

September 14, 2026

The Honorable Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1848-P
P.O. Box 8016
Baltimore, MD 2144-8016

Submitted electronically to: <http://www.regulations.gov>

Re: Calendar Year (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

Dear Administrator Oz:

On behalf of a broad network of specialty physician practices supported by The Specialty Alliance and Navista, we appreciate the opportunity to comment on the CY 2027 Medicare Physician Fee Schedule (MFPS) Proposed Rule. As President of The Specialty Alliance and General Manager of Navista, we represent community-based medical oncology, hematology, radiation oncology, urology, gastroenterology, and other specialty physician practices nationwide that are committed to ensuring patient access to high-quality, locally delivered care.

The Specialty Alliance is a physician-led network supporting gastroenterological and urological care in community-based settings. With over 2,500 independent specialty providers across 29 states, the Specialty Alliance platform provides comprehensive management, operational, and clinical support that enables physicians to focus on delivering exceptional digestive and urological health care in communities across the country.

Navista is an oncology practice alliance empowering independent, community-based oncology providers to serve patients through their cancer journeys, close to home. Navista provides the advanced services, technology, and financial support that oncology practices need to remain independent and continue serving their community for generations to come. Our network includes over 40 medical oncology, radiation oncology, and imaging sites committed to delivering high-quality, patient-centered, multidisciplinary oncology and urology care in local communities nationwide.

Together, these practices serve hundreds of thousands of patients, including Medicare beneficiaries, providing critical access to close-to-home specialty care while managing increasingly complex care coordination, treatment navigation, advanced therapeutics, and value-based care initiatives. As a result, changes to physician payment policy directly impact independent practices' ability to maintain access, invest in innovation, sustain multidisciplinary care teams, and ensure patient continuity of care in lower-cost community settings. The concerns and recommendations

outlined below reflect the real-world operational and financial impacts experienced by the multispecialty providers we support.

Collectively, these practices represent a critical segment of the Medicare delivery system and provide CMS with a frontline perspective on how reimbursement policy affects patient access, practice sustainability, and the continued availability of community-based specialty care.

While we recognize CMS's efforts to modernize physician payment and support value-based care, several provisions in the proposed rule may have unintended consequences for community-based specialty providers, patient access, and the sustainability of independent physician practices.

The Specialty Alliance and Navista would like to address the following proposals included in the CY2027 MPFS Proposed Rule:

1. Oppose Further Erosion of Community Practice Reimbursement

The CMS proposed 1.68% physician conversion factor reduction continues a multi-year trend of reimbursement pressure on physician practices. We are concerned that the CY 2027 MPFS proposed payment policies continue to create uneven reimbursement impacts across specialties and further accelerate the shift in Medicare reimbursement away from direct patient care services, including Evaluation and Management (E/M) services that form the foundation of longitudinal, coordinated care. While CMS projects a 2.4% increase for radiation oncology, several specialty groups that provide complex, ongoing care to Medicare beneficiaries would experience payment reductions. CMS should more carefully evaluate specialty-specific payment impacts and the cumulative effect of successive policy changes on physician practices that are already facing significant workforce, operational, and financial pressures.

Particularly in oncology, the proposal does not adequately account for payment reductions experienced by radiation oncology providers finalized via the CY2026 MPFS Final Rule. To date in 2026, Navista practices delivering radiation oncology services have seen an average of a 30-40% reduction in payment. We strongly recommend that CMS evaluate cumulative reimbursement changes across multiple years, considering how proposed radiation oncology payment increases will not offset decreases over the past two decades.

Payment reductions affecting specialties reliant on E/M services and coordinated care activities are occurring alongside increased administrative scrutiny and utilization controls on care management, navigation, and other patient support programs. These trends could undermine investments in the comprehensive, team-based care models on which Medicare beneficiaries with complex and chronic conditions depend, while creating additional administrative burden without commensurate support for clinical services that drive improved patient outcomes. Left unaddressed, these payment reductions and growing administrative requirements may discourage participation in essential care management programs and weaken the financial sustainability of community-based specialty practices that serve some of Medicare's most vulnerable patients.

