Summary of the CY 2027 Medicare Physician Fee Schedule Final Rule

The CY 2027 Medicare Physician Fee Schedule and Quality Payment Program final rule was released on November 4th, 2026. CMS also released a Fee Schedule Fact Sheet, MSSP Fact Sheet, and QPP Fact Sheet. The provisions in the final rule will take effect on January 1, 2027, except where otherwise specified. The AAFP provided comprehensive comments on the proposed regulation.

Policy	Final Rule Summary	Impact	AAFP Position
PAYMENT UPDATE AND SPECIALTY IMPACT			
Conversion factor(s)	Both conversion factors will see decreases for 2027: • Qualifying APM conversion factor: $32.9548, a 1.83% decrease from 2026. • Non-qualifying APM conversion factor: $32.6286, a 2.31% decrease from 2026 The decreases reflect three factors: • Expiration of the temporary 2.5% increase to both conversion factors provided by H.R. 1; • Statutorily required updates of 0.75% for the qualifying APM conversion factor and 0.25% for the non-qualifying APM conversion factor; and • A budget-neutrality adjustment of -0.12% resulting from changes in relative value units (RVUs) for certain services.	Negative	AAFP has repeatedly urged Congress and CMS to provide stable, inflation-sensitive physician payment and to avoid policies that further erode practice sustainability.
Total allowed charges by family physicians	CMS estimates that changes to RVUs will increase total allowed charges for family physicians by 1% in 2027.	Mixed	While the estimated increase in total allowed charges for family physicians is positive, this modest gain masks potentially significant variation among individual practices, depending on the mix of services they provide and the codes they bill. Importantly, CMS's estimate reflects only changes to RVUs and does not account for reductions to the conversion factors or other payment policy changes, meaning the actual net impact on family physicians could differ.
PRACTICE EXPENSE			
PE methodology	For calendar year 2027, CMS will implement the following changes to its practice expense (PE) relative value unit (RVU) methodology: • Modify step 8 to calculate indirect PE based on both work RVUs and clinical labor RVUs for all services except 010- and 090-day global period codes; • Remove steps 12 through 17 that rely on the indirect practice cost index (IPCI) from the calculation of the PE RVUs over a two-year transition period, and; • Add a new step to apply a stabilization adjustment to the PE RVUs (proposed step 19).	Positive	AAFP reluctantly supported removing IPCI-dependent steps over a two-year transition because the underlying PE-per-hour data are nearly 20 years old, while noting disappointment that CMS did not accept updated PPI/CPI survey data. AAFP supported using both work and clinical labor RVUs for all PFS services except 010- and 090-day global-period codes, pending resolution of their valuation problems. AAFP supported a PE stabilization factor in concept.
Nursing facility visits	For 2026, CMS finalized a policy to allocate half the amount of indirect PE RVUs per work RVU for services furnished in the facility setting compared to those allocated to services furnished in the non-facility setting. Implementation of this policy resulted in an unintended, but significant, site of service differential for physician visits in nursing facility settings based solely on whether the beneficiary's stay is covered under Part A. To rectify this unintended consequence for 2027, CMS will equalize the rate for nursing facility visits without regard to the beneficiary's Part A status by setting the facility PE RVU equal to the non-facility PE RVU for CPT codes 99304-99310 and 99315-99316.	Positive	AAFP supported equalizing rates regardless of the beneficiary's Part A status because a practice's indirect costs do not depend on how the nursing-facility stay is covered.

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TELEHEALTH AND TEACHING PHYSICIANS			
Medicare Telehealth Services List	CMS added five new HCPCS codes to the Medicare Telehealth Services List: • G0572: Advance care planning services furnished under the direction of a treating physician or other qualified health care professional (first 20 minutes); • G0573: Advance care planning services (each additional 20 minutes; add-on code to GACP1); • G0687: 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; • G0903: Individual treatment of speech, language, voice, communication, and/or auditory processing disorders for pediatric patients; • G0576: 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).	Positive	AAFP supported adding separately payable services that can meet the applicable standard of care when furnished via telehealth and urged CMS to presume eligibility when statutory and clinical requirements are met.
