hfma healthcare financial management association

EXECUTIVE IMPACT BRIEF

CY 2027 PFS Proposed Rule

What It Means for Your Organization

CMS PROPOSES STRUCTURAL CHANGES TO PHYSICIAN PAYMENT, SPECIALTY RELATIVITY, ACCOUNTABLE CARE INCENTIVES AND REMOTE MONITORING - WITH MATERIAL IMPACTS FOR PHYSICIAN ENTERPRISE FINANCE.

DO NOT MODEL THE CONVERSION FACTOR ALONE.

The headline rate decline is only part of the story. Practice-expense methodology, same-day E/M reductions, specialty mix and new ACO incentives could materially reshape physician-enterprise revenue.

AT A GLANCE

WHAT HAPPENED?

CMS issued the CY 2027 Physician Fee Schedule proposed rule with major changes to payment methodology, physician service valuation, accountable care and operational requirements.

WHO IS MOST AFFECTED?

Hospital and health system physician enterprises, medical groups, ACOs, procedural specialties, organizations using remote monitoring vendors, and specialists subject to the Ambulatory Specialty Model.

WHY DOES IT MATTER?

The rule can redistribute Medicare professional revenue across specialties and service lines - even when aggregate PFS payment appears relatively stable.

WHEN?

Most proposed PFS changes would take effect January 1, 2027. The mandatory Ambulatory Specialty Model also begins January 1, 2027.

COMMENT DEADLINE

September 14, 2026

PROPOSED BY

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services

THE FINANCIAL IMPACT

-1.19% **QP / Advanced APM CF $33.1693**	**CONVERSION FACTORS MOVE DOWN** Qualifying APM and non-qualifying APM conversion factors are proposed below 2026 levels; non-QP clinicians face a larger decline (-1.68%, CF $32.8409).
±5% **Annual PE RVU stabilizer**	**PRACTICE EXPENSE IS BEING RE-ENGINEERED** CMS would phase out the IPCI over two years, change indirect PE allocation and cap annual PE RVU changes at 5% for most existing codes. This can redistribute payment well beyond 2027.
50% **Payment on other same-day services**	**SAME-DAY E/M + GLOBAL PROCEDURES** When a separately identifiable O/O E/M visit and a 0-, 10- or 90-day global procedure occur the same day, the most expensive service would be paid at 100% and the other service(s) at 50%.
60% **BASIC Track Level E maximum sharing rate**	**MSSP FINANCIAL UPSIDE INCREASES** For new agreement periods beginning in 2027, CMS would raise BASIC Level E shared savings from 50% to 60% and refine benchmark policies, including ACPT and growth adjustments.
±9% **ASM payment adjustment (first payment years)**	**MANDATORY SPECIALTY RISK EXPANDS** ASM begins in 2027 for selected cardiology and low-back-pain specialists in mandatory geographies; performance can drive Part B adjustments beginning two years later, eventually reaching ±12%.

SPECIALTY IMPACTS WILL VARY SHARPLY

Proposed RVU changes (before the conversion-factor effect) include decreases of 9% for dermatology and otolaryngology and 7% for orthopedic surgery, while clinical social work (+12%) and psychology (+11%) rise.

WHAT EXECUTIVES SHOULD DO NOW

MODEL THE NET IMPACT

Run physician-enterprise scenarios by specialty, site of service, modifier -25 utilization, PE RVU shifts and QP status - not just the headline CF.

IDENTIFY CONCENTRATED EXPOSURE

Quantify risk in dermatology, ENT, orthopedics and other procedure-heavy specialties; separately identify services likely to trigger the same-day E/M reduction.

REASSESS ACCOUNTABLE CARE ECONOMICS

Model the value of higher BASIC Level E sharing, benchmark changes and enhanced longitudinal-care payment (MOD2) for ACO-aligned clinicians.

REVIEW OPERATING MODELS

Map RPM/RTM vendor arrangements, employed-staff requirements, initiating-visit workflows, coding rules and ASM readiness across finance, compliance, IT and operations.

QUESTIONS EXECUTIVES SHOULD BE ASKING

1. What is our net PFS impact after CF, RVU, PE and specialty-mix changes?
2. Which service lines have the greatest exposure to modifier -25 payment reductions?
3. Does the revised MSSP business case justify expanding or accelerating ACO participation?
4. Are remote monitoring arrangements compliant if third-party clinical staff can no longer furnish billable services?
5. Which clinicians are in ASM geographies, and what is the 2029 revenue-at-risk range?

TIMELINE

JULY 16, 2026
Proposed rule published

SEPT. 14, 2026
Comment period closes

JAN. 1, 2027
Most changes + ASM begin

JAN. 1, 2028
IPCI fully removed

2029
First ASM payment adjustments

Source: CMS-1848-P; Health Policy Alternatives summaries. Proposed policies are not final. | For more information: hfma.org/regulatory