



September 14, 2026

The Honorable Mehmet Oz, MD
Administrator Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1848-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: 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]

Dear Administrator Oz:

On behalf of The US Oncology Network (The Network), I thank you for the opportunity to comment on the CY 2027 Physician Fee Schedule (PFS) proposed rule.

The Network is the nation's largest network of independent, community-based oncology physicians. Bringing together more than 1,900 like-minded physicians, The Network treats nearly 2 million cancer patients a year nationwide at over 700 sites of care in 31 states. These physicians share a common vision of expanding patient access to high quality, state-of-the-art care close to home and at lower costs for both patients and our entire healthcare system. The value of community oncology has been demonstrated through participation in Medicare value-based care initiatives. Our mission is to help patients fight cancer as effectively and efficiently as possible. We are committed to working with the Centers for Medicare and Medicaid Services (CMS) to enhance the delivery of cancer care and protect patient access to high-quality, cost-effective care.

To facilitate your review, we would like to highlight our comments on the following proposals and Request for Information (RFIs):

- **Overall Reimbursement Policy and the Impact on Community Oncology:** The Network believes the current Medicare physician payment framework is unsustainable as reimbursement continues to fall further behind the cost of delivering cancer care. Physician payments have failed to keep pace with inflation and rising practice costs, increasing pressure on independent community oncology practices.



The Network supports physician payment reform that provides predictable updates tied to medical inflation, recognizes the cost of delivering cancer care, and preserves patient access to community-based oncology services.

- **Proposed Changes to Payments Using Modifier –25:** The Network opposes CMS's proposal to reduce payment for E/M services billed with modifier -25. These services often involve significant physician evaluation, counseling, treatment planning, and care coordination that are separate from the procedure itself. CMS should withdraw the proposal and use existing code-specific review processes if valuation concerns exist.
- **Radiation Oncology Treatment Delivery (CPT codes 77402, 77407, and 77412):** The Network remains concerned that the 2026 radiation oncology payment restructuring created significant reimbursement instability for many community-based providers. While CMS proposes refinements for 2027, additional work is needed to ensure payment reflects modern treatment patterns and the resources required to deliver radiation therapy. CMS should continue evaluating utilization assumptions and monitor impacts on patient access.
- **Proton Beam Treatment Delivery (CPT Codes 77520, 77522, 77523, and 77525):** The Network supports CMS's goal of establishing a national payment methodology for proton therapy but is concerned the proposed rates may not fully reflect the costs of furnishing these highly specialized services. CMS should not finalize the proposal for 2027 and should work with stakeholders to further refine the methodology to support patient access and avoid site-of-care disparities.
- **Payment for Physician-Patient Clinical Trial Discussions:** The Network supports creation of a clinical trial counseling code that reflects the multidisciplinary and longitudinal nature of clinical trial discussions. CMS should allow cumulative time across encounters, recognize pre- and post-service work, support telehealth delivery, and provide payment regardless of whether a patient ultimately enrolls in a trial.
- **Clinical Laboratory Fee Schedule (CLFS) Payment Reductions Under PAMA:** The Network remains concerned that ongoing CLFS payment reductions may threaten laboratory sustainability, diagnostic innovation, and patient access to testing that increasingly guides cancer treatment. CMS should closely monitor the impact of these reductions on access and ensure payment rates reflect the resources necessary to maintain high-quality laboratory services.