Telehealth flexibilities and modifiers	CMS updated its regulations to implement the telehealth flexibilities extended by the Consolidated Appropriations Act, 2026. These flexibilities include the waiver of geographic restrictions on Medicare telehealth services, the expansion of permissible originating sites to include a beneficiary's home and other eligible locations, and the expansion of the types of practitioners eligible to furnish Medicare telehealth services. CMS also finalized the continued delay of the in-person visit requirement for telehealth mental health services and extended coverage of certain audio-only telehealth services through the statutorily specified timeframes. Beginning January 1, 2027, CMS will require modifier BB to identify telehealth services furnished through certain third-party virtual care platforms and modifier BC to identify telehealth services furnished *incident to* a physician's or practitioner's professional services. These modifiers are intended to improve transparency in telehealth claims data and will not affect payment.	Positive	AAFP supported implementing the statutory telehealth flexibilities to preserve access to care. AAFP supported the continued delay of the in-person requirement for mental health telehealth services. AAFP supported transparent data collection in concept but urged CMS to delay implementation of modifiers BB and BC until at least January 1, 2028, and issue detailed operational guidance at least one year before implementation.
Teaching physician presence	In CY 2027, CMS finalized allowing billing for 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. This policy is additive to the existing CY26 policy permitting three-way telehealth visits when the teaching physician, resident, and patient are in different locations. CMS states that it may consider allowing billing when the teaching physician and resident are in the same location while the patient is virtual, in future rulemaking.	Positive	AAFP strongly supported the proposed flexibility and urged CMS to allow virtual teaching-physician presence for appropriate in-person as well as telehealth services, excluding surgical and other high-risk procedures.

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VALUATION, CODING, AND PRIMARY CARE SERVICES			
Modifier 25 / same-day E/M overlap	CMS finalized a 20% payment reduction, rather than the proposed 50% reduction, when a separately identifiable office/outpatient E/M visit is furnished on the same day as a 0-day global procedure by the same practitioner or another practitioner of the same specialty in the same group practice. CMS excluded 10- and 90-day global procedures from the final policy. The highest-valued service will be paid in full, while additional applicable services will be paid at 80%.	Negative	AAFP strongly opposed the proposed payment reduction. Although the final policy is less severe than proposed, it still penalizes comprehensive, same-day care, creates incentives to delay or fragment services, and risks double-counting resource overlap already addressed in RVU valuation. AAFP also raised concerns about the disproportionate impact on primary care physicians, particularly those providing OMT, and urged CMS to exempt primary care physicians if it moved forward with the policy.
G2211 / visit-complexity modifiers	CMS will transition HCPCS code G2211 to a modifier (designated as modifier B1) that can be appended to the associated E/M base code. This modifier will increase the payment of the associated E/M code by 16%, instead of a flat rate. CMS is also establishing modifier B2 to recognize additional resource costs incurred by physicians and others in Accountable Care Organizations (ACOs) when providing longitudinal care. This modifier will be available only for physicians and others participating in a Shared Savings Program ACO or Participant Providers in a Long-term Enhanced ACO Design Model ACO and will increase payment of the associated E/M visit by 32%.	Mixed	AAFP acknowledged potential benefits of the modifier approach but ultimately opposed replacing G2211 at this time, citing concerns about beneficiary cost-sharing, reduced RVU-based compensation for employed physicians, additional billing burdens, and the inequitable payment differential favoring ACO participants over non-ACO physicians, including those in rural areas.
Primary Care Exception	CMS finalized its proposal to expand the primary care exception to allow residents to furnish all levels of office/outpatient E/M visits without the physical presence of a teaching physician, provided the requirements of 42 CFR § 415.174 are met and the teaching physician determines that the arrangement is clinically appropriate.	Positive	AAFP supported expanding the primary care exception and urged CMS to consider adding additional codes in future rulemaking to ensure primary care residents gain sufficient experience managing the increasingly complex needs of the Medicare population.
