American College of Radiology

American College of Radiology Preliminary 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 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 changes to be positive 2% for radiology, 2% for nuclear medicine, 3% for interventional radiology and 3% for radiation oncology.

Medicare Economic Index

For CY 2027, CMS is proposing to continue using the current 2006-based Medicare Economic Index (MEI) due to continued concerns about the redistributive effects that implementing the 2017-based MEI would have on MPFS payments.

New and Revised Codes

For CY 2027, CMS is proposing to accept the American Medical Association Relative Value Scale Update Committee (RUC)-recommended values for most of the radiology-pertinent codes, including fine needle aspiration, MRA head and neck, and CT upper extremity, among others. CMS is proposing a crosswalk methodology for some codes such as percutaneous lumbar decompression and the treatment of incompetent veins. CMS is also proposing to create a new equipment item for a fine needle aspiration (FNA)-specific portable ultrasound machine, priced twice as much as the current portable ultrasound machine.

The ACR will perform a more thorough review of these proposals and coordinate with the appropriate specialty societies in submitting comments to CMS.

Practice Expense (PE)
In the 2027 proposed rule, CMS shared the newest report by RAND Corporation, *Expanding Technical and Professional Components to all Medicare Physician Fee Schedule Services*. CMS contracted RAND to study the PE methodology and propose alternatives. CMS is proposing to allocate indirect PE using both the work RVU and the clinical labor RVU for all services (except 10- and 90-day services) instead of only using that methodology for services—such as diagnostic and imaging services—that can be reported using technical, professional, and global components.

Staff will continue to review the report in detail and provide additional information in the coming weeks.

Potentially Misvalued Services
For CY 2027, CMS received 15 nominations for potentially misvalued codes. One of these nominations includes radiation oncology HCPCS codes related to *Image-guided robotic linear accelerator stereotactic radiosurgery.* The ACR will coordinate with the American Society for Radiation Oncology and the American College of Radiation Oncology in our review of this nomination.

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.

Telehealth Flexibilities and Modifiers
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 2026 MPFS final rule, CMS finalized permanently allowing 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.

For CY 2027, CMS proposes a modification to the 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. CMS is seeking comment on other scenarios in which this may be appropriate.

Quality Payment Program (QPP)

Advanced Alternative Payment Models (APM)
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 (APP)
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 MIPS reporting framework and to retire traditional MIPS reporting beginning with the CY 2029 performance period (2031 payment year). Going forward, most clinicians would participate through an MVP rather than traditional MIPS. For CY 2027, CMS proposes three new MVPs:

1. Diabetic Disease MVP
2. Hypertension MVP
3. Hospitalist MVP

CMS states that its goal is to expand MVP coverage so that nearly all specialties have an appropriate pathway available before traditional MIPS is sunset.

Several broader MIPS changes described in the section following the Requests for Information (summarized below) would also affect MVP participants because MVPs use the same underlying MIPS framework. As CMS updates quality measures, cost measures, Improvement Activities, and Promoting Interoperability requirements, those changes automatically flow into MVP reporting. This means measure additions, removals, and category-specific policy changes in traditional MIPS will also impact MVP participants.

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

Fast Healthcare Interoperability Resources (FHIR) Timeline
This RFI addresses the future shift from current MIPS/QPP quality reporting approaches to FHIR-based digital quality reporting, including a two-year transition timeline, beginning with the CY 2028 performance period, that maintains existing reporting options while also supporting FHIR-based reporting for selected measures.

CMS is also interested in receiving comments on mandatory FHIR-based reporting for applicable measures beginning with the CY 2030 performance period, during which prior electronic reporting approaches would no longer be available for those measures.

MVP Scoring Methodology
CMS is soliciting input on the MVP scoring methodology, specifically on devising a reasonable approach for comparing clinician performance within the same MVP, with each MVP focusing on measures and activities that are relevant to a given specialty or medical condition.

