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CY 2027 Medicare Physician Fee Schedule Proposed Rule

Executive Summary

The CY 2027 Medicare Physician Fee Schedule (PFS) proposed rule recently issued by the Centers for Medicare and Medicaid Services (CMS) represents one of the most consequential physician payment proposals in recent years – not because of the conversion factor change, but because it proposes a fundamental redesign of how Medicare allocates practice expense (PE) payments across physician services. While the projected conversion factor decrease has a modest impact, the proposed overhaul of the PE methodology has the potential to redistribute Medicare payments among specialties and between office-based and hospital-based physicians. Unlike the CY 2026 final rule, which emphasized efficiency adjustments and reduced facility PE allocations, the CY 2027 proposal focuses on replacing long-standing components of the PE methodology with a new approach intended to better reflect contemporary physician practice costs.

Beyond the provisions impacting payment for 2027, the proposed rule includes requests for information that signal further significant methodology overhauls in future rulemaking. These include areas such as exploring new payment approaches for primary care, potentially shifting away from reliance on CPT codes and related input from the American Medical Association (AMA) regarding the relative value assigned to those codes, and whether further reimbursement reductions are warranted for practitioners employed by health systems. Any of these could lead to substantial changes in the future.

Practice Expense Methodology

The most significant proposal in the CY 2027 PFS proposed rule may be CMS's proposed redesign of the Practice Expense (PE) methodology. The CY 2026 final rule implemented significant changes from the historical approach, reducing facility PE RVUs to half the amount allocated to non-facility PE RVUs. This was intended to more accurately account for the resource costs for furnishing care in different settings. The CY 2027 proposed rule continues the PE methodology redesign by proposing structural revisions to how indirect PE is allocated across physician services. CMS's stated rationale for modifying the PE methodology centers on three concerns:

- The current framework anchors indirect PE allocations to specialty-level practice cost survey data that in many cases dates to 2007 or earlier, which CMS believes no longer reflects contemporary practice economics.
- CMS has identified a structural inconsistency in the existing formula. Because indirect PE for services billed with separate professional, technical, and global components is allocated using the sum of wRVUs and clinical labor RVUs, while services billed only globally use the greater of the two, procedural and E/M heavy specialties may be systematically undervalued relative to imaging and diagnostic services.
- CMS has concluded that indirect PE allocated to facility-based services may be overstated since a growing share of physicians no longer maintain a separate private office, a trend attributed in part to continued hospital and health system employment of physicians.

For most PFS services, CMS proposes to allocate indirect practice expense using both work (wRVUs) and clinical labor PE RVUs. The proposed methodology would apply to all services except codes with 10- and 90-day global periods. Additionally, CMS proposes eliminating the Indirect Practice Cost Index (IPCI) over a two-year period. In 2027, only half of the measured IPCI variation would be applied; in 2028, the IPCI would no longer apply. To reduce volatility, CMS proposes a new PE stabilization adjustment limiting annual increases or decreases in PE RVUs to 5% for many existing codes. The cap would not apply to all categories, including certain new, revised, newly nationally priced, or revalued codes. The statutory phase-in rule for total RVU reductions of 20% or more would continue to operate after the PE stabilization step, meaning a code could still experience a total change greater than 5%.

CMS frames the methodology updates as a part of a broader effort to make PFS payments more responsive to current market conditions and more precisely calibrated to where and how care is delivered, rather than as an isolated annual adjustment. Taken together, the proposed PE methodology changes could materially shift Medicare reimbursement across specialties and sites of service. Because the changes must remain budget neutral, increased payments for some providers would be offset by reductions for others, with the ultimate impact depending on each organization's specialty mix and service location. Although the proposed stabilization adjustment may limit near-term volatility, it could also delay the full financial impact into future years.

