American College of Radiology

American College of Radiology (ACR) Detailed Summary of Radiology Provisions in the 2027 Medicare Physician Fee Schedule (MPFS) Proposed Rule

The Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2027 Medicare Physician Fee Schedule (MPFS) proposed rule on Tuesday, July 14, 2026. In this rule, CMS describes proposed changes to payment provisions and to policies for the Quality Payment Program (QPP) and its component participation methods – the Merit-Based Incentives Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

Conversion Factor and CMS Overall Impact Estimates

Beginning CY 2026, there are two separate conversion factors resulting from the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA). The 2027 conversion factor for services provided by a qualifying APM participant is proposed to be $33.1693, down from the current conversion factor of $33.5675. The proposed qualifying APM rate for 2027 is inclusive of a 0.75% annual update and a positive 0.53% budget neutrality adjustment.

Services provided by non-APM participants have a proposed conversion factor of $32.8409, down from the current conversion factor of $33.4009. The proposed non-APM participant rate for 2027 includes a 0.25% annual update and a positive 0.53% budget neutrality adjustment. Both conversion factors see an aggregate decrease due to the expiration of the one year 2.5% conversion factor increase mandated by statute.

If the provisions within the proposed rule are finalized, CMS estimates an overall impact of the MPFS proposed relative value unit (RVU) changes to be positive 2% for radiology, 2% for nuclear medicine, 3% for interventional radiology and 3% for radiation oncology. Note that these estimates do not take into account the reduction in the conversion factor.

Determination of Practice Expense RVUs

Practice expense (PE) RVUs are developed by considering both indirect practice costs such as administrative labor, office expenses, and other expenses, and direct practice costs such as clinical labor staff, medical supplies, and medical equipment per procedure.

In recent years, CMS contracted with RAND Corporation to review the PE methodology and consider alternative methods to improve its accuracy. In their report, *Expanding Technical and Professional Components to all Medicare Physician Fee Schedule Services*, RAND discusses their findings and proposals on how to improve the accuracy of MPFS payments for "triplet services"—such as many diagnostic or radiology procedures which can bill for global, professional, or technical component—versus "non-triplet services" which can only report as a global service. The global payment for "triplet services" is equal to the sum of the professional component (PC) and technical component (TC) RVUs, while the global payment for "non-triplet services" is the maximum of clinical labor PE RVUs and physician work RVUs.

For 2027, CMS is proposing to:

- use the same allocation methodology for all MPFS services and to allocate indirect PE based on both the work RVU and the clinical labor RVU for all services except 010- and 090-day global services.
- remove the steps from the current PE methodology that rely on the indirect practice cost index (IPCI) from the calculation of the PE RVUs and transition this change over two years.
- apply a stabilization adjustment to the PE RVUs to reduce volatility by capping any increase or decrease to the PE RVUs at 5 percent each year.

CMS is also proposing a new approach to account for payment modifiers and other special payment rules. They would calculate the ratio of allowed charges to the national MPFS payment amount for each paid claim line and use the same ratio to adjust time.

CMS shares that while they recognize that the annual maintenance factor in the calculation for equipment cost per minute is not precisely 5% for all equipment, they do not have sufficient information to propose a variable maintenance factor but will continue to investigate ways of capturing such information.

Adjusting RVUs to Match PE Share of the Medicare Economic Index (MEI)
The Medicare Economic Index (MEI) measures the relative weights for physician work, PE, and malpractice (MP). CMS is proposing to continue using the current PE/HR and 2006-based MEI for CY 2027.

Updates to Prices for Existing Direct PE Inputs
CMS is proposing to update the price of nine supplies and two equipment items as a result of public submissions of invoices. The following updated supply items are included in radiology codes:

Item Name	CMS Code	Current Price	Updated Price
Dorsal SI Joint Arthrodesis Implant	SD356	$11,500.00	$12,500.00
Varithena admin pack	SA125	$40.00	$55.00
Varithena (foam)	SA324	$3,195.00	$3,495.00

In CY 2025, CMS began a four-year transition to update the pricing for 15 supply packs. CMS is continuing into the third year of updating this pricing for CY 2027. For more information about the supply packs and the year-to-year pricing transition, please see Table A-B6: Supply Pack Pricing Transition.

Updates to Practice Expense Methodology – Site of Service Payment Differential
For CY 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 in the non-facility setting. This shifted the indirect PE RVUs from the facility setting to the non-facility setting.

Following this implementation, CMS received feedback that this resulted in an unintended but significant site of service differential for physician visits in nursing facility settings based on whether the beneficiary's stay is covered under Part A (hospital or facility setting) or Part B (non-facility setting).

For CY 2027, CMS continues to examine their policy and consider additional refinements to their methodology. CMS is seeking comment on:

- How PE costs vary for physicians and other professionals, not only based on whether they practice in part or exclusively in a facility setting, but also how their costs vary when they are employed by health systems, hospitals, or other entities
- The amount of indirect PE hospital-employed physicians incur when they furnish care within a facility. How accurate is the 50% indirect PE allocation?
- Whether and how they might, alternatively or additionally, define and identify physicians and professionals who are employed by hospitals, health systems, or other entities to ensure the services they furnish are not inappropriately consuming PE RVUs that would be more appropriately assigned to services furnished by professionals incurring comparatively greater practice expenses.
- Whether a new HCPCS modifier for employed physicians would be a reasonable way to identify and reduce facility PE from the services they perform in the facility setting or whether there are other methods they should consider.
- What the primary variables are that they should consider to continue to improve their data sources, allocation methodologies, and payment rates across settings of care to best reflect the resources involved in furnishing MPFS services by professionals and suppliers operating in a complex marketplace, across settings of care.

Efficiency Adjustment

For CY 2026, CMS implemented an efficiency adjustment of 2.5 percent to the work RVUs and physician intraservice time for non-time-based services. CMS will be applying this adjustment every three years.

For CY 2027, CMS clarified that they made refinements to the Relative Value Scale Update Committee (RUC)-recommended values where the values were based on, or crosswalked to, pre-adjusted work RVUs. CMS stated that this only impacted a small number of codes reviewed for 2027.

Procedures Subject to the Multiple Procedure Payment Reduction (MPPR) and the Outpatient Prospective Payment System (OPPS) Cap

Three new MRA head and neck codes were identified by CMS as "imaging services" and are proposed for inclusion in their OPPS cap list.

