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REGULATORY ANALYSIS · CMS-1848-P · COMMENTS DUE SEPTEMBER 14, 2026

The CY 2027 Physician Fee Schedule: What It Means for Women's Health

Full 716-page analysis read through six lenses: OB-GYN & maternal health · menopause & midlife · fertility · autoimmune, Alzheimer's & conditions that disproportionately affect women · women's health business & workforce · payment policy · Prepared by 51& · July 2026

THE HEADLINE

On July 16, CMS published its proposed rule for how Medicare will pay physicians in 2027, 716 pages that restructure maternity care coding, invite open input on the future of the CPT coding and valuation system, redesign primary care payment, and rebuild the machinery that decides what every procedure is worth. **The comment window closes September 14, 2026** (docket CMS-2026-2377). Two findings frame everything below:

1. Maternity care is being actively modernized, and the rest of women's health has an open door. The rule takes on maternity coding directly, in partnership with the field's own clinical societies. Much of the rest of women's health is not yet in its pages: "menopause," "hormone," "osteoporosis," "contraception," "postpartum," "perinatal," and "migraine" appear zero times; "midwife" once. That is not a verdict on the rule, proposed rules are built from the input agencies receive, and women's health has never organized to supply it at scale. This comment period is the field's chance to complete the record, and this cycle CMS is explicitly asking for exactly this kind of input.

2. CMS is inviting exactly the input women's health has been waiting to give. The rule contains an open request for information on the CPT coding and valuation system, a solicitation for empirical evidence of mis-valued codes, a formal pathway to nominate under-valued codes, and RFIs on primary care redesign, specialty attribution, and quality data infrastructure. Every one of these is a door the women's health field can walk through, if it files by September 14.

MATERNITY CARE: THE BIGGEST RESTRUCTURE IN DECADES, WITH AN OPEN QUESTION

The maternity global codes are being unbundled. At the January 2026 RUC meeting, 17 legacy codes were deleted, 12 created, 9 revised, dissolving the decades-old global OB package (the bundled 59400/59510/59610/59618 structure) into individual codes, following ACOG's May 2025 guidelines that replaced the fixed 12-visit prenatal model with tailored schedules (8 visits average-risk, 13 higher-risk).

The good news: CMS proposes to pay MORE than the RUC recommended. CMS concluded the RUC's budget-neutrality math "undervalues the work RVUs" and is reallocating 11,810 work RVUs to the new labor-and-delivery codes, **a 15 percent increase over the RUC recommendation** for each labor and delivery code. CMS explicitly overrode the RUC in the direction of paying maternity care more. This is the clearest evidence in years that CMS will correct women's health under-valuation when the assumption error is documented.

The open question: CMS is asking, in good faith, whether the transition would be too disruptive. A formal comment solicitation asks whether CMS should instead create 15 HCPCS G-codes maintaining the current global-bundle structure for Medicare payment, to reduce transition disruption. It's a legitimate implementation question, and if the G-code path were finalized, the modernization would not apply for Medicare purposes. ACOG has publicly urged adopting the new codes without the G-code alternative. **Whether maternity care coding moves forward or holds is being decided by whoever files comments by September 14.**

The gap nobody noticed: the section is silent on who can bill the new codes. Certified nurse-midwives, who receive 100% of the fee schedule, are not mentioned. Neither is any other maternal health workforce category. The 2027 unbundling is the moment to fix billing pathways for the broader maternity workforce, and the rule doesn't address it.

LACTATION CARE: MEDICARE BUILDS ITS FIRST LACTATION PAYMENT INFRASTRUCTURE

Two new CPT codes (978XX first 30 minutes, 978X1 each additional 15) pay for lactation care directed by a physician or QHP, and with them, CMS creates the first "Lactation Consultant" clinical staff type (L076A) in the Medicare payment system. CMS proposes valuing that staff type at the RN rate and **explicitly asks whether that's the right crosswalk and whether lactation consultants are typically credentialed RNs**, a direct invitation for the lactation field to define itself in federal payment policy. Limitation to flag: this is an incident-to structure. The lactation consultant is clinical staff under a billing physician/QHP, not an independent billing provider. The independent-billing pathway remains unbuilt.

THE VALUATION MACHINERY: FOUR CHANGES THAT DECIDE WHAT WOMEN'S HEALTH IS WORTH

The efficiency adjustment quietly cuts GYN surgery every three years. A 2.5% cut to work RVUs and intraservice time applies to all non-time-based services (i.e., procedures, including all GYN surgery) on a recurring 3-year cycle. Exempt: time-based codes, telehealth services, new codes. CMS presents no specialty-level evidence of actual efficiency gains, it's an economy-wide productivity number applied uniformly. For procedures whose baseline values are already documented as too low, an across-the-board deflator widens the gap arithmetically every cycle.

