services

CMS notes that coding for maternity care services in CPT will change significantly in 2027. To improve payment accuracy of the new codes, CMS proposes to refine the recommended utilization crosswalk to remove four E/M visits from the utilization estimate calculation and reallocate those RVUs within the code family to the new labor and delivery codes. At the same time, CMS seeks comment on whether it should create HCPCS G-codes that would maintain the current coding and payment for maternity services while it continues to consider the potential impact changes in the maternity care code family may have on clinical outcomes for maternal care. These G-codes would be used in lieu of adoption of the new CPT codes for purposes of Medicare payment.

Remote Monitoring

CMS proposes that remote therapeutic monitoring (RTM) be limited to established patients as is the case with remote physiologic monitoring (RPM). Additionally, CMS proposes that those reporting RPM or RTM services must furnish a separately reportable, face-to-face (in-person or telehealth) initiating visit in association with the onset of RPM or RTM. Further, CMS proposes to only allow payment for RPM or RTM services when furnished by clinical staff employed by the practice; as proposed, RPM and RTM codes could not be billed in cases where the service is done by contracting out to third-party companies (i.e., outsourced).

While addressing proposed revaluation of the existing CPT codes for RPM and RTM, CMS also seeks comment on possibly bundling those CPT codes through the creation of four new HCPCS G-codes that describe initial set up and monthly monitoring/management for RPM and RTM. These codes would also be used in rural health clinics and federally qualified health centers.

Smoking and Tobacco Use Cessation and Screening, Brief Intervention, and Referral to Treatment (SBIRT)

CMS proposes to increase the value of the CPT codes for smoking and tobacco use cessation (99406 and 99407) and the G-codes for SBIRT (G2011, G0396, G0397) by 19.1 percent, consistent with an increase in the valuation for timed behavioral health services made in 2024.

Psychiatric Collaborative Care Model (CoCM) (CPT codes 99492, 99493, 99494, G2214) and Advanced Primary Care Management (APCM) BHI add-on codes (HCPCS Codes G0568, G0569)

CMS proposes to increase the work RVUs of each of these codes. Specifically, CMS proposes to increase the work RVUs of CoCM as follows: CPT codes 99492 would be adjusted from a work RVU of 1.88 to 2.75, 99493 from a work RVU of 2.05 to 2.26, and 99494 from a work RVU of 0.82 to 1.13. The work RVU of G2214 is proposed to increase from 0.77 to 1.13. On the other two G-codes, CMS proposes to increase the work RVU of G0568 from 1.88 to 2.75 and the work RVU of G0569 from 2.05 to 2.26.

Evaluation and Management (E/M) Visit Complexity Add-On (HCPCS code G2211)

CMS proposes to replace code G2211 with a modifier (temporarily labeled MOD1) that would be described as "Visit complexity inherent to new or established office/outpatient or home or residence evaluation and management service, associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition." The modifier would increase the value of the E/M code to which it's appended by 16 percent.

CMS also proposes to create a similar modifier (temporarily labeled as MOD2) to be used in accountable care organizations (ACOs). As proposed, MOD2 is described as "Visit complexity inherent to new or established office/outpatient or home or residence evaluation and management service, associated with medical care services furnished by a participant or practitioner participating in a Medicare accountable care organization. Services must serve as the continuing focal point for all needed health care services and/or be part of ongoing care related to a patient's single, serious condition or complex condition." This modifier would increase the value of the E/M to which it's appended by 32 percent and would also be used in beneficiary assignment to ACOs.

Use of both modifiers is proposed as voluntary, and the same limits that apply to using G2211 vis-à-vis an E/M code with modifier -25 appended would also apply to use of these modifiers. That said, CMS seeks comments on potential changes to this policy, such as allowing MOD1 or MOD2 to be billed with modifier -25 when an office/outpatient E/M is done on the same day as a 0-, 10-, or 90-day global procedure.