Over the past two decades, Medicare physician payment rates have consistently failed to keep pace with the rising costs of delivering care as measured through the Medicare Economic Index (MEI).

Continued MPFS payment reductions – layered on years of inadequate inflationary updates – further widen the gap between reimbursement and practice costs, threatening the long-term sustainability of physician practices and access to high-quality, community-based care.

We urge CMS and Congress to pursue longer-term physician payment reform that provides predictable, inflation-adjusted reimbursement for physician services. Physician payment reform is vital to ensuring The Specialty Alliance and Navista practices and their providers can continue to provide high-quality multispecialty care in local communities, close to where patients live.

2. Oppose the Proposed Modifier -25 Same-Day Payment Reduction

CMS proposed a 50% payment reduction when providers bill an evaluation and management (E/M) visit with modifier -25 the same day as any 0/10/90-day global procedure. Under this proposal, providers would see a 50% reduction on other same-day services. The Specialty Alliance and Navista strongly oppose the proposal to reduce payment by 50% when practices bill E/M services on the same day as procedures.

The methodology CMS used for this proposal follows similar reimbursement cuts proposed and finalized through the Multiple Procedure Payment Reduction (MPPR) policy. However, this proposal does not reflect how oncology, urology, and gastroenterology care are delivered. Patients with chronic conditions routinely receive the following services during the same encounter:

- Physician evaluation
- Treatment planning
- Symptom management
- Injections and infusion services
- Procedural interventions

These services – whether for administration of multi-agent therapies such as chemotherapy or radiation – represent distinct, resource-intensive, distinct clinical workflows clinical work, and CMS should continue to reimburse practices appropriately. The proposed reduction would create incentives to fragment care across multiple visits, increasing burden on patients while reducing operational efficiency for community-based oncology providers. Beyond the clinical and operational burden, requiring additional in-person visits would significantly increase financial toxicity for patients and their families through added transportation costs, lost wages from missed work, and greater caregiver time and productivity burdens. Furthermore, annual loss for The Specialty Alliance and Navista practices under this CMS proposal would be significant in addition to the negative impact we expect patients and caregivers to experience with a proposal that would further fragment care.

We appreciate CMS for specifically requesting feedback on preference for a 25% payment reduction vs. 50% reduction. The Specialty Alliance and Navista assert that CMS should not finalize a proposed 50% payment reduction for modifier -25 E/M services billed with a global procedure on the same day.

3. Oppose the RPM/RTM Supervision Proposal Requirements

CMS proposed a policy that would prohibit the use of third-party outsourced monitoring staff for delivery of remote therapeutic monitoring (RTM)/remote patient monitoring (RPM) and would instead require that clinical staff furnishing these services be direct employees and under “incident to” supervision of the billing practitioner. The proposed revisions to RPM and RTM services would create substantial barriers for practices seeking to leverage technology-enabled care management to improve outcomes, reduce avoidable utilization, and support patients undergoing active treatment. While we appreciate CMS' efforts to strengthen program integrity, we are concerned that the proposed direct-employment staffing requirement will curtail innovation that RTM/RPM partnerships offer community programs, given their current structure to operate as extension of the care team.

Care for chronic conditions, particularly cancer, care is increasingly delivered in outpatient settings that rely on continuous monitoring of treatment-related toxicities, medication adherence, symptom burden, weight loss, functional decline, and other clinical indicators that often emerge between scheduled office visits. RTM and RPM programs enable oncology practices to identify deterioration earlier, intervene before emergency department utilization occurs, and support patients receiving oral oncolytics, immunotherapies, radiation therapy, and supportive care therapies. These services are particularly valuable for rural patients, elderly beneficiaries, and those receiving treatment at satellite locations.

We are particularly concerned with CMS' proposal to limit clinical staff participation to direct employees of the billing practice. Many providers utilize specialized monitoring vendors and centralized care management resources to supplement workforce shortages and ensure timely patient outreach. Community practices continue to face significant challenges recruiting and retaining nurses, navigators, and other qualified clinical personnel. Prohibiting appropriately supervised contracted clinical staff would reduce access to monitoring services precisely when demand for cancer care navigation and symptom management continues to increase. Rather than improving access to care, this policy could force practices to curtail or discontinue existing RTM and RPM programs.