CMS says empirical data beats RUC surveys, and put two breast surgery codes on the cut list. Responding to an outside nomination using claims-database time analysis, CMS states the empirical data "may be a better input than limited survey data" and seeks comment on revaluing 13 codes, including 19318 (breast reduction) and 19380 (breast reconstruction revision), possibly as soon as the CY 2027 final rule. The same RAND data CMS credits also found dozens of codes with times "likely too short", under-valuation the nominator didn't pursue. The empirical-data door swings both ways, and women's health should walk through it in the other direction.

The "Harvard-valued codes" precedent is the opening for the 55+ under-valued GYN codes. CMS proposed seven codes as potentially misvalued solely because they hadn't been reviewed in 20+ years, saying "we share their concerns." Many GYN surgical codes fit the identical fact pattern. The public nomination pathway (February 10 annually, with documented evidentiary standards CMS spells out) is the formal vehicle, and this rule's urethral bulking win (new $1,175 supply code for office incontinence treatment, granted through this exact process) proves the pathway produces results.

The practice expense changes disadvantage surgical women's health twice. The new indirect-cost allocation formula benefits office-based services but explicitly excludes 010/090-day global codes, most GYN surgery, with no stated rationale. Separately: the pelvic exam supply pack was cut 86% (from $20.16 to $2.81), a direct hit to every well-woman visit's practice expense. And a new modifier -25 policy pays same-day E/M + procedure combinations at 100%/50%, exactly the billing pattern of office gynecology (biopsy + E/M, IUD + E/M, colposcopy + E/M).

THE CPT RFI: CMS ASKS OPEN QUESTIONS ABOUT THE CODING SYSTEM

The rule contains a standalone request for information on the CPT coding and valuation system, citing MedPAC's longstanding recommendations and a 2025 NASEM report on alternative approaches to valuation. CMS asks five open questions: where the current coding process has created challenges for patient care; whether code creation follows identification of medical necessity; what alternatives or complements to the current standard could exist; how the valuation process could incorporate more objective data; and whether procedures could be grouped for payment differently. However this RFI resolves, it is the most direct invitation in years to put evidence about coding and valuation gaps on the federal record.

Why this RFI matters more than it looks: coding and valuation are where the system's under-investment in women's health actually happens. When a procedure is valued low, the consequences cascade: hospitals deprioritize it in operating room scheduling (lower revenue per OR hour), the clinicians who perform it earn less (compensation follows RVUs), training programs shrink, rural units close (293 rural hospitals, 24% of rural OB units, stopped delivering babies between 2011 and 2023), and patients wait longer for care. Valuation isn't accounting, it's the mechanism that decides whose care the system invests in. This RFI is the first open federal invitation in years to put that cascade on the record.

How to answer the five questions through a women's health lens, whatever seat you're in:

- **Question 1, where has the current coding process created challenges for patient care?** Answer with the cascade. The 20+ documented paired code disparities (women's-anatomy procedures valued below equivalent men's-anatomy procedures) and 55+ under-valued GYN surgery codes translate into: GYN cases pushed to the end of OR schedules, years-long waits for complex endometriosis excision, rural OB unit closures, and clinicians leaving women's health because the economics don't sustain a practice. Part of the challenge is structural representation: women's health holds a single OB/GYN voting seat in the valuation committee process, no dedicated seat for GYN surgical subspecialties (while other surgical disciplines have their own) and none for preventive and reproductive health. A constructive ask: broaden women's health representation in whatever valuation process the future holds. If you run a hospital service line, share your OR-allocation reality. If you're a clinician, share your wait lists. If you're a patient advocate, share what the delays cost.
- **Question 2, does code creation follow medical necessity?** Answer with the gaps. More than 50 women's health conditions and services remain effectively invisible to the coding system, endometriosis, perimenopause, menopause management, PCOS, infertility counseling, team-based women's health care. Menopause affects every woman who lives long enough, there has never been a dedicated code family for its management, so clinically complex midlife care gets billed as generic office visits that undervalue it. There is no distinct code for endometriosis excision reflecting its complexity levels, a specific, nameable fix. Lactation care is getting its first codes in 2027, decades after the evidence. And life-stage care coordination (navigation across puberty, fertility, pregnancy, perimenopause, menopause, patient navigators, health coaches, peer consultation) has no coding home despite successful state Medicaid precedents. Name the condition you know best and its coding gap.
- **Question 3, what alternatives or complements to the current standard should exist?** Answer with the representation requirement, not a teardown. Whatever coding standard the future holds, it must include women's health clinical expertise in its governance, a faster gap-filling mechanism for under-coded conditions (CMS's own G-code creation in this rule shows the fix works), and a pathway for services the market benchmarks even where Medicare doesn't cover them (fertility's ART codes are the case study).
- **Question 4, what objective approaches to valuation could work?** Answer with data and a standing audit. Support empirical inputs, registry time data, all-payer claims analysis, operative logs, applied in BOTH directions (the same datasets that flag over-valued codes flag under-valued ones). And propose a sex-disaggregated relativity audit as routine quality control: any valuation process should be able to detect when clinically equivalent procedures are valued differently by the sex of the patient, because that's exactly what happened for decades and no one was checking. This is also where the pay discrepancy lands: compensation follows RVUs, so systematically low valuations become systematically lower pay for the largely female workforce delivering women's health care.
- **Question 5, should procedures be grouped or bundled for payment differently?** Answer with a caution from history. Bundling is how women's health work got buried the first time, the maternity global bundle paid the same regardless of complexity for decades, and CMS itself is unbundling it in this very rule because it obscured the real work. Any future grouping system should require a sex-stratified impact analysis before adoption, so women's health work is never again made invisible inside someone else's bundle.