- **Request for Information on Duplicate Laboratory Testing, Imaging, and Result Sharing and Interoperability:** The Network is concerned that testing identified as "duplicate" through claims data is often medically necessary in oncology. Rather than relying on payment restrictions, CMS should focus on improving interoperability and access to diagnostic information, which are major drivers of avoidable repeat testing.
- **Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM):** The Network supports CMS's efforts to ensure RPM and RTM services remain clinically integrated and practitioner led. CMS should distinguish between technology vendors, independent monitoring programs, and supervised clinical care teams, while preserving technology-enabled care models and patient access to remote monitoring services.
- **Scalp cooling (CPT code 97007, 97008, 97009):** The Network believes current payment assumptions for scalp cooling underestimate the staff time and operational resources required to furnish the service. CMS should revalue these codes using real-world provider experience to ensure appropriate reimbursement and preserve patient access.
- **Current Procedural Terminology (CPT) Request for Information:** The Network believes the issues identified by CMS are largely related to valuation governance, transparency, and payment methodology rather than deficiencies in the CPT coding system itself. The Network supports retaining CPT as the national coding standard while pursuing targeted valuation reforms, greater transparency, broader stakeholder input, and additional objective data sources to improve payment accuracy and better recognize cognitive, preventive, and longitudinal care services.
- **QPP-MIPS:** The Network supports CMS's efforts to modernize quality reporting and value-based care but believes key policies, including the transition to MVPs, digital quality measurement, and Advanced APM changes, should not move forward until specialty-specific measures, technology capabilities, and operational infrastructure are sufficiently mature. The Network urges CMS to prioritize transparency, flexibility, and specialty readiness while avoiding policies that could increase reporting burden, disadvantage oncology providers, or create barriers to patient access and high-quality cancer care.

Impact on Community Oncology Practices

The Network believes the current Medicare physician payment framework is unsustainable and is accelerating the erosion of independent community oncology practices across the country. The 2027 PFS proposed rule is the latest example of a payment system that continues to move further out of step with the realities of delivering cancer care to Medicare beneficiaries.

While CMS's specialty impact table suggests a relatively modest effect on oncology providers, our analysis indicates many community oncology practices will experience reimbursement reductions that are substantially greater than CMS's published estimates suggest—ranging anywhere from 14% to 40% reductions for certain services. The broad specialty-level estimates included in the specialty impact table fail to capture the unique service mix, patient populations, and operational realities of independent community oncology practices.

At a time when practices are already facing rising labor costs, workforce shortages, inflationary pressures, and increasing operational demands, they are also preparing for significant reimbursement changes associated with implementation of the Inflation Reduction Act's Drug Price Negotiation Program for certain physician-administered therapies. Additional reimbursement reductions further widen the gap between the cost of delivering care and Medicare reimbursement threatening practices' ability to invest in the physicians, nurses, pharmacists, advanced practitioners, technology, and patient support services that make high-quality cancer care possible.

As these financial pressures continue to compound, oncology practices are being forced to make difficult operational decisions today, including delaying or reducing investments in staff, technology, and patient services; consolidating clinical locations; limiting service expansion; or, in some cases, exiting certain markets altogether. These decisions directly affect patient access and the long-term sustainability of community-based cancer care.

The Network believes congressional action is necessary to address potential reimbursement disruptions associated with the implementation of the Medicare Drug Price Negotiation Program and supports H.R. 4299, the *Protecting Patient Access to Cancer and Complex Therapies Act*, as a targeted solution to preserve patient access to physician administered therapies while maintaining the sustainability of community oncology. The policies included in H.R. 4299 could be operationalized similar to existing CMS implementation frameworks and processes.

Left unaddressed, these pressures will continue to weaken independent community oncology, accelerate consolidation into higher-cost hospital systems, and jeopardize patients' ability to receive care close to home.

Impact of Conversion Factor

The proposed CY 2027 conversion factors of \$33.1693 for qualifying APM participants and \$32.8409 for non-qualifying APM participants underscore the ongoing instability in the Medicare physician payment system. While Congress provided a temporary 2.5 percent payment update for CY 2026, the expiration of that adjustment at the end of the year once again leaves physician reimbursement lagging inflation and the rising costs associated with delivering care.



According to the American Medical Association, inflation-adjusted Medicare physician payment has declined by 33 percent since 2001, while physician practice costs, as measured by the Medicare Economic Index (MEI), have increased by approximately 60 percent over the same period.¹

Meanwhile, hospitals and other Medicare providers continue to receive annual inflation-based payment updates through statutory market basket mechanisms, while physicians remain the only major Medicare provider group without a permanent inflationary update. This growing disparity has forced physician practices to absorb substantial increases in labor, technology, compliance, and other operating costs without corresponding Medicare payment updates.