CPT Code	Descriptor
70XX4	*Magnetic resonance angiography, head and neck, including image postprocessing; without contrast material(s)*
70XX5	*Magnetic resonance angiography, head and neck, including image postprocessing; with contrast material(s)*

70XX6	*Magnetic resonance angiography, head and neck; without contrast material(s) in one or both body regions, followed by contrast material(s) and further sequences in one or both body regions, including image postprocessing*

Valuation of Specific Codes for CY 2027

Fine Needle Aspiration (Current Procedural Terminology (CPT ®) codes 10005 and 10006)

CPT Code	Descriptor	Proposed CY 2027 Work RVU
10005	Fine needle aspiration biopsy, including ultrasound guidance; first lesion	1.35
10006	Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion	1.00

The two fine needle aspiration (FNA) biopsy codes with ultrasound guidance, 10005 and 10006, were re-reviewed at the request of a specialty society.

CMS proposes to adopt the RUC-recommended work RVUs for both codes.

CMS is proposing to accept the RUC-recommended PE inputs for CPT codes 10005 and 10006, with one modification. The RUC submitted an invoice to update the price for the existing portable ultrasound (EQ250) equipment from $41,612.53 to $83,750.00. However, CMS expresses concern that current market trends suggest portable ultrasounds are becoming less expensive, not more expensive, and that the invoice submitted by the RUC appears to represent a high-end diagnostic ultrasound system, rather than a typical portable ultrasound. As this equipment and pricing may not accurately reflect the portable ultrasound used across all services that currently utilize EQ250, and increasing the price of EQ250 would affect many other HCPCS/CPT codes, CMS instead proposes to create a new equipment item, "Fine Needle Aspiration portable ultrasound" (ER130), priced at $83,750.00, specifically for CPT codes 10005 and 10006, at the recommended 37 minutes and 17 minutes, respectively.

Ablation Therapy – Bone Tumors (CPT code 209XX)

CPT Code	Descriptor	Proposed CY 2027 Work RVU
209XX	Ablation therapy for reduction or eradication of bone tumor, including adjacent soft tissue when involved by tumor extension, cryoablation, open	2.70

In February 2025, the CPT Editorial Panel approved new Category I add-on code 209XX to describe cryoablation performed during an open surgical procedure after tumor resection, where remaining bone tissue is treated by freezing.

The code was initially reviewed at the April 2025 RUC meeting, where the specialty society recommended an interim value. It was subsequently resurveyed at the September 2025 RUC meeting, and revised recommendations were submitted to CMS.

CMS proposes to adopt the RUC-recommended work RVU for CPT code 209XX. The RUC did not recommend any direct PE inputs for this code.

Intraosseous Fiducial Marker Placement (CPT codes 209X1 and 209X2)

CPT Code	Descriptor	Proposed CY 2027 Work RVU
209X1	Placement of localization marker(s) (eg, fiducial marker[s]), intraosseous, percutaneous, including imaging guidance, when performed; first target site	3.00
209X2	Placement of localization marker(s) (eg, fiducial marker[s]), intraosseous, percutaneous, including imaging guidance, when performed; each additional target site	1.76

At the May 2025 CPT Editorial Panel meeting, two new CPT codes (209X1 and 209X2) were approved to report percutaneous intraosseous fiducial marker placement for the first site and each additional target site. The specialty societies noted that the codes describe existing services rather than new technology and were created to improve coding specificity.

CMS proposes to adopt the RUC-recommended work RVUs and direct PE inputs for both codes without refinement.

Sacroiliac Joint Arthrodesis (CPT codes 27278 and 27279)

CPT Code	Descriptor	Proposed CY 2027 Work RVU
27278	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive, including imaging guidance, unilateral; placement of intra-articular structural bone graft, metal and/or synthetic device(s) without cortical piercing, including use of osteopromotive material and/or obtaining bone graft, when performed	7.66
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive, including imaging guidance, unilateral; placement of transarticular and/or intra-articular device(s) that engage bone with intrinsic fixation (eg, screw[s], flange[s], blade[s]) piercing the lateral cortex of the sacrum and the medial cortex of the ilium (with or without piercing the lateral cortex of the ilium), including use of osteopromotive material and/or obtaining bone graft, when performed	11.00

At the May 2025 CPT Editorial Panel meeting, CPT codes 27278 and 27279 were revised to more clearly distinguish between different percutaneous or minimally invasive sacroiliac (SI) joint arthrodesis techniques. CPT code 27278 was revised to describe procedures involving placement of an intra-articular structural bone graft, metal, and/or synthetic device without cortical piercing, while CPT code 27279 was revised to describe procedures involving transarticular and/or intra-articular fixation devices that engage bone through cortical piercing. The revised codes were reviewed at the September 2025 RUC meeting.

CMS proposes to adopt the RUC-recommended work RVUs and direct PE inputs for both codes without refinement.

Treatment of Incompetent Veins (CPT codes 36470, 36471, 36465, 36466, 36473, and 36474)

CPT Code	Descriptor	Proposed CY 2027 Work RVU
36465	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)	2.29
36466	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg	2.62
36470	Injection of sclerosant; single incompetent vein (other than telangiectasia)	0.73
36471	Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg	1.18
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	3.41
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites	1.71

In April 2025, the Relativity Assessment Workgroup (RAW) flagged CPT code 36465 for review due to Medicare utilization exceeding 10,000 services and increasing by more than 100% between 2018 and 2023. The RUC subsequently reviewed CPT code 36465 and its related sclerosant and mechanochemical ablation codes (36466, 36470, 36471, 36473, and 36474) at the January 2026 meeting.

CMS proposes to adopt the RUC-recommended work RVUs for five of the six codes in the family. For CPT code 36466, CMS noted that, while the intraservice and total time for this procedure decreased, the RUC recommended to maintain the current 2.93 work RVU. CMS does

not believe there is evidence to support a change in clinical practice or an increase in intensity for this procedure to warrant maintaining the value despite the decrease in time. Therefore, CMS is proposing to crosswalk the value of CPT code 36466 to CPT code 57156 *(Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy),* which has the same intraservice time, for a work RVU of 2.62.

CMS is also proposing to accept the RUC-recommended direct PE inputs for all of the codes without refinement.