One-page individual comments answering even a single question are read and counted. The coalition's coordinated comment will address all five.

THE PRIMARY CARE REDESIGN RFI: WHERE MIDLIFE WOMEN'S HEALTH CAN CLAIM ITS PLACE

A sprawling RFI ("Redesigning Primary Care To Make America Healthy Again") asks how to revalue undervalued primary care: new E/M visit categories (longitudinal vs. acute vs. consultative), a simplified care-management code family, technology-enabled care tracks, AI in the Annual Wellness Visit, and prospective primary care payment. Three openings:

- **Longitudinal care categorization.** Menopause management is the archetype of longitudinal, counseling-heavy, between-visit-intensive care CMS says current E/M codes undervalue. CMS explicitly asks for "specific data on the resources used in furnishing longitudinal care", the field should supply menopause care data.

- **AWV redesign.** The Annual Wellness Visit has no menopause, bone-health, or sex-specific midlife risk component. CMS asks how to personalize it. Concrete ask: menopause status, fracture risk, and post-menopause CVD risk in the redesigned health risk assessment.
- **Group visits.** A new Shared Medical Appointments code (GSMAS, ~1.73 work RVUs, 2–10 patients, telehealth-eligible) is a near-perfect chassis for group menopause education and visits, proposed under the MAHA banner. Support it and name menopause as a target condition.

QUALITY AND DATA: THE PIPES ARE BEING LAID NOW, WOMEN'S HEALTH MUST BE IN THEM

The federal quality measurement system, the machinery that scores clinicians, sets bonus payments, and feeds the public star ratings patients see, is being rebuilt on three fronts at once. Traditional MIPS reporting sunsets in 2029, replaced entirely by MVPs (MIPS Value Pathways: curated bundles of quality measures by specialty that define what "good care" officially means in each field). FHIR-based digital quality measurement transitions 2028–2030, standardizing which data elements exist in the national quality data infrastructure. And star ratings move to a new methodology. Separately, an RFI on specialty care in ACOs asks how to attribute patients whose "principal longitudinal care provider" is a specialist, the exact situation of millions of women whose OB/GYN functions as their primary care physician (notably, cervical cancer screening, G0101, already counts as a primary care service for ACO attribution).

The "Focusing on Women's Health" MVP, open for comment by name. Among the 27 existing MVPs is one for women's health: the measure bundle for clinicians in gynecology, obstetrics, and urogynecology, explicitly including certified nurse-midwives, NPs, and PAs. Its proposed core measures are osteoporosis screening (women 65–85), breast cancer screening, and a surgical safety measure for prolapse repair, supported by obstetric measures (including a welcome new measure for CVD risk assessment in pregnant and postpartum patients) and preventive screenings. CMS proposes modifications to this MVP in this rule and **explicitly requests public comment on them**, meaning the federal definition of women's health quality is editable right now, by anyone who writes in. The highest-value additions to request: a menopause management measure (none exists in the federal inventory, commenters can ask CMS to prioritize its development); extending osteoporosis screening to postmenopausal women under 65 at increased risk, consistent with existing USPSTF guidance (a framing that also captures women with early menopause or premature ovarian insufficiency, who are postmenopausal regardless of age); a midlife CVD risk counterpart to the new pregnancy measure; elevating maternal mental health screening from an unscored activity to a scored measure; and preserving the MVP's inclusive clinician-applicability language. Bone health during the menopause transition itself, where bone loss accelerates before guidelines support routine screening, belongs in the Annual Wellness Visit redesign ask as fracture-risk assessment, the vehicle that can move ahead of screening guidelines. **Where to find it and how to comment:** the Women's Health MVP tables are in Appendix 3 of the rule, 91 FR 44509–44512 (full rule at federalregister.gov/d/2026-14327); comments are filed at regulations.gov/docket/CMS-2026-2377 by September 14.

Everything the Women's Health Data Collective exists to fix is being rebuilt right now. (The Data Collective is the coalition-led initiative, formed out of the Women's Health Reimbursement Summit, to make women's health visible and measurable across claims, clinical records, and quality data.) The cheapest moment to make women's health computable in federal data is while the FHIR pipes are being laid: ask for sex-specific, pregnancy-status, and menopause-status data elements in the USCDI+ Quality standard, and for women's health measures designated as MIPS core measures.