Maternity care codes	CMS finalized its proposal to adopt the new and revised CPT codes for maternity care services, effective January 1, 2027. CMS also finalized its proposed valuation of those services, including work relative value unit increases to the labor and delivery codes. CMS is not finalizing the creation of HCPCS G-codes for maternity care services, although it may consider the creation of bundled codes describing maternity care services in future rulemaking. Note: Following publication of the final rule, CMS announced temporary HIPAA enforcement discretion permitting continued use of 2026 maternity care CPT codes for episodes of care that begin in 2026 and extend into 2027, subject to payer rules. This flexibility is intended to prevent disruptions in billing when maternity care spans the transition to the new codes and will expire December 31, 2027.	Positive	AAFP supported the new CPT maternity code set and opposed Medicare-specific G-codes mirroring the old global bundles because dual systems would add administrative burden and undermine transparency.
Smoking cessation and SBIRT	CMS finalized a 19.1% increase to the work RVUs for smoking and tobacco use cessation and structured assessment, brief intervention, and referral to treatment (SBIRT) services, aligning their valuation with the increases for timed psychotherapy services that were phased in over four years.	Positive	AAFP supported the increased work RVUs, noting that the adjustment better recognizes the clinical intensity and evidence-based role of smoking cessation and SBIRT services in preventing and managing chronic disease and behavioral health conditions.

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Remote physiologic/therapeutic monitoring	For CY 2027, CMS finalized its requirement that remote therapeutic monitoring (RTM) services be furnished only to established patients, consistent with existing requirements for remote physiologic monitoring (RPM). CMS also finalized a requirement that RPM and RTM services be initiated during a face-to-face visit, either in person or via telehealth. The initiating visit does not need to be dedicated solely to remote monitoring, and patients already receiving these services before January 1, 2027, are exempt from the new initiating visit requirement. CMS finalized its proposal to require that RPM and RTM services be furnished by clinical staff directly employed by the billing practitioner or practice but delayed implementation until January 1, 2029. Practices may continue using third-party vendors through December 31, 2028, provided existing Medicare billing and supervision requirements are met. CMS also finalized changes to the valuation of certain RPM and RTM services but declined to eliminate direct clinical labor costs for six treatment-management codes, as proposed. CMS did not finalize new Medicare-specific G-codes for RPM and RTM but may reconsider them in future rulemaking.	Mixed	AAFP supported the established-patient and initiating-visit requirements, provided that the initiating visit need not be dedicated solely to RPM or RTM services. AAFP strongly opposed restricting payment to services furnished by clinical staff employed directly by the practice, citing concerns about limiting access for patients of small, independent, and rural practices that rely on third-party vendors. While the two-year delay provides additional time for advocacy and implementation, CMS still intends to prohibit these arrangements beginning in 2029. AAFP opposed the proposed valuation reductions without sufficient supporting data and urged CMS to await further review by the RUC. AAFP also opposed creating duplicative Medicare-specific G-codes that would increase administrative burden.
Psychiatric Collaborative Care Model (CoCM)	For 2027, CMS is refining the valuation of CoCM services by finalizing increases to the work RVUs and updating the clinical labor rates for the Behavioral Health Care Manager.	Positive	AAFP supported increasing the BHCM labor rate but urged higher physician work values, preferably level 4/5 blended E/M benchmarks, with no less than a level 4 valuation floor. CMS adopted AAFP's recommended minimum valuation in the final rule.
Shared medical appointments (SMAs)	CMS finalized separate coding and payment for SMAs including an add-on code to account for additional time beyond the initial 60-minute session. CMS retained its proposed valuation and requirement that patients have an established clinical relationship with the billing practitioner or qualifying practitioner in the same group within the preceding 12 months.	Positive	AAFP supported establishing separate coding and payment for SMAs but recommended using the standard 36-month established-patient definition rather than 12 months and valuing the service based on a level 4 rather than level 3 E/M visit. While CMS did not adopt these recommendations, the new payment pathway represents a positive step toward supporting team-based primary care.
