Illinois Health and Hospital Association

RULE SUMMARY

AUGUST 2026

MEDICARE PFS PROPOSED RULE

Overview and Resources

On July 14, 2026, the Centers for Medicare & Medicaid Services (CMS) released the calendar year (CY) 2027 proposed payment rule for the Medicare Physician Fee Schedule (PFS). The CY 2027 PFS rule includes the following key proposals:

- Reduce overall physician payment and update methodology for indirect practice expense (PE) allocation, based on statutory requirements;
- Increase the work relative value unit (RVU) for certain behavioral health codes;
- Modify coding and payment policies for office/outpatient (O/O) evaluation and management (E/M) visits and telehealth services like remote patient monitoring services;
- Create greater payment flexibility for teaching physicians with a virtual presence, advanced care planning services delivered by clinical staff under supervision, and shared medical visits for a group of patients; and
- Require all 340B-covered entities to submit targeted Part D claims data to a new data repository.

A copy of the proposed rule and other resources related to the Medicare PFS are available on the CMS website. An online version of the proposed rule is available *here*. Comments are due Sep. 14 and can be submitted through the *Federal Register*.

The final rule is expected to be issued by Nov. 1. Program changes adopted by CMS will be effective for services delivered on or after Jan. 1, 2027, unless otherwise noted.

A summary of key changes proposed by CMS for CY 2027 follows.

Physician Payment

- Reduces overall physician payments by implementing a conversion factor for qualifying alternative payment model participants (QPs) of -1.19% and a non-QP conversion factor of -1.68%. These proposed factors reflect statutory and regulatory requirements, including:
    - The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 required implementation of two separate conversion factors in CY 2026, including 0.75% for QPs and 0.25% for non-QPs.
    - The expiration of last year's budget reconciliation act (P. L. 119-21) one-year increase of 2.50%.
    - A positive budget neutrality adjustment of 0.53% to account for changes in the work RVUs.

- Modifies indirect practice expense (PE) methodology by:
    - Allocating indirect PE for all services except codes with 010- and 090-day global periods based on the **sum** of work RVUs and clinical labor RVUs, rather than current allocation for most codes based on the **greater** of either the work RVUs or clinical labor RVUs.
    - Phasing out the indirect practice cost index (IPCI) over a two-year period, then providing a stabilization adjustment cap of +/-5% to any annual changes in a code's PE RVU, with exceptions.
        - This is intended to move away from valuation based on American Medical Association survey data and toward auditable code-level inputs and allocators.
    - To address the broader maternity care CPT code restructuring set to take place in CY 2027, shifting from global codes to service-based reporting:
        - Increases work RVUs for new labor and delivery (L/D) codes by removing four E/M visits from utilization estimates and shifting those RVUs to the new L/D codes.
        - Creates 15 new HCPCS G codes to mirror the current maternity care global package, intended to act as an alternative to the new CPT codes and minimize payment disruption.
    - Sets the facility PE RVU equal to the non-facility PE RVU for certain Current Procedural Terminology (CPT) codes used in nursing facility visits.
        - Last year's modification to reduce facility PE RVUs to half the amount as non-facility PE RVUs resulted in unintentional cost differences solely based on beneficiaries' coverage under Medicare Parts A or B.
    - Updates the 2026 federally qualified health center (FQHC) prospective payment system base rate by 2.5%, resulting in a CY 2027 base rate of $212.91.
    - Adjusts work RVUs upward by 19.1% to the following behavioral health codes:

Codes	Services
CPT codes 99406 and 99407	Smoking and tobacco use cessation
HCPCS codes G2011, G0396, G0397	Screening, Brief Intervention and Referral to Treatment (SBIRT)

Office/Outpatient Evaluation and Management Visits

- Replaces O/O E/M visit complexity add-on code (Healthcare Common Procedure Coding System [HCPCS] code G2211) implemented in CY 2024 with a modifier, expected to increase payment of all levels of the base E/M code by 16%.
    - The current add-on code has a flat-rate increase that disproportionately modifies lower-intensity base codes.
- Proposes a visit complexity modifier for practitioners in a Medicare Shared Savings Plan (MSSP) accountable care organization (ACO) or Long-term Enhanced ACO Design (LEAD) Model to increase payment of the associated E/M visit by 32%.