OPERATIONAL CHANGES EVERY WOMEN'S HEALTH PRACTICE SHOULD KNOW

- **Telehealth cliff:** geographic/originating-site/audio-only flexibilities extended only through December 31, 2027, the entire virtual women's health model lives on a statutory cliff again. New mandatory platform modifiers (BB/BC) flag telehealth furnished via contracted virtual platforms, direct operational impact on virtual menopause companies. Adjacent asks that fit here: coverage modifiers for asynchronous care delivered by credentialed medical groups, and coverage for at-home lab collection to reach preventive screening in care deserts.
- **Remote monitoring restrictions:** mandatory face-to-face initiating visit, established-patients-only for RTM, and a ban on outsourcing monitoring to third-party companies (effective 2027), a direct hit to postpartum hypertension RPM programs built on outsourced monitoring.
- **Conversion factor down ~1.2–1.7%** as the one-year statutory 2.5% boost expires.

- **New precedent for specialty payment models:** the mandatory Ambulatory Specialty Model launches 2027 for heart failure and low back pain, with CMS noting it "continue[s] to explore whether including additional conditions and specialists would be appropriate", the paper trail for a future women's health specialty model starts with comments filed now.
- **Smoking cessation counseling codes got +19% work RVU increases**, precedent for arguing analogous updates for other time-based counseling services (menopause counseling, contraceptive counseling).

WHAT TO DO, DEADLINES AND DOORS

1. **File comments by September 14, 2026** on docket CMS-2026-2377 (regulations.gov). Coordinated coalition comments land harder than fragmented individual ones. Priority sections: maternity G-code solicitation, CPT RFI, empiric time data, efficiency adjustment, primary care RFI, lactation staff type, specialty care RFI.
2. **Prepare a Potentially Misvalued Code nomination by February 10, 2027** for the documented under-valued GYN surgery codes, using CMS's own evidentiary checklist (peer-reviewed literature, anomalous code relationships, registry time data) and riding the Harvard-valued codes precedent from this rule.
3. **Get maternity workforce voices into the maternity coding comment** , the G-code reversion question will be decided by whoever shows up, and the billing-eligibility silence needs to be named.
4. **Put menopause on the record in every prevention-framed RFI** , the AWV redesign, the longitudinal care categories, the care management family, the Alzheimer's lifestyle intervention RFI (women are two-thirds of patients; the rule never mentions sex), and the MVP/quality measure cycle. The zero-mention finding is itself the comment.

WHERE TO FOCUS, BASED ON WHERE YOU WORK

The rule is 716 pages; your part of it isn't. Below, the sections that matter most by segment, through the lens of your business.

If you work in maternal health:

- **Maternity care coding restructure + the G-code question.** The decades-old global OB payment bundle (the single code covering prenatal visits through delivery) is being dissolved into individual codes, following ACOG's 2025 guidelines, and CMS proposes paying the new labor/delivery codes 15% MORE than initially recommended, after concluding the utilization assumptions under-valued the work. But in the same section, CMS asks whether it should instead create 15 G-codes that freeze the old bundle. In plain terms: the entire architecture of how maternity care gets paid, and, downstream, who can bill for which pieces of it, is a live question that closes September 14.
- **Lactation care codes.** Two new codes pay for physician/QHP-directed lactation care, and CMS creates the first "Lactation Consultant" staff type in the Medicare payment system, proposing to price it at registered-nurse rates and explicitly asking whether that's right. If lactation support is part of your model, the federal government is asking you, right now, what your workforce is worth.
- **Remote monitoring restrictions.** Starting January 1, 2027: monitoring staff must be employed by the billing practice (no third-party monitoring vendors), and remote monitoring requires an initiating face-to-face visit. If your postpartum hypertension or remote pregnancy monitoring program runs on an outsourced vendor model, this proposal breaks it for Medicare, and commercial payers copy Medicare's integrity rules.
- **Quality measures.** A new measure scores CVD risk assessment for pregnant/postpartum patients (good, comment in support). Maternal mental health screening remains a checkbox "improvement activity," not a scored measure, which means it doesn't affect payment or public ratings. Both are open for comment.

Bottom line for your business: the codes you bill, who may bill them, and how remote care can be staffed are all being redrawn effective January 1, 2027, and commercial plans will mirror Medicare within a contract cycle.

If you work in menopause or midlife women's health:

- **The zero-mentions finding.** Menopause, hormone, and osteoporosis appear nowhere in 716 pages about prevention and chronic disease. That's not just symbolism: what isn't named in payment policy doesn't get codes, measures, or coverage pathways. Your comment is the correction on the federal record.
- **The Annual Wellness Visit redesign.** Medicare's yearly prevention visit is being rebuilt, and CMS asks openly how to personalize it and which components technology can deliver. Today's AWV has no menopause-status, bone-health, or midlife CVD component. Whoever answers this RFI defines what the midlife well-visit contains, and every commercial "annual physical" template downstream of it.
- **The longitudinal care categories.** CMS is considering splitting office visits into categories, longitudinal vs. acute vs. consultative, and paying longitudinal care better. Menopause management is the textbook longitudinal, counseling-heavy, between-visit-intensive care CMS says current codes undervalue. CMS explicitly asks for resource data on longitudinal care; menopause practices have exactly that data. The care-management redesign is also the opening for life-stage care coordination codes, navigation spanning puberty, fertility, pregnancy, perimenopause, and menopause, building on state Medicaid precedents.
- **The Women's Health MVP.** The federal government's proposed women's health quality bundle, the measure set that will define "good women's health care" for public ratings, contains no menopause measure, starts osteoporosis screening at 65 (ignoring the USPSTF's existing recommendation for younger postmenopausal women at risk), and measures CVD risk only in pregnancy. Open for comment by name.
- **Group visits + the telehealth cliff.** A new shared-medical-appointment code (billable per patient, telehealth-eligible) is a ready chassis for group menopause programs. Meanwhile the telehealth flexibilities every virtual menopause company runs on expire December 31, 2027, and new claim modifiers will flag platform-affiliated telehealth visits, making virtual-care arrangements visible to payers for the first time.