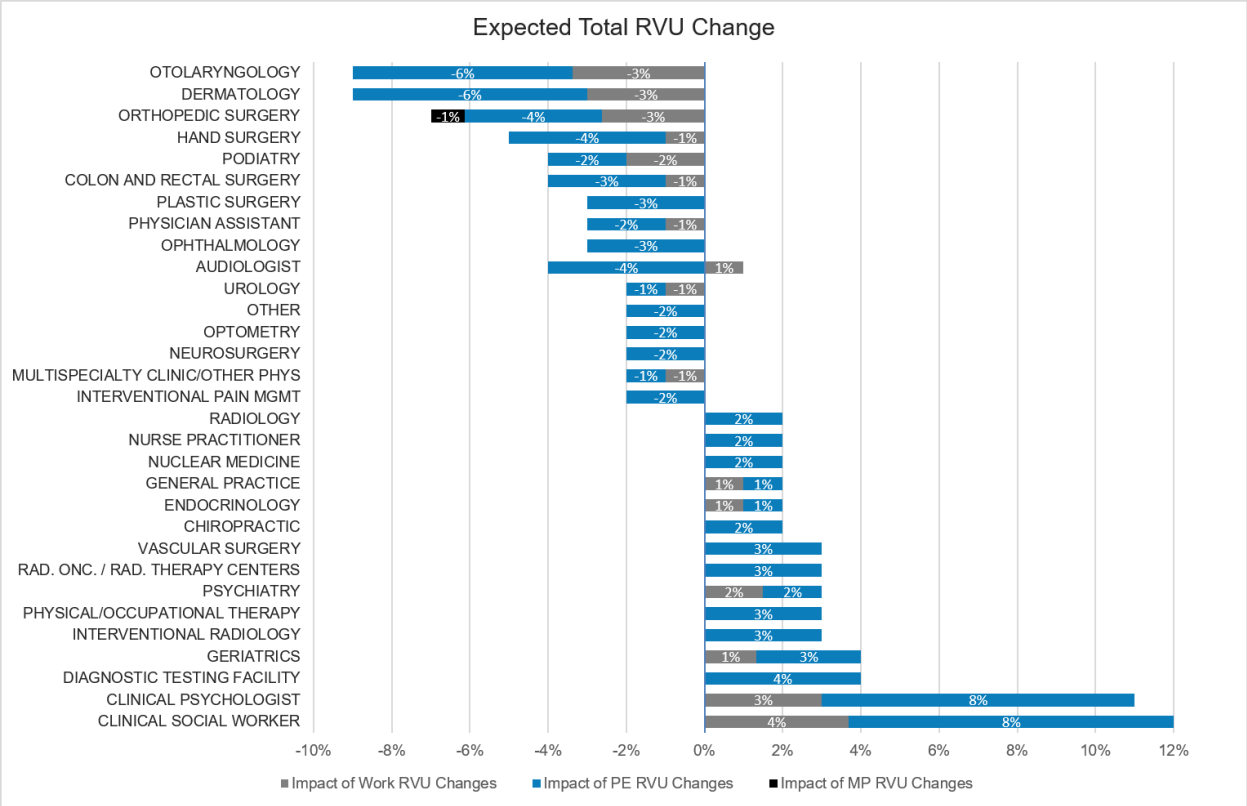
Additionally, CMS is seeking comments on how PE costs vary for providers not only based on whether they practice in a facility or non-facility setting but also based on variations when providers are employed by health systems, hospitals, or other entities. In fact, the proposed rule asks whether the current 50% indirect PE allocation for care furnished within a facility is accurate or whether it could "possibly be less than 50 percent, such as 0 percent." CMS is also seeking comment on 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." Clearly, CMS is exploring whether further reductions in the PE component of reimbursement are warranted.

Importantly, since the PE changes affect reimbursement but not wRVUs, compensation plans based on wRVU productivity may not move in tandem with Medicare revenue after the PE changes are implemented. Physician organizations should begin modeling specialty-specific reimbursement impacts, evaluate differences between office-based and facility-based services, and assess whether current physician compensation arrangements remain appropriately aligned with expected reimbursement. Early financial modeling will allow organizations to understand potential impacts before the rule is finalized.

Specialty Impact Analysis

Preliminary CMS modeling indicates that behavioral health providers, including clinical psychologists and clinical social workers, are among the specialties projected to experience the largest positive payment impacts. Conversely, several procedural and office-based specialties – including otolaryngology, dermatology, orthopedic surgery, and hand surgery – are projected to experience more significant payment reductions. The proposed rule also suggests that some specialties may experience materially different impacts depending upon whether services are furnished in office or facility settings. More detailed modeling at the CPT code level may be warranted for specialties with significant exposure.

The specialties with the greatest expected change in total RVUs (more than 1% change in either direction) are shown in the following chart, derived from Table D-B5 from the proposed rule.