Prostate Biopsy Services (CPT codes 55705, 55707, 55708, 55709, 55710, 55711, 55712, 55714, and 55715)

CPT Code	Descriptor	Proposed CY 2027 Work RVU
55705	Biopsy, prostate, any approach, non-imaging guided	1.88
55707	Biopsy, prostate, transrectal, including imaging guidance, regional	2.63
55708	Biopsy, prostate, transrectal, including imaging guidance, regional and fusion-targeted lesion(s)	3.39
55709	Biopsy, prostate, transperineal, including imaging guidance, regional	3.23
55710	Biopsy, prostate, transperineal, including imaging guidance, regional and of fusion-targeted lesion(s)	3.81
55711	Biopsy, prostate, transrectal or transperineal, including imaging guidance, fusion-targeted lesion(s) without regional; first targeted lesion	2.37
5XX14	Biopsy, prostate, transrectal or transperineal, including imaging guidance, fusion-targeted lesion(s) without regional; each additional targeted lesion (List separately in addition to code for primary procedure)	0.68
55714	Biopsy, prostate, including imaging guidance, in-bore CT- or MRI-guided; first targeted lesion	3.62
55715	Biopsy, prostate, including imaging guidance, in-bore CT- or MRI-guided; each additional targeted lesion (List separately in addition to code for primary procedure)	1.80

This prostate biopsy family was identified during the April 2022 RAW review because the services were reported together by the same physician on the same date of service at least 75% of the time. Survey results presented at the September 2024 RUC meeting indicated that the existing long descriptors did not adequately describe the services, leading CPT to restructure the prostate biopsy code family for CPT 2027.

CMS proposes to adopt the RUC-recommended work RVUs for eight of the nine codes in the prostate biopsy family. For CPT code 5XX14, CMS disagrees with the RUC recommendation of 0.80 RVUs and instead proposes 0.68 RVUs, based on a crosswalk to CPT code 93567 *(Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supravalvular aortography (List separately in addition to code for primary*

procedure)). CMS feels that 0.68 RVU will better maintain relativity with similarly timed codes in the MPFS.

CMS is proposing to accept the RUC-recommended direct PE inputs for all nine codes without refinement.

Percutaneous Lumbar Decompression (CPT code 62287)

CPT Code	Descriptor	Proposed CY 2027 Work RVU
62287	Decompression, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle-based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar	6.23

CPT code 62287 was initially proposed for deletion at the January 2025 RUC meeting due to declining utilization. Following additional utilization review and requests from neurosurgery and radiology to retain the code, CPT elected not to delete the service. As a result, CPT code 62287 was surveyed and reviewed at the September 2025 RUC meeting.

CMS disagrees with the RUC-recommended 7.06 work RVU, instead proposing to crosswalk to CPT code 46707 *(Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS]),* at 6.23 work RVUs. CMS states that the service's physician work time has decreased substantially and there is no evidence that the procedure's intensity has increased.

CMS is proposing to accept the RUC-recommended direct PE inputs without refinement.

MRA – Head, Neck (CPT codes 70544, 70545, 70546, 70547, 70548, 70549, 70XX4, 70XX5, and 70XX6)

CPT Code	Descriptor	Proposed CY 2027 Work RVU
70544	Magnetic resonance angiography, head, including image postprocessing; without contrast material(s)	1.17
70545	Magnetic resonance angiography, head, including image postprocessing; with contrast material(s)	1.17
70546	Magnetic resonance angiography, head, including image postprocessing; without contrast material(s), followed by contrast material(s) and further sequences	1.44
70547	Magnetic resonance angiography, neck, including image postprocessing; without contrast material(s)	1.17

70548	Magnetic resonance angiography, neck, including image postprocessing; with contrast material(s)	1.46
70549	Magnetic resonance angiography, neck, including image postprocessing; without contrast material(s), followed by contrast material(s) and further sequences	1.76
70XX4	Magnetic resonance angiography, head and neck, including image postprocessing; without contrast material(s)	1.77
70XX5	Magnetic resonance angiography, head and neck, including image postprocessing; with contrast material(s)	2.10
70XX6	Magnetic resonance angiography, head and neck; without contrast material(s) in one or both body regions, followed by contrast material(s) and further sequences in one or both body regions, including image postprocessing	2.23

The MRA head and neck code family was first identified by the RAW in 2022 due to the increasing rate that reported-together CPT codes 70544 and 70547 were being reported together. Following a two-year monitoring period, the codes were reviewed again in 2024 as the billing pattern persisted, leading to the September 2025 CPT code revisions to the six existing MRA head and MRA neck codes and the creation of three bundled codes for MRA head and neck.

CMS proposes to adopt the RUC-recommended work RVUs and direct PE inputs for all nine codes without refinement.

Computed Tomography-Upper Extremity with Contrast (CPT codes 73200, 73201, and 73202

CPT Code	Descriptor	Proposed CY 2027 Work RVU
73200	Computed tomography, upper extremity; without contrast material	1.00
73201	Computed tomography, upper extremity; with contrast material(s)	1.16
73202	Computed tomography, upper extremity; without contrast material, followed by contrast material(s) and further sections	1.24

In April 2025, the RAW flagged CPT code 73201 for review due to high Medicare utilization identified through the CMS/Other source and 2023 Medicare utilization over 20,000 screen. As a result, the entire CT upper extremity family, including CPT codes 73200 and 73202, was surveyed for the January 2026 RUC meeting.

CMS proposes to adopt the RUC-recommended work RVUs and direct PE inputs for all three codes without refinement.

Radiation Oncology Treatment Delivery (CPT codes 77402, 77407, and 77412)

CPT Code	Descriptor	Proposed CY 2027 Work RVU
77402	Radiation treatment delivery; Level 1 (e.g., single-electron field, multiple-electron fields, or 2D photons), including imaging guidance, when performed	0.00
77407	Radiation treatment delivery; Level 2, single-isocenter (e.g., 3D or IMRT) photons, including imaging guidance, when performed	0.00
77412	Radiation treatment delivery; Level 3, multiple isocenters with photon therapy (e.g., 2D, 3D, or IMRT) or a single-isocenter photon therapy (e.g., 3D or IMRT) with active motion management, or total skin electrons, or mixed electron/photon field(s), including imaging guidance, when performed	0.00

In the CY 2026 MPFS final rule, CMS finalized their proposal to use the relationship between the OPPS Ambulatory Payment Classifications (APC) relative weights for APCs 5621, 5622, and 5623 to value the PE-only radiation treatment delivery codes, 77402, 77407, and 77412. Since CY 2026, stakeholders have reported that CMS has overestimated the actual utilization of CPT code 77412.

Following review of early 2026 claims data showing that CPT 77412 accounted for only about 18% of utilization instead of the estimated 35%, CMS proposes to refine the relativity within this family for CY 2027 by revaluing the PE RVUs using the observed distribution of services, such that the PE and MP RVUs for these services represent the same share of total PE and MP RVUs as they did in CY 2025.