Bottom line for your business: the federal definition of midlife women's healthcare is currently blank, and three separate open questions (the AWV, the visit categories, the quality measures) are asking someone to fill it in. First movers write the template.

If you work in fertility:

- **The same-day visit + procedure cut.** When an office visit and a procedure happen the same day, CMS proposes paying the most expensive at 100% and everything else at 50%. Cycle-based care is built on same-day stacking, monitoring visit + IUI, visit + biopsy, that ovulation timing makes medically unavoidable. Commercial payers attempted this policy before and retreated; a finalized Medicare version re-arms them.
- **The practice-expense rebuild.** The formulas allocating overhead costs to every ultrasound and office procedure are being rewritten, and CMS states in the rule that reproductive endocrinology is excluded from the underlying cost survey because it "is not separately recognized by Medicare." Your specialty's costs have never informed the prices your contracts benchmark to, and the rebuild is happening without them.
- **The CPT RFI.** CMS asks open questions about the coding and valuation system, including where codes are missing and how valuation could use better data. The ART code set was never meaningfully resourced through the Medicare process, and dedicated codes for infertility counseling and preconception planning simply do not exist, so that clinical work disappears into generic visit codes. If the process evolves, fertility needs a seat at the table; this RFI is where you name both gaps.
- **The missing IVF Executive Order.** The rule cites the MAHA executive order repeatedly; the administration's own February 2025 IVF EO, never. A short comment asking CMS to state how physician payment policy will implement it is a fair and pointed ask.
- **Quality measures: fertility has none.** There is no fertility MVP and no fertility outcome measure anywhere in the federal quality inventory, and with quality reporting going MVP-only in 2029, a field without measures is invisible in the system that defines quality. Commenters can ask CMS to prioritize fertility measure development through its candidate-measure pipeline.
- **The wellness-visit opening: a fertility and preconception assessment.** The AWV redesign RFI asks how to personalize the annual visit, and reproductive health is systematically absent from it today, so fertility-affecting conditions (endometriosis, PCOS, diminished ovarian reserve, male factor) are typically found only after years of failed conception attempts. The ask: a standardized fertility/preconception wellness assessment, think PHQ-9, but for reproductive health, for reproductive-age beneficiaries (Medicare covers roughly two million women of reproductive age

through the disability pathway), knowing the AWV design becomes the template every commercial annual-visit product follows.

Bottom line for your business: Medicare covers no IVF but writes your price list, most commercial contracts pay as a percentage of Medicare's rates. These changes reach fertility clinic revenue within one or two contract cycles without a single Medicare patient in your waiting room.

If you work in autoimmune, cardiovascular, or other chronic conditions that disproportionately affect women:

- **The Annual Wellness Visit redesign.** The AWV is the front door for chronic-disease risk detection, and CMS is asking what a rebuilt, personalized, technology-assisted version should contain. Sex-stratified risk, autoimmune symptom patterns, post-menopause lipid shifts, the female-predominant presentation of cardiovascular disease, is absent from today's AWV and unmentioned in the redesign questions. That's the opening.
- **The chronic-care payment machinery.** CMS admits uptake of its care-management codes has been poor and asks how to consolidate the code family, change supervision rules, and build technology-enabled tracks. The new E/M complexity add-on (16% of visit value, replacing a flat fee) pays proportionally more on complex longitudinal visits, structurally favorable to chronic-condition practices.
- **The specialty model precedent.** A new mandatory payment model (ASM) launches in 2027 holding specialists accountable for chronic conditions, starting with heart failure and low back pain, with payment adjustments reaching ±12%. CMS says it's exploring additional conditions. Whether women-predominant conditions enter that pipeline, with sex-stratified measures, is being decided by who comments now.
- **The Alzheimer's lifestyle RFI.** CMS is designing a potential intensive lifestyle intervention benefit for cognitive decline. Women are two-thirds of Alzheimer's patients; the RFI never mentions sex. The design questions (which domains, which team members, virtual delivery) are all open.
- **The duplicate-testing RFI.** CMS floats frequency limits on labs and imaging to cut waste. Two-sided opportunity: the women's health field has itself documented real over-testing and over-treatment in women's care, so engage constructively with clinically grounded reduction targets, while defining the exceptions that protect guideline-concordant serial testing (autoimmune monitoring labs, lipid panels, DXA scans). Bring solutions and safeguards in the same comment.
- **Behavioral health economics improve, with a hole.** The psychotherapy work-value uplift (+19.1%) completes in 2027, and collaborative-care codes get substantial increases (the initial-month code moves from 1.88 to a proposed 2.75 work RVUs), favorable for the depression/anxiety care women disproportionately use. But "perinatal" and "postpartum" appear zero times in the rule that's raising behavioral health payment.
- **Caregiver training payment is on the table.** CMS asks whether standalone caregiver-training codes should be folded into office-visit payment, which could erase the only distinct Medicare recognition of caregiver-facing clinical work. Women are the majority of unpaid caregivers; this quiet solicitation is a women's economic issue.
- **Migraine: zero.** A condition three times more common in women appears nowhere in the rule, no code changes, no mentions. Another silence worth naming on the record.
- **Quality measures: partial coverage, no sex lens.** The rheumatology MVP includes osteoporosis screening and a bone-health registry measure, good, but no MVP measure anywhere is sex-stratified, despite the strong female predominance of autoimmune disease. The new specialty model's patient-reported-outcome pipeline is the place to ask for sex-stratified measurement from the start.
- **Infusion economics for women's cancers.** CMS's standing discarded-drug policy declines accommodation for weight- and BSA-based dosing, the dosing model breast and gynecologic oncology infusion regimens run on. And mandatory 340B claim reporting (with billing-privilege revocation as the enforcement mechanism) adds real administrative load to 340B clinics with women's health service lines.