According to CMS, those with expected increases are favorably impacted by changes stemming from the misvalued code initiative, including RVUs for new and revised codes, as well as the PE methodology changes. The proposed changes relating to HCPCS code G2211 also impact these specialties. Additionally, 2027 is the fourth and final year of a phased-in behavioral health work update which has a positive impact on such specialties. Specialties expected to experience the greatest negative impact are more significantly impacted by the changes to modifier -25 as well as the proposal to remove the IPCI from the calculation of PE RVUs. The effects on the PE changes are mitigated by the proposed PE stabilization adjustment, which means the same specialties are likely to experience further negative adjustments next year.

Some specialties have significant disparity between the expected facility and non-facility impact. For example, the expected impact for nurse anesthetists / anesthesia assistants is a 10% increase in total non-facility RVUs, but only a 1% increase in total facility-based RVUs. Below are the specialties with the largest discrepancies (more than a 2% difference in expected changes in facility / non-facility total RVUs):

	Combined RVU Impact			
Specialty	**Total**	**Non-Facility**	**Facility**	**Difference betwwen Facility & Non-Facility**
NURSE ANES / ANES ASST	1%	10%	1%	-9%
RAD. ONC./ RAD. THERAPY CENTERS	3%	5%	-1%	-6%
VASCULAR SURGERY	3%	4%	0%	-4%
INTERVENTIONAL RADIOLOGY	3%	5%	1%	-4%
ORTHOPEDIC SURGERY	-7%	-5%	-8%	-3%
PHYSICAL/OCCUPATIONAL THERAPY	3%	3%	0%	-3%
CLINICAL PSYCHOLOGIST	11%	11%	8%	-3%
PLASTIC SURGERY	-3%	-4%	-1%	3%
AUDIOLOGIST	-3%	-3%	0%	3%
PODIATRY	-4%	-4%	0%	4%
MULTISPECIALTY CLINIC/OTHER PHYS	-2%	-4%	0%	4%
GENERAL PRACTICE	2%	1%	5%	4%
HAND SURGERY	-5%	-7%	-3%	4%
GERIATRICS	4%	2%	7%	5%
PHYSICAL MEDICINE	1%	-2%	4%	6%
NURSE PRACTITIONER	2%	0%	6%	6%
PHYSICIAN ASSISTANT	-3%	-5%	1%	6%
OTOLARYNGOLOGY	-9%	-10%	-3%	7%
COLON AND RECTAL SURGERY	-4%	-9%	-1%	8%

Orthopedic surgery merits particular attention given the scale and structure of its projected reduction. CMS estimates an aggregate 7% decline in orthopedic RVUs, split unevenly by site of service. This is largely attributed to proposed wRVU reductions to major joint replacement codes, most notably CPT 23470 and 23472 (shoulder arthroplasty), 27130 (total hip arthroplasty), and 27447 (total knee arthroplasty). CMS attributes these reductions to a "site-of-service anomaly." Medicare utilization data from 2021 through 2023 indicates these procedures are furnished in the inpatient setting less than half the time, even though their 90-day global valuations continue to assume inpatient stays and inpatient follow-up visits. As a result, CMS proposes revaluing these codes based on other 90-day global services that it believes better reflect their revised time and intensity. The proposed wRVUs reflect a decrease of 17% to 21% from current values for these codes, which heavily impacts the overall decrease in expected RVU for orthopedic surgery.

The facility/non-facility split compounds the concern for hospital-employed orthopedic groups. Notably, CMS projects a 20% decrease in reimbursement for total hip and knee arthroplasties performed in a facility setting. Also, as discussed later, CMS is separately soliciting comment on whether the current 50% indirect PE allocation for facility-based services should be reduced even more. That has the potential to widen the facility/non-facility gap even further for these orthopedic services.