Shared Medical Appointments (SMAs)

CMS proposes to create coding and valuation specifically for SMAs, also known as group visits. CMS proposes SMAs be limited to beneficiaries who have received a professional service from the billing physician or other qualified health professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice within the previous 12 months. Beneficiaries would need to consent to SMAs, which CMS proposes as 60-minute sessions with a maximum of 10 beneficiaries per session. They could be provided in person or via telehealth.

CMS proposes to create a G-code for an SMA that would be described as "Voluntary, group-based medical session involving multiple patients with common medical condition(s), receiving medical care in a group setting; billed and led by a physician or qualified nonphysician practitioner and may include services provided by other qualified healthcare professionals, clinical staff, or auxiliary personnel under the direction of the supervising physician or other practitioner. Session integrates group education, counseling, and peer support with individualized patient clinical assessment and care, 2-10 patients, billed once per patient, per session."

Finally, CMS seeks comments on guardrails to prevent fraud, waste, and abuse related to SMAs as well as comments on when SMAs are clinically appropriate.

Vaccine adverse effects management

CMS proposes to create and value a HCPCS G-code for vaccine adverse effects management. The code would be described as "Office or other outpatient evaluation and management service(s) for the diagnosis and treatment of vaccine adverse effects, new or established patient; each 15 minutes personally performed by the physician or qualified healthcare professional (list separately in addition to CPT codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350)." It would be payable when a physician or nonphysician practitioner (NPP): (1) establishes and documents a temporal relationship to vaccination, and (2) performs a medically-appropriate assessment to rule out alternative causes. CMS welcomes comments on whether a second HCPCS code for 15 minutes of physician or NPP work time should be finalized and structured as a stand-alone code to more accurately capture the work entailed in cases where a patient is being evaluated for only a vaccine-related complaint, outside the context of an E/M visit being furnished for a separate complaint.

Health Coaching

CMS proposes payment for three existing CPT Category III codes for health coaching: 0591T, 0592T, and 0593T. There would be no frequency limits on the codes. CMS solicits comments on the valuation of these services and the conditions of payment. It also solicits comment on whether it should consider creating HCPCS G-codes to describe these services for 2027, rather than actively pricing the Category III CPT codes that describe health coaching services, including what the potential benefits of G-codes would be compared to using the existing codes.

E/M Resource Overlap with Codes that have a global period

CMS proposes to reduce payment when a separately identifiable office/outpatient E/M visit is furnished by the same physician (or a physician in the same group practice) on the same day as a 0-, 10-, and 90-day global procedure. Under this proposal, the most expensive service (either surgical or E/M visit) would be paid at 100 percent, and all other surgical procedure(s) or E/M visit(s) would be paid at 50 percent. CMS seeks comment on whether to apply this policy to other E/M visits, such as those in the inpatient setting.

Revisions to Teaching Physician Policy Related to the Primary Care Exception

CMS proposes that all levels of an office/outpatient E/M service provided in primary care centers and meeting the requirements of the primary care exception to Medicare's teaching physician policy may be provided under direct supervision of the teaching physician in such cases where the teaching physician believes such care is clinically appropriate without the presence of a teaching physician. Currently, only levels 1-3 may be provided without direct supervision under the primary care exception.

Redesigning Primary Care to Make America Healthy Again Request for Information (RFI)

CMS issued an RFI on the future of primary care payment and delivery. The agency seeks information on numerous topics, including the relative undervaluation of primary care services, how CMS might pay for technology-enabled primary care, and the potential for CMS to establish prospective primary care payments (PPCP). CMS also requests feedback on potentially distinguishing between one-time consultative visits and care that is part of a longitudinal relationship within the office/outpatient E/M code set, revisions to care management codes to improve value and uptake, and improvements to the Initial Preventive Physical Exam (IPPE) and Annual Wellness Visit (AWV). The RFI signals CMS' interest in reevaluating how primary care is defined, delivered, and paid for within Medicare, including

potential movement toward prospective and outcomes-based payment approaches.