Bottom line for your business: this rule moves money toward longitudinal chronic-condition care and builds new payment models around named diseases. The conditions that get named, measured, and modeled get funded, and women-predominant conditions are currently absent from every list.

If you work in general women's health or preventive care:

- **The AWV redesign + prevention agenda.** CMS asks how to make the Annual Wellness Visit effective and personalized, while conceding evidence for the current version is mixed. Sex-specific

risk elements are the answer this rule never gives. Whoever supplies the redesign content shapes the national prevention visit.

- **The ACO attribution question.** CMS asks how to handle patients whose principal longitudinal provider is a specialist. Millions of women's de facto PCP is their OB/GYN, and cervical cancer screening (G0101) already counts as a primary care service for attribution purposes. The precedent exists; the comment connects the dots.
- **Office-practice economics, line by line.** The same-day visit + procedure cut hits the standard well-woman pattern (exam + biopsy, exam + IUD work). The pelvic exam supply pack was repriced from $20.16 to $2.81, an 86% cut baked into every office code that uses it. Small line items, multiplied across every visit, are the practice margin.
- **The rural preventive template.** CMS proposes making diabetes education and nutrition therapy standalone billable visits at rural health clinics to close an access gap. The identical logic extends to lactation care, cervical screening, and bone-density services in rural settings, but CMS says it doesn't currently plan to add more. The comment challenges that ceiling.
- **Quality measures: high leverage, few slots.** Breast cancer screening is one of only five quality measures every Medicare ACO in the country reports, that's how much weight a single measure placement carries. The Women's Health MVP's core measures (osteoporosis screening 65–85, breast screening, prolapse-repair safety) are open for comment now, and CMS's own specialty impact estimate puts OB/GYN at −1% overall (−2% in facility settings), worth knowing when you model next year.

Bottom line for your business: the economics of the well-woman visit are being reset item by item, what the annual visit contains, how same-day care is paid, what supplies are worth, and which quality metrics your care is scored on.

If you're not in the industry, but you're a woman or an advocate who cares:

You don't need to be technical to comment. Federal comments from patients, caregivers, and advocates are read, counted, and cited, personal experience is evidence. File at regulations.gov (docket CMS-2026-2377) before September 14. Speak to what you know: what it cost you (in dollars, delays, or dismissals) to get menopause care, maternity care, a bone density scan, or fertility treatment. If the annual wellness visit never once addressed your menopause or bone health, say that, because CMS is redesigning that visit right now. If your maternity or postpartum care depended on a nurse, midwife, or lactation consultant the system couldn't pay, say that. One page, in your own words, about your own experience, is a comment.

Looking at this rule through a women's health lens we haven't covered? Reach out and we'll help you interpret it for your corner of the field: **jodi@51and.com**

More to come on how we coordinate the response. If you want to be part of a joint comment, contribute expertise to a section, or understand what this rule means for your organization: **jodi@51and.com**

Prepared by 51& from a complete multi-lens analysis of CMS-1848-P (91 FR 43842, July 16, 2026). This is an initial analysis of a proposed rule during an open comment period; corrections and additions are welcome at jodi@51and.com.