Vaccine adverse-effects management	CMS finalized a new add-on code (HCPCS G0576) to provide additional payment for evaluating and managing suspected vaccine adverse effects when the work goes beyond what is captured in an E/M visit.	Mixed	AAFP appreciated CMS' efforts to appropriately pay for added work but expressed concerns about overlap between the new code and E/M services. AAFP did not support a second stand-alone code for vaccine-related complaints. AAFP also opposed establishing a separate stand-alone code for vaccine-related complaints, which CMS did not finalize.
Health coaching	CMS finalized its proposal with modifications. Specifically, CMS finalized the valuation for health and well-being coaching CPT codes 0591T and 0592T based on a crosswalk to CPT codes 99487 and 99489, with work RVUs of 1.81 and 1.00 (an increase from the original CMS proposal) and finalized the valuation of CPT code 0593T as proposed. CMS also finalized that health coaching may be furnished under general, rather than direct, supervision.	Positive	AAFP supported national payment and CPT prefatory language, and opposed creating duplicative Medicare-specific G-codes. AAFP also urged CMS to recognize the full clinical staff time required by these services, which CMS addressed through increased valuations in the final rule.
Advance care planning (ACP) by clinical staff	CMS finalized use of two new G-codes (HCPCS codes G0572 and G0573) to describe ACP services furnished by clinical staff under the direct supervision of the billing physician or other practitioner. CMS is further finalizing that the existing CPT codes describing ACP services (codes 99497 and 99498) would only be used to report time personally spent by the billing physician or other qualified healthcare practitioner. CMS will update its Advance Care Planning Medicare Learning Network Fact Sheet soon to improve awareness and understanding of related billing guidance (e.g., relationship of new G-codes to existing CPT codes).	Mixed	AAFP supported meaningful, team-based advance care planning but recommended that CMS clarify existing policy for CPT 99497 and 99498 before creating G0572 and G0573. AAFP warned that separate staff-time codes could add time-tracking, documentation, and compliance burden, and urged CMS to update guidance and work with the CPT Editorial Panel instead.

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Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)			
Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) services	CMS will pay RHCs for Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) services as stand-alone visits paid through the RHC all-inclusive rate (AIR). These services may be furnished by providers other than RHC practitioners, such as registered dietitians, but must be furnished under the direct supervision of an RHC practitioner. DSMT or MNT services provided on the same day as another qualified visit would only yield one AIR payment.	Positive	The AAFP supported CMS' proposal to allow RHCs to bill for DSMT and MNT services as stand-alone visits paid through the RHC AIR.
OTHER MEDICARE PART B / PROGRAM-INTEGRITY PROVISIONS			
Eligibility / coverage of certain individuals	CMS finalized regulations implementing statutory restrictions on Medicare eligibility, limiting coverage to U.S. citizens and nationals and certain categories of lawfully present noncitizens. Existing beneficiaries who do not meet these requirements will lose Medicare coverage effective February 1, 2027, including related Medicare Advantage and Part D coverage. Instead of the proposed 6-month special enrollment period (SEP), CMS finalized a 12-month SEP for individuals who subsequently gain or regain an eligible status and will allow up to six months of retroactive Part A and Part B coverage, subject to applicable eligibility and premium requirements.	Negative	AAFP maintained that all people should have access to essential health care regardless of immigration status. AAFP urged CMS to delay verification-based terminations, strengthen multilingual notice and appeal safeguards, prohibit terminations based only on incomplete data matches, and maintain coverage during review. AAFP also recommended extending the proposed six-month special enrollment period, which CMS increased to 12 months in the final rule.
MEDICARE SHARED SAVINGS PROGRAM			
BASIC Track Level E shared-savings rate	CMS finalized its proposal to increase the sharing rate for BASIC Level E from 50% to 60% for agreement periods beginning on or after January 1, 2027.	Positive	AAFP supported increasing the BASIC Track Level E shared-savings rate to 60 percent for new agreement periods, noting that it would give ACOs more time and resources to build the infrastructure, technology, and staffing needed before assuming greater downside risk.