For independent community oncology practices, this recurring cycle of payment reductions creates significant financial pressure and threatens the long-term sustainability of care delivered in community settings. These practices continue to face increasing costs related to staffing, drugs, technology, compliance, and other operational expenses, yet Medicare payment updates do not adequately reflect these realities.

We recognize that CMS is constrained by the statutory framework governing the Physician Fee Schedule and has limited authority to address these challenges through rulemaking alone. Nevertheless, the proposed conversion factor reductions highlight the urgent need for broader physician payment reform. We encourage CMS to continue working with Congress and stakeholders to support modernization of the Medicare physician payment system, including reforms to MACRA that would provide stable, predictable payment updates tied to medical inflation.

Absent such reforms, physicians will continue to face annual payment uncertainty, and Medicare beneficiaries may ultimately experience reduced access to care in community-based settings. Establishing a sustainable payment framework is essential to preserving patient access and ensuring that practices can continue investing in the workforce, infrastructure, and innovations necessary to provide high-quality cancer care.

The Network Has Demonstrated Success in Value-Based Care

At a time when practices are facing Medicare cuts, The Network continues to deliver value-based cancer care. The Network has a long history of participation in oncology payment reform models, including the Oncology Care Model (OCM) and the Enhancing Oncology Model (EOM) demonstrating our commitment to value-based care. Community oncology is improving quality while lowering costs. During the six-year Oncology Care Model (OCM), practices in The Network generated approximately \$337 million in savings relative to Medicare benchmarks.

¹ American Medical Association, Medicare Physician Pay Has Plummeted Since 2001. Find Out Why (Apr. 21, 2025), <https://www.ama-assn.org/practice-management/medicare-medicare/medicare-physician-pay-has-plummeted-2001-find-out-why>

Building on that success, practices participating in the Enhancing Oncology Model (EOM) have generated approximately \$120 million in gross Medicare savings through the first three performance periods. Collectively, these value-based care initiatives have produced more than \$450 million in savings relative to benchmark spending while preserving patient access to high-quality cancer care in community settings.

These results demonstrate that community oncology practices are not simply lower-cost sites of service; they are proven partners in Medicare's efforts to improve quality and affordability through value-based care.

Indirect Practice Expense Methodology and Community Oncology Sustainability

The Network appreciates CMS's efforts to improve payment accuracy and to evaluate whether current practice expense methodologies appropriately reflect the costs incurred by different physician practice models. In the CY 2027 PFS proposed rule, CMS seeks comment on whether the current facility indirect practice expense (PE) allocation accurately reflects physician practice costs, whether employed physicians incur materially different indirect expenses than independent practitioners, and whether alternative approaches should be adopted to identify physicians whose overhead costs may be supported by hospitals, health systems, or other entities.

The Network believes CMS is appropriately examining whether practice expense payments accurately reflect the resources required to furnish care. However, as CMS continues this evaluation, it is important to recognize that independent community oncology practices incur substantial indirect costs that differ significantly from those of physicians employed by hospitals or integrated delivery systems.

Community oncology practices directly finance and maintain the infrastructure necessary to deliver comprehensive cancer care, including patient navigation programs, pharmacy operations, financial counseling, prior authorization teams, treatment planning resources, compliance programs, quality reporting systems, clinical triage services, and care coordination functions. These investments are essential to delivering timely, high-quality cancer treatment and are funded directly by physician practices rather than through broader institutional support structures.

Cancer care is also uniquely longitudinal and multidisciplinary. Independent oncology practices remain responsible for coordinating treatment across multiple providers and settings, managing complex medication regimens, monitoring toxicities, communicating with patients and caregivers, and supporting patients throughout extended treatment courses. These activities require substantial administrative and clinical infrastructure that may not be fully reflected in claims-based analyses of individual services.



The Network is concerned that payment methodologies that do not adequately recognize these indirect costs may disproportionately affect independent physician practices while favoring larger health systems that can spread administrative overhead across multiple service lines and revenue sources. Such outcomes could accelerate consolidation within oncology, reducing competition and potentially shifting care away from lower-cost community settings.