Proton Beam Treatment Delivery (CPT Codes 77520, 77522, 77523, and 77525)

CPT Code	Descriptor	Proposed CY 2027 Work RVU
77520	Proton treatment delivery; simple, without compensation	0.00
77522	Proton treatment delivery; simple, with compensation	0.00
77523	Proton treatment delivery; intermediate	0.00
77525	Proton treatment delivery; complex	0.00

CMS currently does not assign national RVUs for CPT codes 77520, 77522, 77523, and 77525, and payment is determined by local Medicare Administrative Contractors (MACs). However, concerns have been raised about the geographic payment disparities with contractor pricing and CMS was urged to nationally price these services.

CMS is proposing to calculate the PE RVUs for these services by:

- Using the total allowed charges paid by the MACs for these services to establish the pool of PE RVUs to allocate to the services in this family.
- Allocating PE RVUs to the individual services using the relationship between the APC relative weights for APCs 5625 (to which CPT codes 77522, 77523, and 77525 are assigned) and APC 5623 (to which CPT code 77520 is assigned) under the OPPS.

Potentially Misvalued Services Under the MPFS

For CY 2027, CMS received 15 nominations for potentially misvalued codes, with one of them pertaining to radiation oncology.

Image-guided Robotic Linear Accelerator Stereotactic Radiosurgery (HCPCS code G0339 and G0340)

Image-guided robotic linear accelerator-based stereotactic radiosurgery services are currently reported with G0339 *(Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment)* and G0340 *(Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment)* and are contractor priced.

During the September 2025 RAW, the submitted action plan recommended deletion of the G-codes, as CPT code 77373 *(Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions)* was identified as an available code to report these procedures. However, Medicare claims indicated that G0339 and G0340 are frequently billed, at 3,000 and 12,000 times, respectively, in 2024. CMS believes that the G-codes should be maintained so as not to disrupt current billing practices. The RAW will review an action plan on these codes at the September 2026 RUC meeting. If the codes are not deleted for CY 2027, CMS welcomes the RUC's additional information regarding appropriate coding and payment for these services.

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

The Current Procedural Terminology (CPT ®) coding system, owned and copyrighted by the American Medical Association (AMA), was introduced in 1966 to "encourage the use of standard terms and descriptors to document procedures in the medical record". CMS uses the CPT coding system under a royalty-free licensing agreement with the AMA.

The CPT ® Advisory Committee, established in 1966, creates new codes and then the AMA Relative Value Scale Update Committee (RUC), established in 1992, assigns a payment value for these codes. Over the years, there has been concern about the influence of the AMA RUC over the value of services, as many specialty societies have a financial stake in the process. Therefore, CMS is seeking comment on the following questions:

- What, if any, evidence is there for CMS to consider regarding the harms or challenges associated with AMA's monopoly over CPT-4 licenses for health care entities? Please cite potential improvements to patient care diverted or delayed due to AMA's monopoly

over CPT codes, including inhibited innovations and acquisition or maintenance costs of CPT ® licensure.

- What, if any, evidence is there that the generation of CPT-4 codes follows a process of identification of medical necessity? What opportunities or examples from other populations, sites of care, or international health systems could instruct a process of identification of medical necessity in the CPT-4 code development process?
- A combination of CPT-4 and HCPCS codes were formally adopted by the Department of Health and Human Services (HHS) as the legal standard for national coding for physician and other services as part of implementing the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If CMS were to revisit this standard in future rulemaking, which if any alternatives exist to CPT-4 for CMS to consider as part of the national coding standard for physician service? Would CMS need to specify a separate legal standard, or could CMS allow for private competition to supplement the existing CPT-4 coding standard?
- What objective alternatives exist, or could be developed, to maintain a more objective process to the current AMA CPT and RUC processes? How would these alternatives support or inhibit innovation?
- What are the benefits and drawbacks of paying for physician procedural services on the basis of the underlying International Classification of Diseases, 10th Revision (ICD-10) procedure code, as an alternative to CPT-4 code? How could underlying International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) services be grouped or bundled into payment categories, similar to Medicare Severity Diagnosis Related Groups (MS-DRGs) or Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classifications (APCs)? What other alternatives exist for bundling or grouping procedural services?

Request for Information on Duplicate Laboratory Testing, Imaging, and Result Sharing and Interoperability

CMS explains that diagnostic imaging and lab tests are important because they help providers decide how a patient should be treated. However, the results are often stored only in the electronic health record system where the test was performed. Providers in other health systems may not be able to access the results or may not even know that the testing was already completed.

When providers cannot see previous results, patient care may be delayed or based on incomplete information. It can also lead to tests being repeated unnecessarily, which increases costs and may expose patients to additional radiation when imaging is repeated.

CMS is asking groups of interest for feedback on ways to improve the sharing of test results and reduce duplicate testing.

CMS is also considering several ways to address payment for duplicate tests, including:

- Giving labs and imaging centers clearer billing instructions about when a test is considered a duplicate;

- Using Medicare Administrative Contractor edits to deny or reduce payment for duplicate tests when appropriate;
- Recovering payments from providers or suppliers that performed duplicate tests; and
- Limiting how often certain tests may be performed when clinically appropriate.

Changes to Primary Care and Care Management Due to Technology and Clinical Artificial Intelligence

CMS discusses the use of artificial intelligence (AI) technology throughout primary care and indicates a wish to better understand that usage. CMS is seeking comment on how to develop a comprehensive and consistent approach to payment for technology-enabled care.

CMS poses the following specific questions for feedback:

- CMS believes that clinical documentation and clinical decision support tools are currently the most commonly used applications of AI in primary care. Does this reflect current practice? In particular, are there additional clinical AI tools and new technologies that are frequently being used in primary care settings with high accuracy, demonstrated safety, and clinical outcomes reported? If so, please describe how they impact the clinical workflow and the beneficiary experience.
- If you are a physician furnishing primary care services, how has your practice been impacted or how do you expect it will be impacted by clinical AI tools?
- How has incorporating technology and AI tools impacted the resource costs associated with primary care practice, in terms of the time and intensity of services delivered?
- How has the implementation of clinical AI tools led to improvements in the quality of care, or reduced downstream costs? In general, please cite any evidence available for your comments.
- If these tools are increasing productivity, what are clinicians and other health professionals doing with the additional time/bandwidth created? Are you seeing more patients in visits, engaging more with population-health management or care management, accomplishing administrative tasks, or something else?
- How do you ensure patient data and privacy is adequately protected during use of these tools?
- Please describe areas where clinical AI tools in primary care are not well captured in the current coding and payment system and suggest how these may be incorporated to facilitate high-value, technology-enabled primary care.
- What lessons can CMS learn and adopt from private payors with respect to clinical AI?

