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Policy Brief

# CY 2027 Medicare Payment Rules: Physician Fee Schedule, OPPS/ASC, Home Health, and ESRD Proposed Rules

The Centers for Medicare & Medicaid Services (CMS) released its annual Medicare payment rules for calendar year (CY) 2027, covering physician services, hospital outpatient and ambulatory surgical center care, home health, and end-stage renal disease (ESRD) dialysis facilities.[1] These rules are issued together each summer and set Medicare payment rates and quality reporting requirements across much of the outpatient and post-acute care system for the coming year.

The comment deadlines fall within a compressed and staggered window:

- ESRD PPS proposed rule (CMS-1846-P) closes August 24th
- OPPS/ASC proposed rule (CMS-1850-P) and the Home Health PPS proposed rule (CMS-1844-P) both close August 31st
- Physician Fee Schedule proposed rule (CMS-1848-P) closes September 14th.

Civitas intends to comment on the provisions most relevant to members and is seeking input to inform that response.

**Why This Rule Cycle Matters to Civitas Members**
Taken together, these rules further embed interoperability and quality measurement expectations into CMS' Medicare payment programs. The Shared Savings Program would gain a health information exchange compliance pathway for accountable care organizations, CMS is asking directly why laboratory and imaging results still fail to follow patients across care settings, and new quality measure development around Advance Care Planning is underway. .

## What CMS Is Proposing

Several themes are crosscutting in this rule cycle, appearing in different programs and at different stages of development: (1) Advance Care Planning (ACP) is moving forward in payment and measurement at the same time, (2) quality measurement continues shifting toward digital, aggregated data, and (3) more measures are being retired than added, largely on burden-reduction grounds.

The Physician Fee Schedule (PFS) creates billing codes distinguishing practitioner ACP time from clinical staff time, while OPPS and Home Health each ask whether ACP should become a quality measure in their settings. A new Medicare eCQM collection type for ACOs and

[1] CMS also issued final rules for the FY 2027 Inpatient Rehabilitation Facility PPS (CMS-1845-F) and the FY 2027 Hospice Wage Index and Payment Rate Update (CMS-1851-F). Both are final, with no comment period open, and relevant impacts will be provided in future member communications.

restructured certified health IT attestation options in the Shared Savings Program both point toward measurement built on interoperable data rather than manual abstraction. The eCQM proposal states plainly that all-payer, all-patient aggregation is a barrier for ACOs seeking to report digitally. And numerous quality measures are proposed for removal, in several cases on the rationale that reporting burden has come to exceed the measure's continued value. Members with direct experience in quality measure development and validation are encouraged to share their perspective with Civitas.

The table below summarizes the provisions in each rule most likely to intersect with member work. Payment rate updates, wage index changes, and provider enrollment provisions are not included except where they carry broader significance.

**Payment Rule Provisions**

| Rule | Payment and Program Provisions | Quality Reporting and Measurement |
|---|---|---|
| **Physician Fee Schedule (CMS-1848-P)** | Conversion factor update of roughly 1.2-1.7% depending on advanced APM participation. Shared Savings Program reforms including a higher shared savings rate for BASIC track Level E, a growth adjustment rewarding ACOs that bring in participants new to value-based care, and an option to reduce or eliminate Part B cost-sharing. New billing codes separating practitioner and clinical staff time for Advance Care Planning. | Restructured certified health IT requirement for ACOs, replacing blanket MIPS Promoting Interoperability reporting with three attestation options, one of which is an explicit ACO Health Information Exchange metric requiring bi-directional exchange with an HIE using certified technology. New Medicare eCQM collection type for ACOs scored against flat benchmarks, intended for ACOs unable to readily aggregate all-payer, all-patient data. |
| **OPPS / ASC (CMS-1850-P)** | Payment update of 2.4%. Continued multi-year phase-out of the inpatient-only list. Reduced 340B drug payments based on a new acquisition cost survey. | Hospital Star Rating methodology revised to weight the Safety of Care measure group more heavily. Colonoscopy follow-up documentation measure removed from both the Hospital Outpatient Quality Reporting and ASC Quality Reporting programs in favor of a measure tied more directly to patient outcomes. |
| **ESRD PPS (CMS-1846-P)** | Updated base payment rate. Phosphate binders incorporated into the payment bundle. Wage index updates and a restructured low-volume facility payment adjustment. | Substantial reshaping of the ESRD Quality Incentive Program beginning in payment year 2029: retirement of the Medication Reconciliation and COVID-19 healthcare personnel vaccination reporting measures, replacement of the Hypercalcemia |