ABOUT 51&

51& is a member-driven network that unites women's voices, dollars, and voting power to rebuild the foundation of a health system that was never designed for them. By connecting members, institutions, organizations, and healthcare companies, 51& turns community, data, and influence into impact, directly funding research, advocacy, bipartisan policy, and innovation, while creating value for members through education, events, community, and shared economic power. Through its pooled membership model, 51& creates sustainable, system-wide funding for women's health, building the infrastructure and influence needed to drive long-term change. 51& convened the first-ever Women's Health Reimbursement Summit in 2025 and most recently hosted the second annual Summit in New York in May 2026. Founded by women entrepreneurs, hundreds of healthcare leaders, and every woman with a story, 51& is built on the belief that when women unite, the system shifts. **Learn more at 51and.com.**

APPENDIX: CLAIM-BY-CLAIM SOURCE CITATIONS

Every load-bearing claim in this analysis is listed below with its location in the rule and how it was verified. Verification tiers: **Verbatim** (quoted directly from rule text); **Rule text + CMS fact sheet** (confirmed in both the rule and CMS's official July 14 fact sheet); **Mechanically verified** (reproducible by searching the rule PDF); **Read visually** (tables published as images in the Federal Register, read from the page images); **Cross-source** (confirmed by an independent specialty-society or industry analysis). Independent analyses from ACOG, the College of American Pathologists, Aledade, and industry policy analysts were reviewed after this analysis was complete; no contradictions were found.

CLAIM (as stated in this analysis)	WHERE IN THE RULE	VERIFICATION STATUS
Comment deadline September 14, 2026; docket CMS-2026-2377; file code CMS-1848-P	Rule DATES/ADDRESSES section, 91 FR 43842 (p.1 of rule)	Verbatim from rule text
Conversion factors: QP $33.17 (−1.19%); non-QP $32.84 (−1.68%); 2.5% one-year boost expires; +0.53% adjustment	Rule Executive Summary + Regulatory Impact Analysis; CMS Fact Sheet (7/14/26)	Verified, rule text AND CMS fact sheet
Same-day E/M + global procedure: most expensive at 100%, all else at 50% (modifier -25 policy)	Section II.D.(58), ~91 FR 43908; CMS Fact Sheet	Verified, rule text AND CMS fact sheet
G2211 becomes MOD1 (16% of E/M value); MOD2 (32%) for Shared Savings/LEAD ACO participants only	Section II.D.(53), ~91 FR 43898; CMS Fact Sheet	Verified, rule text AND CMS fact sheet; Aledade analysis concurs
Maternity restructure: 17 codes deleted, 12 created, 9 revised; global OB bundle dissolved; per ACOG May 2025 guidelines (8 avg-risk / 13 higher-risk visits); new codes jointly developed by AMA and ACOG	Section II.D.4.c.(27), 91 FR 43880–43882; ACOG public statement (July 2026)	Verbatim from rule text; cross-confirmed by ACOG statement
CMS proposes 15% increase over RUC-recommended labor/delivery values; 11,810 work RVUs reallocated	Section II.D.4.c.(27)(a), ~91 FR 43881; ACOG statement notes approval of increased values	Verbatim quote; cross-confirmed by ACOG
Comment solicitation on 15 HCPCS G-codes that would maintain current maternity coding (the "snap-back" option); ACOG publicly opposes the G-codes and urges a "clean break"	Section II.D.4.c.(27)(b), ~91 FR 43881–82; ACOG President statement (July 2026)	Verbatim from rule text; ACOG position from public statement
New lactation codes 978XX/978X1; first "Lactation Consultant" clinical staff type (L076A); RN-rate crosswalk open for comment	Section II.D.4.c.(46), 91 FR 43890–91	Verbatim quotes from rule text
RPM/RTM: staff must be employed by billing practice (no contractors); mandatory initiating visit; RTM established-patients only; downward device revaluation; 17→4 G-code bundling solicitation	Section II.D.(48), ~91 FR 43892–93; CMS Fact Sheet	Verified, rule text AND CMS fact sheet; independent industry analyses concur
Zero mentions in 716 pages: "menopause," "hormone" (excl. CEHRT), "estrogen," "osteoporosis," "contraception," "postpartum," "doula," "community health worker"; "midwife" once (RHC practitioner list)	Full-text search of complete rule text	Mechanically verified, reproducible by searching the PDF
IVF Executive Order (Feb 2025) never cited, while MAHA EO cited repeatedly	Full-text search of complete rule text	Mechanically verified, reproducible
Standalone CPT RFI with five open questions incl. alternatives; cites MedPAC and 2025 NASEM report	Section II.H, 91 FR 43951–53	Verbatim from rule text (not covered in fact sheet)
Efficiency adjustment: −2.5% to work RVUs + intraservice time, non-time-based codes, recurring every 3 years; CY2027 RUC recommendations treated as pre-adjusted	Section II.D.2.b, ~91 FR 43868 (citing 90 FR 49334–49345)	Verbatim from rule text
Empiric time revaluation solicitation: 13 codes incl. 19318, 19380 (breast) + 88305/88307 (pathology); CMS: empirical data "may be a better input than limited survey data"	Section II.D.4.b.(9), 91 FR 43933–34	Verbatim quote; CAP summary concurs on 88305
Harvard-valued codes precedent: 7 codes proposed misvalued for being unreviewed 20+ years; "we share their concerns"	Section II.D.4.b.(10), ~91 FR 43934	Verbatim quote from rule text