Changes to the Medicare Telehealth Services List

CMS did not receive any requests to add or remove services from the Medicare Telehealth Services List for CY 2027.

<u>Telehealth Flexibilities and Modifiers</u>

As discussed in the CY 2021 MPFS final rule (85 FR 84506), legislation enacted to address

the public health emergency (PHE) for COVID-19 provided the Secretary with new authorities under section 1135(b)(8) of the Act, as added by section 102 of the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (Pub. L. 116-123, March 6, 2020) and subsequently amended by section 6010 of the Families First Coronavirus Response Act (Pub. L. 116-127, March 18, 2020) and section 3703 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (Pub.L. 116-136, March 27, 2020), to waive or modify Medicare telehealth payment requirements during the PHE for COVID-19. Section 6209(d) of the CAA, 2026 delayed the in-person visit requirements for mental health services furnished through telehealth from January 30, 2026, to the extended date of January 1, 2028. Section 6209(e) of the CAA, 2026 extends the flexibilities to allow audio-only Medicare telehealth services from January 30, 2026, to the extended date of January 1, 2028. To align with these extensions, §410.78 has been revised.

In accordance with section 6209(g) of Consolidated Appropriations Act, 2026 (CAA, 2026) CMS is creating modifiers BB and BC. Section 6209(g) of the CAA, 2026, requires CMS to establish modifiers for telehealth services in certain instances, effective January 1, 2027. These modifiers do not affect payment and are required for claims for telehealth services that are furnished through a virtual telehealth platform by a physician or practitioner that contracts with an entity that owns such virtual platform; or for which a physician or practitioner has a payment arrangement with an entity for use of such virtual platform; and for claims for telehealth services that are furnished incident to a physician's or practitioner's professional service.

Guidance on use of these modifiers will be available on the CMS website.

Changes to Teaching Physicians' Billing for Services Involving Residents or Teaching Physicians with Virtual Presence

In the CY 2021 MPFS final rule, CMS finalized a temporary policy that allowed the teaching physician to have a virtual presence in all teaching settings, but only in clinical instances when the service was furnished virtually. In the CY 2026 MPFS final rule, CMS finalized to permanently allow teaching physicians to have a virtual presence in all teaching settings, only in clinical instances when the service is a three-way telehealth visit, with the teaching physician, resident, and patient in different locations.

CMS received stakeholder feedback that current policy for teaching physicians and residents can, cause logistical complexities in scenarios where either the teaching physician or resident is already in the same physical location as the Medicare beneficiary.

For CY 2027, CMS proposes a modification to previously finalized policy. Rather than requiring the teaching physician, resident, and patient to each be in a different location, CMS proposes to allow teaching physicians to bill for services involving residents when either the teaching physician or resident is in the same physical location as the beneficiary. CMS states they generally interpret physical presence to be defined as either the teaching physician or resident in the same room as the beneficiary. In accordance with section 1842(b)(7)(A)(i)(I) of the Act, the teaching physician must have personal oversight and involvement over the management of the portion of the case for which the payment is sought.

CMS is seeking comments on other scenarios in which this may be appropriate.

Quality Payment Program (QPP)

CMS proposals continue to move the Quality Payment Program (QPP) forward, including focusing more on alignment between the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APM) tracks of participation, alignment with broader CMS initiatives, and new options for clinicians to participate in more meaningful ways.PY

Advanced Alternative Payment Models

For the Advanced APM track, if an eligible clinician participates in an Advanced APM and achieves Qualifying APM Participant (QP) or Partial QP status, they are excluded from the MIPS reporting requirements and payment adjustment.

CMS proposes to apply QP and Partial QP determinations at the Taxpayer Identification Number/National Provider Identifier (TIN/NPI) level, ensuring that financial incentives are directed only to TINs actively participating in Advanced APMs. CMS proposes updates to the QP and Partial QP thresholds and APM Incentive Payment, as a result of the CAA, 2026.

APM Performance Pathway

The APP was designed as a reporting and scoring pathway available only to MIPS eligible clinicians identified on the Participation List or Affiliated Practitioner List of an APM Entity participating in a MIPS APM. CMS proposes to align quality measures in the APM Performance Pathway (APP), original quality measure set and the APP Plus quality measure set to reflect the proposed changes to measures specified for the quality performance category.

MIPS Value Pathways (MVPs)

CMS is proposing to make MIPS Value Pathways (MVPs) the primary participation option within MIPS and to sunset traditional MIPS reporting beginning with the CY 2029 performance period (2031 payment year). Under the proposal, CY 2028 would be the final year clinicians could report through traditional MIPS, after which most clinicians would be expected to participate through an MVP. CMS describes this proposal as part of a broader effort to move away from broad, menu-based reporting and toward more focused, specialty- and condition-based reporting pathways.

CMS states that MVPs are intended to provide a more clinically meaningful reporting framework by organizing quality measures, cost measures, Improvement Activities, and Promoting Interoperability requirements into cohesive specialty- or condition-focused pathways rather than allowing clinicians to select measures from a broad inventory of reporting options. According to the agency, this approach is intended to better align reporting requirements with a clinician's scope of practice and improve the relevance of MIPS participation.

For the CY 2027 performance period, CMS proposes three new MVPs:

1. Diabetic Disease MVP
2. Hypertension MVP

3. Hospitalist MVP

CMS also proposes modifications to all existing MVPs, including the Diagnostic and Interventional Radiology MVPs, like updates to quality measures and other reporting elements within the pathways. The agency states that it intends to continue expanding MVP availability so that clinicians across nearly all specialties have an applicable reporting pathway available prior to the retirement of traditional MIPS.

Because MVPs are built on the broader MIPS framework, many policy changes proposed elsewhere in the rule would also affect MVP participants. The updates detailed below, regarding quality measures, cost measures, Improvement Activities, Promoting Interoperability requirements, scoring methodologies, and other MIPS policies would generally flow through to clinicians reporting through MVPs. As a result, future MIPS policy changes could directly affect reporting requirements and performance assessment within MVPs.

Overall, the proposal represents a significant shift in the future direction of the QPP by establishing a timeline for the eventual retirement of traditional MIPS reporting and positioning MVPs as the primary framework for MIPS participation.

Requests for Information (RFIs)
CMS seeks feedback on two RFIs that would affect MIPS quality measure reporting and the MVP scoring methodology.