Supporting Beneficiaries Planning for Future Medical Decisions

CMS proposes the creation of additional codes in the advance care planning (ACP) family that more explicitly describe and value the contributions of clinical staff in the provision of ACP services. The proposed new codes would be: HCPCS G-code GACP1 and GACP2, describing the first and additional 20 minutes of ACP performed by clinical staff. Under this proposal, the new G codes and CPT codes 99497 and 99498 could be reported together, if time thresholds by the billing practitioner and clinical staff were each met with these respective code sets. CMS also includes an RFI on new pathways for payment for community-based palliative care services and Alzheimer's disease intensive lifestyle intervention.

Current Procedural Terminology (CPT) Request for Information (RFI)

CMS issued a broad RFI examining the role of the American Medical Association's CPT coding system and Relative Value Scale Update Committee (RUC) in physician payment policy. CMS seeks comment on several issues, including the impact of AMA's control of CPT licensing, whether the current process appropriately reflects medical necessity, potential alternatives to CPT as the national coding standard, and whether payment systems based on ICD-10 codes or other grouping methodologies could serve as an alternative.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

CMS proposes to pay RHCs for Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) services. If finalized, these services would be paid through the RHC's all-inclusive rate (AIR) as stand-alone encounters. Under this proposal, DSMT and MNT services could be furnished by providers other than RHC practitioners, such as registered dietitians, but must be furnished under the direct supervision of an RHC practitioner. This

means the supervising practitioner would be required to be present at the RHC and "immediately available" to provide direction but would not have to be present in the exam room when the service is being rendered. DSMT or MNT services provided on the same day as another qualified visit would only yield one AIR payment.

Limiting Medicare Coverage of Certain Individuals

CMS proposes implementing new Medicare eligibility restrictions established by H.R. 1 by creating a Medicare-specific definition of "eligible noncitizen," which would include Lawful Permanent Residents (subject to applicable 5-year continuous U.S. residency requirements), Cuban-Haitian Entrants, and individuals lawfully residing in the United States under a Compact of Free Association (COFA). Under the proposal, Medicare eligibility would be limited to U.S. citizens, U.S. nationals, and eligible noncitizens. These requirements would apply across Medicare Parts A and B and, because Medicare Advantage (Part C) and Part D eligibility depend on underlying Medicare eligibility, individuals who do not meet the new requirements would also be ineligible to enroll in or remain enrolled in those programs.

CMS also proposes a one-time review of current beneficiaries, with Medicare coverage for individuals identified as ineligible based on Social Security Administration data terminating February 1, 2027, unless eligibility is established through the existing appeals process. The rule would also establish an ongoing process for terminating coverage when an individual no longer meets the citizenship, nationality, or immigration-status requirements. It would create a new six-month Special Enrollment Period for individuals who subsequently gain or regain eligibility.

Medicare Shared Savings Program (SSP)

CMS is continuing its efforts to encourage greater participation in the SSP to further CMS' goal of aligning spending and value in Original Medicare.

CMS is proposing to modify the beneficiary assignment methodology to address areas of incongruence and increase the number of Medicare beneficiaries in accountable care relationships. CMS proposes to modify the claims-based assignment methodology to exclude allowed charges for primary care services billed by an ACO professional through a non-ACO taxpayer identification number (TIN). This would address instances when a beneficiary is receiving the plurality of their primary care services from an ACO professional but is not assigned to the ACO because the services were provided outside of current ACO attribution rules.

CMS also proposes to expand the criteria for assignment eligibility to permit the assignment of a Medicare fee-for-service (FFS) beneficiary with at least one month of Part A and Part B enrollment during the assignment window and no Medicare group health plan enrollment during that same month. This change would address the misalignment between 1) the criteria used to determine the "assignable beneficiary" population that is used in determining factors based on national, and 2) regional FFS expenditures and the criteria used to assign a beneficiary to an ACO.

CMS is making several proposals to address ACOs' concerns related to the transition to digital clinical quality measures (dCQM) reporting. CMS proposes extending the availability of the MIPS clinical quality measures (CQMs) collection type and related reporting incentive for SSP ACOs reporting the APM Performance Pathway (APP) Plus quality measure set for PY 2027 and subsequent PYs. CMS anticipates sunsetting the MIPS CQM collection type beginning in PY 2030, when mandatory FHIR-based reporting for electronic clinical quality measures (eCQMs) and proposed Medicare eCQMs goes into effect.