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| | | measure with a new Hyperphosphatemia clinical measure, updated baseline data and revised risk adjustment for the bloodstream infection measure, and elimination of the Reporting Measure Domain with its weight redistributed across the Clinical Care and Care Coordination domains. |
| **Home Health PPS (CMS-1844-P)** | Payment update of 2.1%. PDGM case-mix recalibration. Provider enrollment and program integrity changes including expanded grounds for revocation. Expanded coverage for durable medical equipment and infusion pumps. | Revised data submission deadlines and a shift to calendar-year reporting timeframes for the Home Health Quality Reporting Program. |

**Requests for Information**

Also included in the proposed rules are several requests for information on areas directly relevant to the Civitas community.

| Request for Information | Rule | What CMS Is Asking | Where Member Experience Applies |
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| **Duplicate laboratory testing, imaging, and result sharing** | PFS | Why diagnostic results generated in one system so often remain inaccessible to a patient's other treating providers, citing duplicate testing, delayed care, avoidable program cost, and unnecessary radiation exposure; and what role standards-based exchange should play in closing that gap. | Results delivery at community and state scale, identity matching, cross-organization query, and the specific points at which source systems decline to release results. Members can describe both what connected infrastructure delivers today and what remains unsolved. |
| **Hospital price transparency data standardization** | OPPS | How to standardize reporting of complex payment contract terms including outlier payments, stop-loss provisions, and rate tiering; how to improve comparability across machine-readable files; how to strengthen the consumer-friendly display | Working with machine-readable files and pricing data in practice, and what standardization would make that data analytically useful rather than merely posted. APCD members have direct experience with what makes |

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| | | requirement; and whether the deemed-compliance policy for internet-based price estimator tools should change. | payer and provider price data usable for analysis. |
| **Advance Care Planning measurement** | OPPS and Home Health | Whether and how Advance Care Planning should become a quality measure, asked separately for hospital outpatient departments and for home health agencies. Neither rule proposes measure specifications; both are exploratory. | How ACP conversations are documented and captured today, and how a measure could be defined so that it remains consistent across care settings rather than diverging by program. |
| **Dialysis facility discussion of patient life goals (D-PaLS)** | ESRD | Whether to develop a patient-reported outcome measure assessing whether dialysis facilities conduct structured conversations with patients about their life goals, ahead of any formal proposal in future rulemaking. | Patient-reported outcome measure development and the data capture such a measure would require. Early-stage RFIs of this kind are where quality measurement expertise has the most influence, before specifications are set. |

## Strategic Implications

This Medicare fee schedule cycle engages a broad range of member expertise . Alongside the interoperability provisions Civitas comments on regularly, it contains substantial quality measure activity across the Quality Incentive Program, the hospital outpatient and ASC programs, and the home health program. Following are strategic implications for where member input will matter most:

- Federal policy is beginning to name HIE participation rather than assume it. The ACO Health Information Exchange attestation option describes an organizational relationship with an exchange rather than a technology requirement satisfied through a certified product, which is closer to how members actually operate. Comment letters that document what member networks already deliver would give CMS concrete evidence for extending this approach to other programs.
- Advance Care Planning measurement may depend on documentation that does not currently move between care settings. Advance directives and goals-of-care documentation are among the least portable records in the system, often held in a single organization's chart and unavailable when a patient presents elsewhere. CMS is developing ACP measures in two settings, and whether those measures assume the underlying documentation is accessible across settings will shape what they can meaningfully capture. Members working with advance directive registries, care coordination platforms, or goals-of-care data are encouraged to share what they see,

both to inform Civitas's response and to indicate whether this is an area where the membership has a distinct perspective.
- Reporting burden is often a data infrastructure problem rather than an inherent cost of a measure. Civitas has made this argument in prior comments, including on the FY2026 IPPS rule, where CMS proposed removing the social drivers of health measures on burden grounds. Whether that reasoning applies to the measures proposed for retirement in this cycle depends on the specifics of each measure, and member input would inform Civitas's position.

## Next Steps, Member Experience Needed

Civitas will prepare comments on the Physician Fee Schedule and OPPS/ASC rules and RFIs, where the provisions are most directly relevant to members. Member experience and input are welcome on any aspect of these rules, and particularly on the following:

- **Results delivery and duplicate testing (PFS):** where do laboratory and imaging results fail to reach treating providers in your service area, and what has your organization built to address it? What remains unsolved, and what would federal policy need to do to help?
- **ACO health information exchange attestation (PFS):** if you work with ACOs, how would this attestation option change those relationships, and is the metric as described something your participants could meet today?
- **Price transparency data (OPPS):** what have you encountered in working with hospital machine-readable files or price transparency data, and what standardization would make that data analytically useful?
- **Advance Care Planning measurement (OPPS and Home Health):** how should ACP be defined and captured so that it is consistent across care settings, and what documentation practices do you see today?
- **ESRD Quality Incentive Program (ESRD):** do the proposed measure retirements reflect performance saturation or a reporting burden that better data infrastructure could reduce? What effects would the revised risk adjustment and domain reweighting have on how facilities are scored?

Please send feedback or questions to Karen Ostrowski.