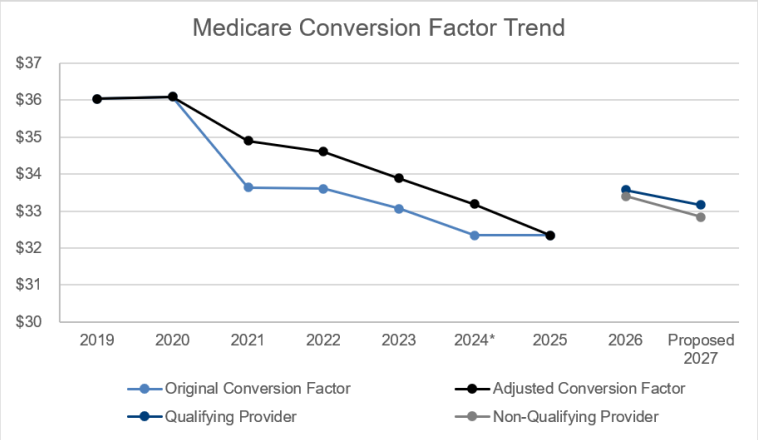
Medicare Conversion Factor

In accordance with current law, the proposed rule contains separate conversion factors for qualifying Advanced Alternative Payment Model (APM) participants (QPs) and another for those not meeting the APM requirements, a concept first implemented in 2026. To be a QP, a practitioner must participate in an Advanced APM and meet required payment or patient count thresholds. Advanced APMs must use certified electronic health record (EHR) technology, provide payment based on certain quality measures, and bear appropriate financial risk. The proposed qualifying APM conversion factor reflects a decline of approximately 1.2% from the 2026 rate, while the non-qualifying APM conversion factor would decline by 1.7%. The primary reason for the reduction is that the 2027 calculations remove the one-year 2.5% increase applicable in 2026 resulting from the One Big Beautiful Bill legislation. A similar dynamic applies to the anesthesia conversion factor, with a .9% proposed decrease to $20.42 for the Qualifying APM conversion factor and a 1.4% decrease to $20.21 for non-qualifying APMs.

	Anesthesia Qualifying APM Conversion Factor		Anesthesia Non-Qualifying APM Conversion Factor	
CY 2026 National Average Anesthesia Conversion Factor		$ 20.32		$ 20.32
CY 2026 Qualifying APM Update Factor	0.75%	20.4702	0.25%	20.3686
CY 2026 RVU Budget Neutrality Adjustment	0.49%	20.5705	0.49%	20.4684
CY 2026 2.5% Increase	2.50%	21.0847	2.50%	20.9801
CY 2026 Anesthesia Fee Schedule PE and Malpractice Adjustment	-2.30%	20.5998	-2.30%	20.4976
CY 2026 Conversion Factor		**$ 20.60**		**$ 20.50**
CY 2026 Conversion Factor without One-Year 2.5% Increase		20.0974		19.9976
CY 2027 Qualifying APM Update Factor	0.75%	20.2481	0.25%	20.0476
CY 2027 RVU Budget Neutrality Adjustment	0.53%	20.3554	0.53%	20.1539
CY 2027 Anesthesia Fee Schedule PE and Malpractice Adjustment	0.30%	20.4165	0.30%	20.2143
Proposed CY 2027 Conversion Factor		**$ 20.42**		**$ 20.21**

Derived from Tables D-B5 and D-B6 of the CY 2026 Medicare Physician Fee Schedule final rule and Tables D-B3 and D-B4 of the CY 2027 Medicare Physician Fee Schedule Proposed Rule.

For providers, the impact is much bigger than the single year decline. The proposed conversion factors for 2027 continue years of reimbursement failing to keep pace with inflation. Significant volatility in the conversion factor began in 2021 in response to substantial increases in wRVUs for many office visits and other services that were determined to be undervalued historically. Ever since, physicians have battled statutory restrictions limiting reimbursement increases, which have often (but not always) been mitigated by legislative action. Even with legislative intervention the conversion factor has consistently remained below the 2020 level. The higher QP rate for 2027 is still around 8% lower than the 2020 conversion factor. Sequestration reductions further exacerbate the problem. Meanwhile, inflation has significantly increased the cost of operating a medical practice.



E/M Payment Changes

The proposed rule includes several modifications that would impact reimbursement for certain evaluation and management (E/M) services.

Replacement of G2211

CMS proposes to replace HCPCS code G2211 with a modifier (placeholder MOD1) applied to the underlying office/outpatient or home/residence E/M code. Rather than a flat add-on payment, MOD1 would increase total RVUs for the base E/M service by 16%. CMS believes a percentage-based approach better reflects variation among E/M visit levels, and that using a modifier reduces the claims processing burden by eliminating a separate claim line.