1. Fast Healthcare Interoperability Resources (FHIR) Timeline
   CMS is asking for feedback on how to move QPP reporting to a more digital, FHIR-based approach, which would change how quality measures are developed, shared, and reported. The information collected would build on the agency's ongoing transition to digital quality measurement (dQM) by seeking feedback on current QPP measure specifications and reporting standards to FHIR-based digital measure specifications.
   Though not proposed for rulemaking, CMS is considering a gradual transition starting in CY 2028 to assess measure development and reporting readiness. Current reporting options would remain available in CY 2028 and CY 2029, while FHIR-based reporting would be introduced for selected measures and expanded overtime. Following this potential timeline, CMS may require FHIR-based reporting for measures with digital specifications in CY 2030.

2. MVP Scoring Methodology
   CMS is requesting feedback on future MVP scoring methods to determine MIPS payment adjustments for clinicians reporting the same MVPs. It is specifically interested in whether performance comparisons among those reporting the same MVP should occur at the final score level or individual performance category level. The agency is also seeking input on when to adopt future determined method(s). CMS is considering whether to implement such scoring changes in CY 2029, when the proposed full transition to MVP reporting begins, or to test it earlier through a phased rollout.
   Since radiologists' MIPS participation will rely on specialty-specific MVPs in the future, changes to MVP scoring could affect performance assessment and MIPS payment

determinations. The RFI raises questions about whether comparing clinicians within the same MVP would result in a fairer assessment of specialty-specific performance and how such changes could affect scoring outcomes across different MVPs.

MIPS Scoring Overview

The category weights for the 2027 performance year will remain unchanged: **Quality – 30%, Cost – 30%, PI – 25%, and IAs – 15%.** Previously established reweighting formulas for non-patient-facing clinicians and small practices are set to continue with no proposed changes. In the 2026 MPFS Final Rule, CMS finalized its proposal to maintain the performance threshold at 75 points through the 2028 performance year.

Given CMS's decision to enact payment adjustments of +/- nine percent for performance years 2020 and beyond, no changes were proposed to the MIPS adjustment. The agency will maintain the small practice bonus of six points for the Quality Performance category score, and all previously finalized considerations for small practices.

Quality Performance Category

CMS has proposed to implement the "core measure" designation to measures in traditional MIPS and in MVPs, while removing the "high priority" designation entirely. The CMS Core Quality Measures Collaborative (CQMC) has recognized that these measures are particularly relevant to patients, consumers and clinicians. For radiology, the following are proposed as core measures for traditional MIPS and MVPs in 2027:

- **#145:** Radiology: Exposure Dose Indices Reported for Procedures Using Fluoroscopy
- **#360:** Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: Computed Tomography (CT) and Cardiac Nuclear Medicine Studies
- **#405:** Appropriate Follow-up Imaging for Incidental Abdominal Lesions

Additionally, CMS proposes to remove the requirement that MIPS clinicians must submit at least one Outcome measure; this will be replaced with a requirement to report at least one MIPS core measure, if available. Like the prior Outcome measure requirement, this will apply to MVPs as well. If this proposed change is implemented, groups who are unable to submit a core measure must submit an attestation to CMS stating that no MIPS core measures were available or applicable for them to report. Small practices will be exempt from the requirement to submit a core measure, and will not be obligated to submit the aforementioned attestation to CMS.

Previously, if a MIPS clinician or group was unable to submit an Outcome measure, the next-highest high priority measure would take its place. With the proposed core measure implementation and the removal of the high priority designation, a MIPS clinician unable to report a core measure would simply be required to submit one additional non-core measure in its place.

CMS has also proposed some notable measure updates for the 2027 performance year. First, the Qualified Clinical Data Registry (QCDR) measure **ACRad34: Overall Percent of CT Exams for which Dose Length Product is at or below the Size-Specific Diagnostic Reference Level**

is proposed for addition to the Diagnostic Radiology MVP, as well as a selection of Dementia measures to the Nuclear Medicine clinical grouping.

CMS will continue the measure scoring policy established in 2025 which identifies certain measure sets affected by limited measure choice and adjusts the benchmarks of point-capped measures to allow for a maximum score of 10 points.

The Diagnostic Radiology measure set continues to receive this adjustment, as most of the MIPS measures in that set are topped out. The following radiology measures are proposed to receive an adjusted benchmark in 2027:

- **(NEW) #145:** Radiology: Exposure Dose Indices Reported for Procedures Using Fluoroscopy
- **#360:** Count of Potential High Dose Radiation Imaging Studies: CT and Cardiac Nuclear Medicine Studies
- **#364:** Appropriateness: Follow-up CT Imaging for Incidentally Detected Pulmonary Nodules
- **#405:** Appropriate Follow-up Imaging for Incidental Abdominal Lesions
- **#406:** Appropriate Follow-up Imaging for Incidental Thyroid Nodules

During the previous two performance years, measure #145 was not included in this list as it was not considered point-capped at the time of rulemaking. The measure was given a seven-point cap at the beginning of the 2026 MIPS performance year and therefore became eligible for adjusted benchmarking in 2027.

CMS has proposed the addition of a new MIPS electronic Clinical Quality Measure (eCQM) to the Diagnostic Radiology specialty set beginning in performance year **2028** titled **Rate of Timely Follow-up on Abnormal Screening Mammograms for Breast Cancer Detection**. If approved, this measure's denominator would be "Female patients aged 40-75 years with an abnormal screening (BI-RADS 0) or screening-to-diagnostic (BI-RADS 4, 5) mammogram during the measurement period," and the numerator would be "Patients in the denominator population who received timely diagnostic resolution defined as negative/benign/probably benign follow-up imaging (BI-RADS 1, 2, 3) or breast biopsy within 60 days after the date of their index abnormal screening." The measure is proposed with a one-year implementation delay, much like the previous radiology eCQM, to allow groups and clinicians time to adapt their workflows to requirements of this new measure.

For 2027, there are no proposed measure additions or measure removals to the Diagnostic Radiology specialty set.

<u>Improvement Activities Performance Category</u>
CMS has proposed the addition of six new Improvement Activities (IAs) within the Care Coordination and Advancing Health and Wellness categories, the modification of five IAs, and the removal of 11 existing IAs.