CLAIM (as stated in this analysis)	WHERE IN THE RULE	VERIFICATION STATUS
Public misvalued-code nominations due February 10 annually, with documented evidence standards; 88305 nominated by Maryland Health Care Commission (state agency precedent)	Section II.D.4.a–b; CAP analysis confirms MHCC nominator	Verified, rule text; cross-confirmed by CAP
PE methodology: indirect allocation change excludes 010/090-day global codes; IPCI phased out over 2 years; ±5% PE stabilization cap	Section II.B, 91 FR 43845–51; CMS Fact Sheet (direction)	Verified, rule text; fact sheet confirms direction
Pelvic exam supply pack (SA051) repriced $20.16 → $2.81	PE supply section (multi-year supply-pack correction, third transition year)	Verified, rule text
Primary care RFI: three topics (relative valuation, technology enablement, prospective payment) + AWV redesign + AI questions	Section II.E, 91 FR 43936–46; CMS Fact Sheet confirms 3 topics	Verified, rule text AND CMS fact sheet
New shared medical appointments code (2–10 patients, ~1.73 work RVU building block, telehealth-eligible)	Section II.D.(54); CMS Fact Sheet confirms proposal	Verified, rule text AND CMS fact sheet
Women's Health MVP: core measures Q039 (osteoporosis 65–85), Q112 (breast screening), Q432 (POP repair injury); no menopause measure; CVD risk measured only in pregnancy (Q496); names CNMs/NPs/PAs as applicable clinicians	Appendix 3 (B.9), 91 FR 44509–44512	Read visually from FR pages (tables published as images); page images on file
Traditional MIPS sunsets. MVP-only reporting from CY 2029; FHIR digital quality transition 2028–2030	QPP sections IV.A, ~91 FR 44148+	Verified, rule text; CAP and Aledade analyses concur
Telehealth flexibilities extended only through December 31, 2027 (CAA 2026); new BB/BC platform modifiers effective 2027	Section II.C, ~91 FR 43862–65; CMS Fact Sheet (RHC dates)	Verified, rule text AND fact sheet
Ambulatory Specialty Model: mandatory, heart failure + low back pain, 2027–2031, adjustments ±9% growing to 12%; CMS exploring additional conditions	Section III.D, ~91 FR 44000+	Verified, rule text
Shared Savings specialty RFI (attribution, benchmarking, specialist measures); G0101 cervical screening counts as primary care service for ACO assignment; new benchmark adjustment for recruiting VBC-inexperienced practices	Section III.G.10 + regulatory text; Aledade analysis (benchmark adjustment)	Verified, rule text; cross-confirmed by Aledade
FNA codes 10005 (1.42→1.35) / 10006 (0.98→1.00)	CAP analysis; rule Section II.D	Cross-source (CAP), spot-check against rule text before quoting in filings
Psychotherapy +19.1% work uplift completes in CY 2027 (final year of 4-year transition); collaborative care increases (99492: 1.88→2.75; 99493: 2.05→2.26; 99494: 0.82→1.13); "perinatal" and "postpartum" appear zero times	Behavioral health valuation items (50)–(51), ~91 FR area; full-text search	Verified, rule text; zero-findings mechanically verified
Caregiver training comment solicitation: CMS asks whether G0541–G0543 resource costs should instead be reflected in E/M valuation	Caregiver Training Services item (62)	Verbatim from rule text
Migraine, botulinum, and CGRP: zero mentions anywhere in the rule	Full-text search of complete rule text	Mechanically verified, reproducible
340B: mandatory quarterly claim-level reporting for Part D covered entities from January 1, 2027, enforced via potential billing-privilege revocation	Section III.F; §§424.516(f)(4), 424.535(a)(10)	Verified, rule text

KNOWN LIMITATIONS, STATED PLAINLY

- **Specialty impact table read visually.** Table D–B5 is published as an image in the Federal Register. The OB/GYN row (91 FR 44246) was read directly from the page image: total allowed charges $558M; combined impact −1% (0% work, −1% PE); non-facility −1%, facility −2%. Other specialty rows quoted from this table should likewise be verified against the page images or CMS's public use file.

- **Code-level RVU tables not independently extracted.** Proposed values for individual maternity codes (Tables A–D2/A–D3) are image-rendered; the 15% labor/delivery increase comes from CMS's narrative text, quoted verbatim.
- **Everything here is PROPOSED, not final.** The final rule (expected ~November 2026) may differ on any point. That is the purpose of the comment period.
- **Interpretive framings are ours.** Characterizations such as "the most consequential window in years" and projections about commercial-payer adoption timelines are analytical judgment, not rule text.

PRIMARY SOURCES

- Proposed rule: CMS-1848-P, 91 FR 43842 (July 16, 2026), federalregister.gov
- CMS Fact Sheet (July 14, 2026): cms.gov/newsroom/fact-sheets/calendar-year-cy-2027-medicare-physician-fee-schedule-proposed-rule
- ACOG statement on the maternity codes (July 2026): acog.org/news
- Comment docket: regulations.gov/docket/CMS-2026-2377