Furthermore, the proposed reduction in practice expense valuations for monitoring-related codes, combined with additional operational requirements, may make many RPM and RTM programs financially unsustainable. This is especially concerning as CMS simultaneously continues to emphasize proactive symptom management, care coordination, and value-based care models that rely upon the same infrastructure supported by these services.

We urge CMS to permit services furnished by qualified contracted or outsourced clinical staff operating under the applicable supervision requirements, rather than limiting participation exclusively to direct employees. We also encourage CMS to preserve reimbursement levels that reflect the clinical intensity and staffing resources required to monitor medically complex patients. Accordingly, it is imperative that CMS avoid policies that restrict access to utilizing innovative technology-enabled symptom monitoring and care management services that have demonstrated value in preventing acute care utilization and supporting patients throughout active treatment.

These modifications would better align the RTM and RPM framework with the realities of modern medical care while preserving CMS's goals of program integrity and beneficiary protection.

4. Support for New Coding/Reimbursement Opportunities that Strengthen Care Delivery

The Specialty Alliance and Navista support CMS proposals that recognize the importance of coordinated team-based care via the addition of two new advanced care planning (ACP) G-codes for clinical staff time (GACP1 and GACP2). Currently, physicians can bill ACP services with CPT 99497 (first 30-minutes) and CPT 99498 (add-on 30-minute visit), which is inclusive of practitioner time. As of 2016, ACP services are inclusive of other clinical staff time (i.e., nurses, navigators, social works, etc.). We are supportive of the creation of two new codes to capture staff time for ACP services furnished incident-to under direct supervision.

The Specialty Alliance and Navista encourage CMS to advance these proposed ACP codes that would support navigator-led, nursing-led, and social work-led care activities, including via in-person and telehealth delivery. ACP service utilization grew from 650,000 visits annually in 2016 to 2.5 million in 2025¹. These codes more accurately recognize the multidisciplinary nature of complex care and may improve patient outcomes while supporting care model innovation. In alignment with CMS's proposal, The Specialty Alliance and Navista support utilization of a single code combining practitioner and staff time as this mirrors process and infrastructure of other care management programs for oncology care.

Additionally, we appreciate CMS's request for stakeholder feedback on reimbursement for clinical trial discussion and counseling activities via HCPCS G-code describing a minimum of 20 minutes of physician or other qualified health professional time. Community practices play a critical role in expanding access to research participation. Physician and care team time spent counseling patients regarding clinical trials deserves recognition and reimbursement to ensure providers offer patients clinically appropriate innovative trial options. As CMS noted in the proposed rule, as of 2026 only 7% of adults with cancer enroll in clinical trials; however, more than 50% of eligible patients enroll when offered the opportunity².

The Specialty Alliance and Navista support the new proposed HCPCS G-code as a combined code for all time spent related to clinical trial counseling, similar to prior proposals in creation of care management code sets. Documentation requirements to utilize this code should include discussion of the clinical trial identified, risks and benefits, goals, duration of trial, and standard alternatives.

Conclusion

CMS has an opportunity to strengthen access to community-based care while supporting innovation in care delivery. The Specialty Alliance and Navista respectfully urge CMS to:

1. Reconsider the 1.68% physician conversion factor reduction and pursue longer-term, sustainable reimbursement reform that endangers community-based care.

¹ Page 292, CY 2027 CMS MPFS Proposed Rule

² Page 662, CY 2027 CMS MPFS Proposed Rule

2. Not finalize a proposed 50% payment reduction for modifier -25 E/M services billed with a global procedure on the same day.
3. Permit services furnished by qualified contracted or outsourced clinical staff operating under the applicable supervision requirements, rather than limiting participation exclusively to direct employees.
4. Advance reimbursement pathways for care coordination and clinical trial discussions.

The Specialty Alliance and Navista appreciate the opportunity to provide these comments, and we look forward to working collaboratively with CMS to ensure Medicare beneficiaries retain access to high-quality, affordable, community-based specialty care.

Sincerely,



Nathan Walcker
President, The Specialty Alliance



Diana Verrilli
General Manager, Navista

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