In addition, the agency requests feedback on whether it should consider MVP score normalization within an MVP to ensure scoring fairness across MVPs. CMS is also interested in stakeholder input on the timeline for implementing a new MVP scoring methodology.

MIPS Scoring Overview
The category weights for the 2027 performance year will remain unchanged from previous years: **Quality – 30%, Cost – 30%, Promoting Interoperability (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 PFS Final Rule, CMS finalized its proposal to maintain the performance threshold at 75 points through the 2028 performance year.

CMS finalized a payment adjustment of +/- nine percent for performance years 2020 and beyond. No changes have been proposed to the MIPS adjustment. CMS will maintain the small practice bonus of 6 points for the quality performance category score and all previously finalized considerations for small practices.

Quality Performance Category
CMS proposes removing 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 implemented, small practices will be exempt from the requirement to submit a core measure.

The Diagnostic Radiology measures proposed to be designated as **core measures** in 2027 are:

- **#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

CMS also proposes adding 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** to the Diagnostic Radiology MVP, as well as a selection of dementia measures to the Nuclear Medicine clinical grouping.
CMS will maintain 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:

- **#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

Lastly, CMS proposes to remove the "high priority" designation as one of the retention criteria for measures in MIPS and the MVP inventory.

<u>Improvement Activities Performance Category</u>
CMS proposes adding six new Improvement Activities (IAs), modifying five IAs, and removing 11 existing IAs.

The IAs proposed for addition to the program are:

- **IA_CC_XX:** Use of Data to Improve Practice Workflows
- **IA_CC_XX:** Understand and Improve Diagnostic Performance
- **IA_AHW_XX:** Systematic Screening and Intervention for Nutrition and Other Health-Impacting, Non-Clinical Issues
- **IA_AHW_XX:** Advance Care Planning Conversations to Support Patient Wellness and Care Preferences
- **IA_AHW_XX:** Clinician Use of Artificial Intelligence (AI) to Improve Patient Care
- **IA_AHW_XX:** Lifestyle Approaches to Diabetes Remediation

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

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

CMS proposes several changes to the MIPS Promoting Interoperability (PI) performance category. Beginning with the CY 2027 performance period, CMS would revise the definition of certified electronic health record (EHR) technology (CEHRT) to align with ONC's proposed health IT certification updates and remove the Security Risk Analysis measure, citing existing HIPAA Security Rule requirements. CMS also proposes a new electronic prior authorization measure for prescription drugs, which would initially be optional before becoming required beginning with the CY 2028 performance period. In addition, CMS proposes to discontinue the Office of the National Coordinator for Health Information Technology (ONC) Direct Review and ONC-ACB Surveillance attestation requirements.

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 health care 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. CMS stated they are focused on developing policies that would grow the number of health care providers and beneficiaries in accountable care relationships and grow savings to the Medicare Trust Funds.

CMS proposes to revise policies for determining beneficiary assignment under MSSP. CMS also proposes to revise the quality performance standard and other quality reporting requirements. CMS also proposes revise MSSP CEHRT use requirements by simplifying MSSP CEHRT use requirements.

CMS proposes to revise policies for MSSP financial methodology including to encourage 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.

Additionally, CMS proposes to increase beneficiary engagement by allowing ACO's to reduce or eliminate Part B cost sharing and discontinue availability of the option for prepaid shared savings.

Lastly, CMS is requesting information on potential future policy developments, including:

1. The transition to Fast Healthcare Interoperability Resources®-based quality measurement in the Shared Savings Program;
2. Potential approaches to more effectively integrate and meaningfully engage specialty care in the Shared Savings Program; and
3. Potential approaches to introducing primary care–focused capitated payment arrangements in the Shared Savings Program (section II.E. of this proposed rule).

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.

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 staff will review the entire MPFS proposed rule in the coming weeks and will provide a comprehensive summary of the rule. The ACR will also submit comments to CMS by the comment period deadline.