Regional adjustment / ENHANCED Track	CMS finalized its proposal to reduce the maximum positive regional adjustment weight from 50% to 35% for lower-spending ACOs in the ENHANCED track. ACOs with higher spending than their region and all BASIC track ACOs are unaffected. Given the timing of the final rule, CMS will allow ACOs applying for an agreement period with a start date of January 1, 2027, a time-limited opportunity to change their final selection between the BASIC and ENHANCED track. ACOs can update their selection during the Phase 2 RFI period, which will run from November 12-17, 2026, at 12 pm ET.	Negative	AAFP opposed reducing the maximum positive regional-adjustment weight for ENHANCED Track ACOs from 50 percent to 35 percent. AAFP urged CMS to conduct more rigorous analysis before adopting a policy that could intensify the benchmark ratchet and penalize mature, efficient ACOs.
Prior-savings adjustment and rebasing	CMS finalized its proposal to increase the prior savings adjustment scaling factor from 50% to 75% for agreement periods beginning on or after January 1, 2027. For agreement periods beginning on January 1, 2027, and subsequent years, CMS will risk adjust the five percent cap on each of the upward adjustments to the historical benchmark (regional, prior savings and population). CMS would risk-adjust the national per capita expenditures used in calculating each adjustment cap.	Positive	AAFP supported increasing the prior-savings adjustment scaling factor from 50 percent to 75 percent and risk-adjusting the cap on upward benchmark adjustments. AAFP also urged CMS to raise the combined cap from 5 percent to at least 7 percent and strengthen protections against the benchmark ratchet for long-standing ACOs.

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Growth adjustment / inexperienced ACO professionals	CMS finalized its proposal to establish a growth adjustment to be applied to the historical benchmark. The new growth adjustment amount will be added to the highest of the positive regional adjustment, prior savings adjustment and population adjustment. New growth will be measured as the number of assigned beneficiary person years inexperienced with a shared savings initiative who are assigned to an ACO professional who is inexperienced with a shared savings initiative.	Positive	AAFP generally supported the proposed growth adjustment but urged CMS to remove the requirement that newly assigned beneficiaries also be attributed to an ACO professional who is new to shared-savings initiatives. AAFP recommended rewarding beneficiary growth whether assignment is through a new or existing ACO professional. CMS did not adopt this recommendation.
Accountable Care Prospective Trend (ACPT) guardrail	CMS finalized an ACPT guardrail policy that limits the effect of under-projection or over-projection as compared to observed growth in expenditures for the national assignable FFS population such that the ACPT is no more than 1 percentage point below (or no more than 1.5 percentage points above) national growth. The guardrail applies to agreement periods beginning on or after January 1, 2027. CMS will retroactively apply the lower guardrail for ACOs within existing agreement periods with 2024, 2025, and 2026 start dates. CMS will calculate annualized growth rates for each performance year for all ACOs in agreement periods beginning on or after January 1, 2027, rather than calculating an annualized growth rate on an agreement period basis.	Positive	AAFP supported performance-year-specific ACPT growth rates and the proposed asymmetric guardrail, which would allow ACOs to share in more savings than losses. AAFP viewed these changes as an important step toward improving benchmark accuracy and addressing large differences between projected and actual spending growth.
Part B cost-sharing reduction	CMS finalized its proposal to allow ACOs to reduce or eliminate Part B cost sharing for items and services. ACOs must submit an implementation plan. CMS will begin accepting initial applications in early 2027, and approved ACOs can begin eliminating or reducing cost sharing beginning in the second quarter of 2027.	Positive	AAFP supported reducing beneficiary cost sharing when it is designed to improve access and engagement, while emphasizing that incentives should be operationally workable, voluntary, and structured so primary care practices and patients can participate without added administrative burden or fragmentation.