The six IAs proposed for addition to the program are:

- **IA_CC_XX:** Use of Data to Improve Practice Workflows
  - This IA aims to allow clinicians to improve integration of evidence-based guidelines into their clinical workflows.
- **IA_CC_XX:** Understand and Improve Diagnostic Performance
  - This IA intends to support clinicians in improving patient safety by reducing safety events through tracking discrepancies, near-misses and data inaccuracy.
- **IA_AHW_XX:** Systematic Screening and Intervention for Nutrition and Other Health-Impacting, Non-Clinical Issues
  - This IA encourages clinicians to implement screening for nutrition, housing, transportation and financial strain into their workflows.
- **IA_AHW_XX:** Advance Care Planning Conversations to Support Patient Wellness and Care Preferences
  - This IA encourages the use of structured communication tools in advance care planning and end-of-life discussions.
- **IA_AHW_XX:** Clinician Use of Artificial Intelligence (AI) to Improve Patient Care
  - This IA allows clinicians to implement organizational initiatives to improve patient care through the responsible and transparent use of AI in their workflows.
- **IA_AHW_XX:** Lifestyle Approaches to Diabetes Remediation
  - This IA relates to lifestyle interventions aimed at diabetes management, such as nutrition, sleep and stress through programs like LEADR and DSMES.

The following IAs have been proposed for modification in 2027:

- **IA_BMH_4:** Depression Screening
  - Combined with elements of IA_BMH_5
- **IA_CC_8:** Implementation of Documentation Improvements for Practice/Process Improvements
  - Combined with elements from IA_CC_10, IA_CC_11 and IA_CC_12
- **IA_CC_9:** Implementation of Practices/Processes for Developing Regular Individual Care Plans
  - Combined with elements from IA_BE_15
- **IA_PM_4:** Glycemic Management Services
  - Combined with elements of IA_PM_19 and IA_PM_20
- **IA_PSPA_16:** Use Decision Support and Standardized Treatment Protocols to Manage Workflow on the Care Team to Meet Patient Needs
  - Modified to explicitly include AI-enabled decision support and strengthen oversight requirements.

The IAs proposed for removal in 2027 are:

- **IA_BMH_5:** MDD Prevention and Treatment Interventions
- **IA_CC_10:** Care Transition Documentation Practice Improvements
- **IA_CC_11:** Care Transition Standard Operational Improvements
- **IA_CC_12:** Care Coordination Agreements that Promote Improvements in Patient Tracking Across Settings

- **IA_CC_16:** Primary Care Physician and Behavioral Health Bilateral Electronic Exchange
- **IA_PSPA_2:** Participation in MOC Part IV
- **IA_BE_15:** Engagement of Patients, Family, and Caregivers in Developing a Plan of Care
- **IA_PM_19:** Glycemic Screening Services
- **IA_PM_20:** Glycemic Referring Services
- **IA_EPA_4:** Additional Improvements in Access as a Result of QIN/QIU TA
- **IA_PM_2:** Anticoagulant Management Improvements

Apart from these additions, modifications and removals, there are no changes proposed to the Improvement Activities performance category.

Cost Performance Category

For the CY 2027 performance year, CMS is proposing relatively few changes to the MIPS Cost performance category. It is not proposing or removing any cost measures or making substantive changes to the cost scoring methodology. The current inventory of population-based and episode-based cost measures will remain in place.

Promoting Interoperability Performance Category

For participants in the MIPS Promoting Interoperability (PI) performance category, CMS proposes to revise the definition of "certified EHR technology (CEHRT)" at 42 CFR 414.1305 to align with recent HHS Office of the National Coordinator for Health IT (ONC) proposals related to health IT certification regulations, including removal of references to the certification criteria proposed by ONC for discontinuation.

To reduce reporting burden, CMS proposes to remove the "Security Risk Analysis" measure (beginning with the CY 2027 performance period) that currently requires clinicians to attest that a security risk analysis has been conducted. This is due to duplication with existing HIPAA Security Rule compliance requirements.

Additionally, CMS proposes to discontinue the "ONC Direct Review" and "ONC-ACB Surveillance" attestation requirements (beginning with the CY 2026 performance period). These previously required attestation of cooperation with ONC and ONC-authorized certification body oversight activities.

In terms of new compliance obligations, CMS proposes "Electronic Prior Authorization" measure language clarifications tied to certified capabilities that support FHIR-based prior authorization workflows. CMS also proposes an all-new "Electronic Prior Authorization for Prescription Drugs" measure that would initially be optional for the CY 2027 performance period before becoming required in CY 2028. If finalized, the "ePA for Rx Drugs" measure would require use of CEHRT to electronically submit at least one prior authorization request for a prescription drug during the performance period.

Medicare Shared Savings Program

As of January 1, 2026, the Medicare Shared Savings Program (MSSP) has 511 accountable care organizations (ACOs) with over 700,000 healthcare providers and organizations providing care to over 12.6 million assigned beneficiaries. Eligible groups of providers and suppliers, such as physicians, hospitals, and other healthcare providers, may participate in the MSSP by forming or joining an ACO and in so doing agree to become accountable for the total cost and quality of care provided to an assigned population of Medicare FFS beneficiaries. Under the MSSP, providers and suppliers that participate in an ACO continue to receive Original Medicare (OM) payments under Parts A and B, and the ACO may be eligible to receive a shared savings payment if it meets specified quality and savings requirements, and in some instances may be required to share in losses if it increases healthcare spending. CMS stated that it is focused on developing policies that would increase the number of healthcare providers and beneficiaries in accountable care relationships and grow savings to the Medicare Trust Funds.

CMS estimates these proposals are projected to reduce Trust Fund expenditures by $5.5 billion in total through the end of the 10-year period 2027 through 2036, ranging from approximately $8.9 billion lower spending at the 10th percentile to $2.3 billion lower spending at the 90th percentile.

<u>Proposed Modifications to the Shared Savings Program Assignment Methodology</u>

CMS proposes several changes to the MSSP beneficiary assignment methodology, applicable for the performance year starting on January 1, 2028, and subsequent performance years, with the goal of increasing the number of Medicare beneficiaries involved in accountable care relationships.

CMS proposes to exclude from assignment calculations allowed charges for primary care services billed through a non-ACO Taxpayer Identification Number (TIN) by an ACO professional used in assignment. This would be a tailored approach to reduce the potential for ACO professionals' billing patterns, inside and outside the ACO for the care of the same beneficiaries, to result in differences in assignment outcomes that advantage the ACO's financial performance.