For PY 2027 and subsequent years, CMS proposes to score all Medicare CQMs using flat benchmarks. CMS proposes to score three Medicare CQMs using flat benchmarks in PY 2026 (Quality ID: 001, Quality ID: 134, Quality ID: 236).

Beginning with PY 2026, CMS proposes allowing an ACO to exclude one or more participant TINs that meet applicable exclusion criteria from the ACO's quality data submission for each measure. After the exclusions, the data submitted for each measure must include ACO participant TINs that represent at least 95 percent of the beneficiaries assigned to the ACO.

CMS proposes establishing a Medicare eCQM collection type for SSP ACOs. They would use the same measure specifications as eCQMs but would be limited to Medicare beneficiaries assigned to the ACO. There would be five eCQMs/MIPS CQMs/Medicare CQMs/Medicare eCQMs in the APP Plus quality measure set. ACOs would have the option to report a combination of eCQMs/MIPS CQMs/Medicare CQMs/Medicare eCQMs measures to meet the quality performance standard. They are not proposing to include Medicare eCQMs in the eCQM/MIPS CQM reporting incentive or the Complex Organizational Adjustment. CMS also proposes to revise the definition of "beneficiary eligible for Medicare CQMs" to align with the population of beneficiaries assigned to the ACO.

CMS proposes to remove two measures from the APP Plus quality measure set: Initiation and Engagement of Substance Use Disorder Treatment (Quality ID: 305) and Adult Immunization Status (Quality ID 493).

Beginning with PY 2027, CMS proposes to sunset the requirement that SSP ACOs report the MIPS Promoting Interoperability performance category. Instead, ACOs would be required to

perform one of three activities: Use certified electronic health record technology (CEHRT) to completely report at least one ACO quality measure; attest that the ACO uses FHIR-based technology to support reporting of at least one ACO quality measure; or attest to meeting one SSP CEHRT use metric related to electronic information sharing.

CMS proposes that eligible ACOs apply to reduce or eliminate cost-sharing for categories of eligible Part B items and services and eligible beneficiaries. Cost sharing support could include both the FFS deductible and coinsurance amounts, or either of the two. If finalized, CMS would open applications in early 2027 and approve participation by the second quarter of 2027.

For agreement periods that start on or after January 1, 2027, CMS proposes to:

- Increase the savings rate for BASIC Level E from 50 percent to 60 percent. The current maximum of 50 percent would continue to apply to ACOs completing existing agreement periods in the BASIC track;
- Replace the phase-in schedule and set the maximum weight used to calculate the regional adjustment to 35 percent for ACOs in the ENHANCED track that have lower spending relative to their region. The weights used for ACOs with higher spending and the ACOs in the BASIC track will remain unchanged;
- Increase the prior savings adjustment scaling factor from 50 percent to 75 percent;
- Risk adjust the caps on each of the upward adjustments to the historical benchmark, which includes the positive regional adjustment, the prior savings adjustment, and the population adjustment;
- Establish a growth adjustment for ACOs that increase the number of beneficiaries who are new to the program and are brought into the program by ACO professionals who are inexperienced in shared savings initiatives. The adjustment will be subject to a cap, and CMS will apply the growth adjustment to the historical benchmark;
- Use performance year-specific modified US Per Capita Cost (USPCC) annualized growth rates to construct the Accountable Care Prospective Trend (ACPT). CMS also proposes to establish guardrails so that the modified USPCC cumulative growth is not more than one percent below or 1.5 percent above the corresponding observed cumulative growth rate. CMS proposes to retroactively establish a guardrail on instances in which the modified USPCC cumulative growth rates used to construct the ACPT values are substantially lower than observed cumulative growth rates in national expenditures for agreement periods beginning on January 1, 2024, and before January 1, 2027. This will delay the financial reconciliation for PY 2025. CMS plans to issue PY 2025 financial results and distribute shared savings payments in November 2026 and December 2026, respectively.