A second proposed modifier (placeholder MOD2) would be used for qualifying E/M services furnished in connection with certain ACO participation, valued at 32% of the total RVUs for the base E/M service. The proposal is intended to recognize additional resource costs associated with accountable care and would increase payment for practitioners with a larger proportion of eligible services furnished in ACO arrangements. This modifier would only be available to ACO participants, ACO professionals, and ACO providers/suppliers, as well as LEAD Participant Providers, and only when the applicable visit complexity is met.

Modifier -25 Payment Reduction

CMS proposes to reduce payment when a separately identifiable office/outpatient E/M visit is furnished by the same physician – or a physician in the same group practice – on the same day as a 0-, 10-, or 90-day global procedure. CMS argues that the current methodology may duplicate the PE resources already included in the global procedure. Instead, CMS proposes reimbursing the most expensive service at 100% and all other visits or procedures provided the same day at 50%. However, CMS seeks comments on this proposal, including whether a different adjustment, “such as 25%,” would be more appropriate.

This proposal revives an issue considered but not finalized in 2019. One of the primary reasons the proposal was not ultimately adopted at that time was a concern that physicians would start splitting services across separate days to maximize reimbursement. CMS notes in the proposed rule that “we have a number of data analysis tools to monitor for potentially problematic utilization patterns” to mitigate any scheduling practices that might create “undue burden and potential medical risk for beneficiaries.”

This proposal is a major driver of the projected decreases in total RVUs for dermatology, otolaryngology, podiatry, hand surgery, and colon and rectal surgery because these specialties frequently report separately identifiable E/M services on the same day as procedures with global periods. Accordingly, practices with a high volume of visits that frequently involve same-day procedures should perform modeling to determine

potential financial impacts of this provision.

Remote Monitoring

CMS proposes significant changes affecting remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM). Most notably, CMS would permit clinical-staff time to support Medicare billing *only when the staff member is a direct employee of the billing practitioner or the practitioner's practice*. If finalized, beginning January 1, 2027, practitioners generally could not count services furnished by contracted third-party clinical staff toward RPM or RTM billing. Clinical staff would not have to be physically located in the practice but would have to operate under the billing practitioner's general supervision and satisfy the applicable "incident to" requirements. CMS contends that some outsourced arrangements may fragment care, provide insufficient practitioner oversight, and lack the clinical integration necessary to ensure that all required RPM or RTM service components are furnished. The agency specifically expresses concern about services furnished through entities with only a loose association with the treating practitioner. The proposal appears directed at outsourced clinical staffing rather than the acquisition of monitoring technology, software, or devices from third-party vendors.

The operational implications could be significant for organizations that rely on vendor-provided clinical personnel, which is common because building an in-house clinical monitoring team is expensive and operationally challenging. Practices should identify which service elements are performed by contractors, determine whether the services could be transitioned to employed staff or furnished personally by qualified practitioners, and model the Medicare revenue potentially affected. Organizations unable to restructure their staffing arrangements before the effective date could be required to scale back, suspend, or redesign affected programs. The timing of CMS's proposal is challenging, as the final rule is typically not issued until early November, leaving only about 60 days before compliance is required on January 1, 2027. This introduces a timeline that may be unachievable and may leave some practices with no other option than discontinuing their RPM/RTM programs entirely, at least temporarily.

CMS is also soliciting comment on potentially replacing seventeen existing RPM and RTM codes with four bundled HCPCS G-codes—GRPM1, GRPM2, GRTM1, and GRTM2. Under the contemplated structure, the relevant service elements would be bundled and required to be provided each month the codes are billed. CMS cites a report from the Office of Inspector General (OIG) finding that 43% of RPM enrollees did not receive at least one of the three principal components: education and setup, device supply, or treatment management. Although CMS has not presented the four-code structure as a definitive proposal, it could still finalize the new codes after considering public comments. This could result in a much different reimbursement structure even if organizations are able to overcome the in-house staffing hurdle.

In addition to considering revenue implications, organizations must also consider compensation repercussions. Providers who are credited with RPM and RTM revenue in their compensation model need to understand how their compensation may be impacted if those services are discontinued because of outsourced staffing restrictions. Additionally, any vendor staffing agreements or medical director agreements tied to a monitoring program need a sunset clause built in now rather than waiting for issuance of the final rule. Such agreements should be reviewed to ensure the terms remain consistent with fair market value in light of the new requirements.