- Reduces payment when any O/O E/M visit is provided by the same physician or a physician in the same group practice as a 0-, 10- or 90-day global procedure:
    - The highest paid service (global surgical or E/M visit) would be paid at 100% and all other services would be paid at 50%.

Telehealth Services

- Requires an established patient relationship and initiating visit for remote physiologic monitoring (RPM) and remote therapy monitoring (RTM) services, as audits found relationships were not always established and providers would "cold call" patients to solicit services.
- Only allows payment for RPM or RTM services when performed by clinical staff employed by the practice and prohibiting services delivered by third-party contractors.
- Reduces payment for certain devices and set-up codes by revising PE RVUs and eliminates PE inputs for treatment management codes.
    - Device and education costs are seen as overstated, and PE inputs are seen as not requiring clinical staff time beyond work RVUs.
- Bundles the 17 total RPM and RTM CPT codes to create four new HCPCS G-Codes to describe remote monitoring services, as federal audits found almost half of patients that receive remote monitoring did not receive all three components of it (i.e., setup and education, device supply and data, and treatment management):

Proposed G-Code	Service Bundle Requirements
GRPM1	RPM initial set-up and patient education
GRPM2	Remote monitoring of physiologic parameters per calendar month
GRPM3	RTM initial set-up and patient education
GRPM4	Remote monitoring of therapeutic parameters per calendar month

Physician Oversight & Care Flexibility

- Permits teaching physicians to bill for services when either the teacher or resident is in the same location as the patient, whereas current policy only permits billing when the teaching physician, resident and patient are all in separate locations.
- Establishes two new HCPCS codes to describe advance care planning (ACP) services furnished by clinical staff under the direct supervision of the billing physician or other practitioner.
- Isolates use of existing ACP CPT codes 99497 and 99498 to time spent by the billing practitioner.
- Creates payment for shared medical appointments (SMA) for targeted patients to receive care together:
    - Limits eligibility to patients that had a previous service within the past 12 months from the billing practitioner or another in the same specialty **and** subspecialty in that group practice.

- Establishes SNAs as 60-minute sessions for a maximum of 10 patients, permitted in-person and via telehealth.
- Seeks guidance on what chronic medical and behavioral health conditions that are modifiable with lifestyle changes (e.g., diet, physical activity, and self-management) should be included.

340B Entities

- Requires all 340B-covered entities to submit targeted Part D claims data to the 340B claims data repository, rather than voluntary submissions as currently planned, for the following claims data elements:
  - Date of service
  - Prescription or service reference number
  - Fill number
  - Dispensing pharmacy NPI
  - Drug's 11-digit NDC
  - 340B ID
  - Entity name (as it appears in HRSA's OPAIS system)
- Aligns mandatory reporting with CY 2027 PFS implementation, although the new repository is slated to go live in fall 2026.
- Proposes that failure to report data constitutes a violation of Medicare enrollment requirements and subjects providers or suppliers to losing Medicare billing privileges.

PFS-Related Payment Programs

- Incentivizes new ACO participation within the Medicare Shared Savings Program by updating payment methodology to generate new savings in two-sided risk tracks, quality performance requirements, and beneficiary assignment methodology.
- Sunsets the Merit-based Incentive Program (MIPS) reporting option after CY 2028 and adds three MIPS value pathways.
- Updates the ambulatory specialty model finalized for CY 2026, by clarifying quality measure scoring, excluding targeted participants based on subspecialty, adding a rural adjustment, and adding a voluntary data submission option for Patient-Reported Outcomes.

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