Due to low uptake, CMS proposes discontinuing the prepaid shared savings option.

CMS proposes to remove the area deprivation index from the advance investment payment methodology. CMS proposes to add a rural component to the payment calculation, as well as a flat $25 rate for all beneficiaries who are not low-income subsidy/dually eligible. The changes would be implemented for ACOs that apply for the advance investment payment (AIP) option with an effective date of January 1, 2028, as well as for the second year of payments for ACOs who began receiving payments in 2027.

CMS proposes to modify the definitions of "experienced" and "inexperienced" with performance-based risk Medicare ACO initiatives to exclude Legacy TINs or CMS certification numbers (CCNs).

CMS proposes to update the beneficiary notification requirements to require that ACOs provide the standard written notification to beneficiaries by May 30 each year rather than prior to or at their first primary care encounter of the year. They also propose to remove the follow-up communication requirement.

Lastly, CMS issued a request for information to better understand how to integrate specialty care in the SSP.

Updates to the Quality Payment Program (QPP) and Medicare Promoting Interoperability Program

CMS continues their efforts to align the QPP with their broader aims to promote prevention, wellness, and chronic disease management.

To further encourage adoption of the MIPS Value Pathway (MVP) reporting option, CMS proposes to phase out traditional MIPS reporting for MIPS eligible clinicians (ECs) who are not participating in the APM Performance Pathway (APP) beginning with the 2029 performance year. The current MVP inventory provides nearly all MIPS ECs an applicable MVP that they could report. CMS will continue developing MVPs and intends to explore strategies for subspecialists who do not have many applicable and available measures in the MIPS measure inventory. CMS is also issuing an RFI to further discussions and considerations for the future of MVP reporting.

CMS proposes to include virtual groups in MVP reporting.

CMS proposes three new MVPs: Diabetic Disease, Hospitalist, and Hypertension. They propose modifications to the existing 27 MVPs.

CMS proposes to establish a "core measure" designation. Core measures were selected from existing MIPS measures and overlap with the high-priority designation, which CMS proposes to eliminate. They reflect the essential components of care specific to a given specialty, medical condition, or episode of care. ECs reporting via traditional MIPS will select core measures from the complete quality measure inventory. ECs reporting via MVPs will select core measures from their selected MVP.

CMS proposes to remove the requirement to report at least one outcome measure and replace it with a requirement to report at least one core measure. This requirement applies to those reporting via traditional MIPS and MVPs. ECs who do not have an applicable core measure can self-attest that there is no applicable measure. They will be required to submit any other applicable measure. Small practices (15 ECs or fewer) would be exempt from the core measure requirement.

Consistent with previous years, CMS proposes to update the quality measure and improvement activities inventories. CMS is not proposing any changes to the cost measure inventory.

CMS proposes modifying the definition of CEHRT to align with the applicable ONC proposals to remove and revise certain ONC health IT certification criteria proposed in the HTI-5 proposed rule.

Beginning with the 2026 performance year, CMS proposes to eliminate the ONC direct review and ONC-authorized certification bodies surveillance attestation requirements. CMS also proposes to eliminate the security risk analysis attestation requirements. Although practices will no longer be required to attest that they have conducted an analysis for the purposes of MIPS, they will still be required to complete an analysis to maintain HIPAA compliance.

CMS is proposing modifications to the electronic prior authorization measure, as well as a new electronic prior authorization for prescription drugs measure.

CMS is issuing an RFI to investigate improvements to the star rating assignment methodology used for public reporting via Care Compare for administrative claims quality measures.

CMS proposes to apply the qualifying APM participant (QP) and partial QP status at the TIN/NPI level. As such, the financial incentives (e.g., APM conversion factor) would only apply to an NPI's claims for the TINs participating with the APM Entity. Additionally, a QP or partial QP may be subject to MIPS at any TINs not associated with the APM Entity.