Quality Payment Program and Alternative Payment Models

The proposed rule includes updates to the Merit-based Incentive Payment System (MIPS) and Advanced APMs, continuing CMS's gradual transition toward value-based reimbursement. A particularly relevant proposal would apply QP and Partial QP status at the TIN/NPI combination level rather than to the clinician across all billing relationships. A clinician could therefore be a QP under one tax identification number and subject to MIPS under another. This has implications for multi-TIN physicians, physician employment arrangements, and the application of the higher qualifying APM conversion factor.

CMS proposes to phase out MIPS reporting beginning with the CY 2029 performance period (2031 payment year) as it fully transitions to the MIPS Value Pathway (MVP) strategy.

Medicare Shared Savings Program

CMS proposes additional refinements to the Medicare Shared Savings Program (MSSP) intended to strengthen accountable care participation, reduce administrative burden, and improve long-term program sustainability. The proposed changes would strengthen financial incentives for Accountable Care Organizations (ACOs) to participate in the program while mitigating selection issues and benchmark rebasing concerns. Revisions to quality performance standards and reporting requirements would encourage use of digital quality measures. Specific proposals related to the MSSP are beyond the scope of this article. However, providers currently participating in ACOs, or considering future participation, should evaluate how these proposed changes may affect financial benchmarks, quality reporting, and care management strategies.

Other Notable Provisions

Beginning in 2027, maternity global codes are scheduled to be unbundled, with a set of new and revised CPT codes to be used for billing each episode of antepartum, labor and delivery, and postpartum care. In the proposed rule, CMS expressed concern that this transition from the longstanding practice of global billing for maternity care will be disruptive. Accordingly, CMS is seeking comments on whether HCPCS G-codes should be created to allow providers to maintain current coding and payment for maternity services instead of adopting the new CPT codes.

The 2026 Medicare PFS Final Rule adopted a mandatory alternate payment model focused on care provided by specialists involved in treating heart failure and lower back pain. The Ambulatory Specialty Model (ASM) will begin in 2027 and run for five years. The CY 2027 proposed rule does not alter the mandatory nature of the ASM. Instead, CMS proposes a series of technical and operational refinements intended to improve implementation before the model begins on January 1, 2027. The proposed rule makes no changes to the specialty types included in each ASM cohort.

The proposed rule also introduces a new shared medical appointment (SMA) code (HCPCS GSMAS) intended to support group-based clinical encounters involving education, peer support, and management of chronic disease. CMS is proposing to establish SMAs as 60-minute sessions with up to 10 beneficiaries per session who must consent to SMA participation. SMA session would be billed and led by a physician or a qualified nonphysician practitioner but may include other clinicians as well. The code would be billed once per patient, per session.

Additionally, CMS proposes two new HCPCS codes that can be used for advance care planning (ACP) services provided by clinical staff under the direct supervision of a billing physician. The existing CPT codes for ACP services (99497 and 99498) would continue to be used for services personally provided by the billing practitioner. CMS seeks further feedback relating to community-based palliative care services and care management services.

Long-Term Initiatives

CMS continues to emphasize strengthening primary care through both payment policy and future program development. In addition to proposing payment refinements for certain primary care services, CMS issued a broad Request for Information (RFI) seeking stakeholder input on the future direction of primary care payment. While the RFI does not change reimbursement for 2027, it provides insight into the agency's long-term priorities. CMS is concerned that primary care services may be undervalued, and is seeking feedback on various topics, including whether primary care providers' would be open to capitated payment arrangements. Organizations with significant primary care operations should view this as an opportunity to help shape future Medicare payment policy.

The proposed rule also includes an RFI relating to the CPT coding system, which is owned and copyrighted by the AMA. The rule notes that there has been "longstanding concern expressed over the Federal reliance on a private organization with such an obvious conflict of interest as providing information on the time and

resource requirements to conduct physician services when this information may influence their own payment." Questions include whether generation of CPT codes consider medical necessity, and what alternatives exist or could be developed to maintain a more objective process. In the RFI, CMS insinuates that paying for physician procedural services based on the underlying International Classification of Diseases, 10th Revision (ICD-10) procedure codes may be under consideration. Any changes that shift away from the longstanding CPT coding system could have massive implications in future rulemaking.