Next, CMS proposes to modify assignment eligibility criteria and prospective assignment exclusion criteria based on Medicare enrollment status. Currently, to be eligible for assignment to an ACO for a performance year or benchmark year, a beneficiary must meet criteria including having at least one month of Part A and Part B enrollment without any month of Part A only or Part B only enrollment, or Medicare group health plan enrollment during the assignment window. For an ACO participating under prospective assignment, a beneficiary may be excluded later from the ACO's prospective assignment list if they no longer meet these eligibility criteria. Additionally, CMS proposes to modify the assignment criteria based on Medicare enrollment status to align with its current operational approach to identifying the assignable beneficiary population. If finalized, CMS would consider as eligible for assignment beneficiaries who have at least one month of Part A and Part B enrollment and no Medicare group health plan enrollment (including MA) during that same month during the 12-month assignment window for the relevant performance year or benchmark year.

Lastly, CMS proposes updates to the definition of primary care services used for beneficiary assignment under the MSSP to align with payment policy proposals. CMS proposes to include, among other services for determining beneficiary assignment for the performance year starting on January 1, 2027, and subsequent performance years, new codes for Screening, Brief Intervention, and Referral to Treatment, Vaccine Adverse Effects Management, and Advance Care Planning.

Strengthen Financial Incentives to Participate and Encourage Additional Savings in Two-Sided Risk

CMS proposes changes to the MSSP's financial methodology. CMS proposes to revise MSSP financial methodology to encourage participation in two-sided risk models by increasing the share rate under Level E of the BASIC track and reduce the maximum weight on the regional adjustment for ACOs under the ENHANCED track for ACOs that are lower spending compared to their regional service area. CMS proposes to increase the shared savings rate ("sharing rate") for Level E of the BASIC track from 50% to 60%. CMS proposes to reduce the maximum weight used in calculating the positive regional adjustment for ACOs participating under the ENHANCED track from 50% to 35%. The proposed reduction in the positive regional adjustment weight for these ACOs, paired with a proposed increase in the shared savings rate for BASIC track Level E, is designed to rebalance financial incentives across tracks and encourage ACOs to select their tracks based on their actual capacity to reduce costs rather than differences in financial advantages embedded in track design thereby potentially improving Medicare Trust Fund net savings.

Proposal to Incentivize New Participation through a Growth Adjustment to the Historical Benchmark

CMS proposes to establish a growth adjustment to the historical benchmark to reward ACOs for recruiting ACO professionals who are inexperienced with value-based care arrangements and serving beneficiaries new to value-based care. This growth adjustment would be applied on top of the highest existing benchmark adjustments for which an ACO is eligible, either a positive regional adjustment, prior savings adjustment, or population adjustment, and would not exceed the proposed risk-adjusted 5% cap. Additionally, the growth incentive would be included in a subsequent agreement period's prior savings adjustment (if applicable), if the ACO continued to maintain or increase the growth it achieved in the previous agreement period.

Proposal to Reform the Accountable Care Prospective Trend (ACPT) Component of the Benchmark Update Factor

The Accountable Care Prospective Trend (ACPT) is part of a three-way blended benchmark update factor that projects an administrative growth target to partially insulate ACOs from a downward "ratchet effect" in benchmarks from both individual and collective success in lowering programmatic costs. For ACOs within existing agreement periods with 2024, 2025, and 2026 start dates, CMS proposes to retroactively apply the lower guardrail, which would limit the ACPT to no more than 1 percentage point below the national growth rate in determining financial reconciliation for performance year (PY) 2025 and any subsequent performance year of the ACO's agreement period. CMS will delay PY 2025 financial reconciliation until November 2026, after the final rule is issued, so that, if finalized, CMS can implement this proposal for PY

2025 reconciliation. Additionally, CMS proposes to calculate annualized growth rates used in determining the ACPT for each performance year for all ACOs in agreement periods beginning on or after January 1, 2027, rather than calculating the annualized growth rates on an agreement period basis (under the existing policy).

Proposal to Allow ACOs To Reduce or Eliminate Part B Cost Sharing

CMS proposes to allow ACOs to reduce or eliminate Part B cost sharing for beneficiaries in accordance with an approved implementation plan starting April 1, 2027. CMS believes this would remove cost barriers for beneficiaries to receive services that will positively impact their health. Under the proposed approach, eligible ACOs could enter Part B cost-sharing support arrangements with ACO participants to reduce or eliminate cost sharing for certain categories of Part B items and services and eligible beneficiaries identified by the ACO. CMS would allow ACOs to reduce or eliminate beneficiary cost sharing for all OM Part B items and services except for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), and prescription drugs.

An ACO would be required to apply to and receive approval from CMS to enter Part B cost-sharing support arrangements with its ACO participants. To allow ACOs to participate as quickly as possible, if this policy is finalized, CMS anticipates collecting initial applications in early 2027 to approve eligible ACOs and their ACO participants to begin eliminating or reducing Part B cost sharing for beneficiaries by the second quarter of CY 2027.

CMS proposes to remove the prepaid shared savings payment option from the MSSP because of low uptake and because similar outcomes could be achieved for beneficiaries through the proposal to offer ACOs the ability to reduce or eliminate Part B cost sharing. Under this proposal, no additional cohorts of ACOs would be allowed to apply for the prepaid shared savings payment option after the application cycle for the January 1, 2027, start date. Participating ACOs would receive prepaid shared savings payments through December 31, 2027.

Proposed Modifications to the Shared Savings Program Quality and CEHRT Use Requirements to Advance ACO Use of dQMs

CMS proposes extending the availability of the MIPS CQMs collection type for Shared Savings Program ACOs reporting the APP Plus quality measure set for PY 2027 and subsequent PYs. To align the reporting incentive with the MIPS CQMs collection type, CMS proposes to extend the reporting incentive to ACOs reporting MIPS CQMs for PY 2027 and subsequent PYs to further support ACOs in meeting the Shared Savings Program quality performance standard to be eligible to share in savings at the maximum rate available for the ACO's track/level of participation and for ACOs participating in the ENHANCED track to avoid maximum shared losses.

Additionally, CMS proposes that, for PY 2027 and subsequent PYs, all measures of the Medicare CQMs collection type would be scored using flat benchmarks. In addition, CMS proposes that Diabetes: Glycemic Status Assessment Greater Than 9% (Quality ID: 001), Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID: 134), and Controlling

High Blood Pressure (Quality ID: 236), if reported via the Medicare CQMs collection type for PY 2026 (and subsequent PYs), would be scored using flat benchmarks.

Fact Sheets
CMS published Fact Sheets on the overall MPFS proposed rule, the Quality Payment Program, the Shared Savings Program, and a Press Release.

ACR will also submit comments to CMS by the comment period deadline on September 14.