ACO Quality Reporting and CEHRT Requirements	CMS finalized its proposals to extend the MIPS CQM collection type and establish a new Medicare eCQMs collection type. They also finalized their proposal to allow ACOs to exclude participant TINs' data if the TIN experienced issues collecting data. CMS finalized revisions to the CEHRT reporting requirements. Instead of requiring ACOs to meet the MIPS promoting interoperability performance category requirements, CMS will allow ACOs to attest to one of three activities.	Positive	AAFP supported the extension of the MIPS CQM collection type, the establishment of the Medicare eCQM collection type, and increased flexibility to meet the quality reporting requirements. AAFP also supported revisions to the CEHRT use requirements. The changes address longstanding concerns with burdensome and operationally challenging requirements that were not always aligned with the goals of accountable care.
QUALITY PAYMENT PROGRAM			
MVP transition and traditional MIPS sunset	CMS finalized a two-year delay in the sunset of traditional MIPS, which will remain available through the 2030 performance period instead of 2028, as proposed. Beginning in 2031, the reporting options will be MVPs or the APM Performance Pathway. They also finalized three new MVPs: Diabetic Disease, Hospitalist, and Hypertension.	Mixed	AAFP supported the goal of more clinically relevant MVP reporting but opposed requiring universal MVP participation in 2029 before the policies are fully tested and stable. AAFP urged CMS to delay the mandate, retain traditional MIPS during a longer transition, establish readiness benchmarks, and test the approach with small and rural practices.
MIPS core measures	CMS finalized the removal of the outcome/high priority measure requirement and replaced it with a new core measure requirement. Small practices are exempt from this requirement. ECs that do not have an applicable core measure available to them must self-attest that they do no have an applicable measure and choose another measure to report in place of the MIPS core measure.	Neutral	AAFP opposed a mandatory core-measure requirement that could reduce measure choice and inadequately reflect comprehensive primary care. If CMS proceeds, AAFP supported broad self-attestation flexibility and a small-practice exemption, and urged testing for clinical relevance, physician influence, reporting burden, and specialty applicability before expansion.
Performance thresholds, scoring, and measure changes	CMS retained the MIPS performance threshold at 75 points. CMS removed two previously finalized measures from the APP Plus measure set: Initiation and Engagement of Substance Use Disorder Treatment (Quality ID: 305) and Adult Immunization Status (Quality ID: 493). CMS finalized the removal of the Person-Centered Primary Care measure as it had limited adoption that did not allow for the creation of a benchmark.	Neutral	AAFP supported fair scoring protections, including defined topped-out benchmarks when measure choice is limited, but opposed policies that could penalize physicians for reporting clinically meaningful measures. AAFP supported removing APP Plus measures 305 and 493, opposed the MCC measure 484 and continued use of CAHPS for small populations, and urged CMS to preserve PCPCM and other measures important to primary care.

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FHIR-based quality reporting	CMS reaffirmed its goal of transitioning the QPP and other CMS quality programs to FHIR-based digital quality measurement, but it did not finalize a mandatory FHIR transition timeline or detailed implementation requirements in this rule. CMS described a potential phased approach beginning in 2028, during which existing reporting methods would continue alongside newly introduced FHIR-based digital quality measures, with mandatory FHIR-based reporting potentially beginning around 2030, subject to future rulemaking. CMS acknowledged that organizations vary considerably in their interoperability, health IT, and data-aggregation capabilities and emphasized maintaining reporting flexibility while the technology and standards mature. Overall, CMS continued to signal a clear commitment to FHIR as the future of quality reporting, while recognizing that additional implementation work, specifications, infrastructure development, and future policymaking are needed before FHIR-based reporting can become mandatory.	Neutral	AAFP supported a phased transition to FHIR-based quality reporting, with current reporting options preserved until infrastructure is ready. AAFP urged CMS to require successful testing, broad EHR availability, reliable interoperability, clear specifications, technical assistance, and demonstrated burden reduction before making FHIR-based reporting mandatory. AAFP also called for technical assistance for practices, ACOs, and measure developers; advance guidance on benchmarking, scoring and submission; and particular attention to small, rural, and independent physician-led organizations. The Academy also cautioned that the proposed sunset of traditional MIPS falls too close to the potential mandatory FHIR timeline.