Provider Compensation Considerations

For many organizations, the proposed rule highlights a growing disconnect between reimbursement and physician productivity. Most physician compensation plans continue to rely primarily on wRVUs, while many of the proposed payment redistributions are driven by PE RVUs. Consequently, reimbursement may increase or decrease – sometimes substantially – without a corresponding change in physician productivity. This divergence could create financial pressure, particularly where compensation formulas have not been updated to incorporate recent Medicare payment reforms. Accordingly, physician practices – whether independent or hospital-owned – may experience reduced margins or increased subsidy requirements.

It will be critical for physician groups to reassess physician compensation models to ensure they produce results that remain commercially reasonable and reflective of fair market value. Changes may be required to ensure compensation arrangements are financially sustainable and aligned with organizational objectives. Organizations should identify their highest-volume services, estimate reimbursement sensitivity under the proposed methodology, and evaluate whether existing compensation arrangements continue to appropriately balance physician productivity with organizational financial performance. This analysis is particularly important for organizations employing multiple specialties that may experience materially different payment impacts under the proposed rule. Even physicians with a limited Medicare patient base could be exposed, given that commercial reimbursement rates often link to Medicare.

Industry and Legislative Response

As expected, the proposed rule drew criticism from medical practice advocacy groups, particularly regarding the conversion factor decrease. Most continue to advocate for a legislative solution that would address the instability that results from the current payment structure.

The day after CMS issued the proposed rule, three physicians in Congress introduced bipartisan legislation that would address many long-standing concerns surrounding the physician payment methodology. The Patients First Act of 2026 would link annual physician payment updates to the Medicare Economic Index (MEI) minus 1 percentage point. It would also soften budget neutrality restrictions, which currently restrict CMS from increasing spending by more than $20 million annually. The proposed legislation would increase that threshold to $54.3 million, which would be indexed annually with inflation. Other significant provisions include a pilot program to reimburse primary care physicians on a capitated basis, revisions to streamline quality reporting, and modifications to encourage greater participation in advanced APMs.

What's Next for Physician Organizations?

The significance of the proposed rule is not limited to any single provision. CMS is signaling a payment environment that may be more variable, more site-sensitive, and less directly tied to traditional measures of physician productivity than it historically has been. For healthcare leaders, the practical question is how these policy changes could translate into reimbursement, margin, compensation, and strategic planning challenges for their own organizations. That assessment should begin before the rule is finalized, particularly since comments on the proposed rule are due to CMS by September 14, 2026. Key questions leaders should be asking in light of the proposed rule include:

- Which physician specialties within our organization appear most affected by the proposed payment changes?
- How dependent are our physician enterprises on Medicare reimbursement for affected services?

- Will the proposed reimbursement changes materially alter physician practice profitability?
- To what extent are our significant commercial payer contracts linked to Medicare reimbursement rates, and what impact would that have on overall practice revenue?
- Do our current physician compensation models remain appropriately aligned with reimbursement?
- Should we perform specialty or CPT-level financial modeling to assess potential impacts before the final rule is issued?
- Are there strategic opportunities or risks associated with the continued movement toward value-based and longitudinal care?

How JTaylor Can Help

The proposed rule presents both financial and strategic considerations for physician organizations. JTaylor's healthcare consulting professionals are available to assist hospitals and physician groups with reimbursement modeling, physician compensation design and review, provider compensation valuation, service line financial analysis, and strategic planning. Evaluating the potential impacts of the proposed rule before it is finalized can help organizations better understand possible financial impacts, prepare for implementation, and make informed operational and compensation decisions.

Sources:

- Proposed Rule - *Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program.* [CMS-1848-P]. 91 FR 43842. (16 July 2026).
- Fact Sheet – Center for Medicare and Medicaid Services (CMS). *Calendar Year (CY) 2027 Medicare Physician Fee Schedule Proposed Rule.* (14 July 2026).
- Fact Sheet: 2027 MPFS Proposed Rule – MSSP Changes– CMS. *Calendar Year (CY) 2027 Medicare Physician Fee Schedule Proposed Rule (CMS-1848-P) — Medicare Shared Savings Program Proposals.* (14 July 2026).