Accordingly, The Network urges CMS to ensure that any future refinements to the indirect PE methodology appropriately distinguish between independent physician practices and physicians whose infrastructure costs are supported by hospital systems or affiliated entities. Payment policies should recognize the substantial investments required to operate independent community oncology practices and should avoid creating unintended incentives that disadvantage physician-owned practices that furnish high-quality, accessible cancer care in community settings.

Proposed Changes to Payments Using Modifier -25

The Network strongly opposes CMS's proposal to apply a 50 percent payment reduction when a separately identifiable Evaluation and Management (E/M) service is furnished on the same day as a surgical procedure. The proposal is based on the unsupported assumption that these services represent duplicative physician work. In surgical practice, procedures do not occur in isolation. They occur within the context of a patient's full clinical presentation, changing symptoms, cancer risk, treatment history, and need for timely physician judgment.

Even when an office-based procedure is anticipated, the physician's evaluation may uncover new findings, previously unidentified risk factors, or clinical concerns that require same-day assessment, counseling, care planning, diagnostic testing, treatment modification, or coordination of care. This work is separate from the routine pre- and post-procedural services associated with informed consent and procedural preparation. It is precisely the type of significant, separately identifiable E/M service that modifier 25 was designed to recognize.

CMS has not demonstrated that separately identifiable same-day E/M services systematically contain duplicative physician work warranting an across-the-board 50 percent payment reduction.

Modifier 25 may only be reported when the E/M service is significant, medically necessary, and distinct from the work associated with the procedure. Moreover, CMS has long maintained valuation methodologies designed to identify and remove overlapping physician work and practice expense when services are commonly furnished together. If CMS believes particular services remain misvalued, the agency has established mechanisms to review and revalue those codes through the existing valuation process. A uniform payment reduction applied across thousands of services and clinical circumstances is not a substitute for identifying and quantifying specific duplicative resources.



One common scenario in oncology occurs when a physician identifies a previously unrecognized clinical concern during the pre-procedure evaluation. For example, a patient may present to a colon and rectal surgeon for an anoscopy to evaluate suspected internal hemorrhoids.

As part of the evaluation, the surgeon reviews the patient's medical history, medications, review of systems, and family history. During that assessment, the surgeon discovers that the patient has a significant hereditary risk for colorectal cancer based on family history that has not previously been addressed. While the anoscopy may still be performed as planned, the surgeon must also educate the patient about the significance of the family history, discuss the implications for cancer risk, arrange for colonoscopy, coordinate referral for genetic counseling and potential genetic testing, and develop an appropriate surveillance plan. This additional evaluation, education, risk assessment, and care coordination are not part of the routine work of performing an anoscopy. They represent medically necessary physician services addressing a separate and clinically important issue identified during the encounter.

A second common scenario occurs when a significant finding is discovered during the procedure itself. For example, a patient may present to a urologist for cystoscopy to evaluate hematuria. The pre-procedure evaluation may reveal no new concerns beyond the indication for the procedure. However, during the cystoscopy, the surgeon may identify a bladder mass that is highly suspicious for malignancy. If clinically appropriate, a biopsy may be performed. The physician's work, however, extends far beyond completion of the procedure.

The surgeon must explain the findings to the patient and family, discuss the likelihood of cancer, answer questions regarding prognosis and treatment options, counsel the patient regarding the potential need for a larger surgical intervention, order additional imaging and diagnostic testing, coordinate pathology review, and potentially initiate referrals to medical oncology and other specialists. The cognitive work, decision-making, counseling, and coordination of care generated by this unexpected finding often far exceed the complexity and time required to perform the cystoscopy itself.

These examples reflect the reality of surgical practice. Whether a physician identifies an important new issue during the evaluation preceding a procedure or discovers a concerning diagnosis during the procedure itself, the patient appropriately expects that concern to be addressed immediately. Managing these issues during the same encounter helps avoid delays in diagnosis, reduces fragmentation of care, improves patient understanding, and facilitates timely treatment planning. Patients and families leave with answers, a coordinated care plan, and a clear understanding of next steps rather than facing additional visits and unnecessary delays.



Treating this work as duplicative or automatically discounting it fails to recognize the realities of modern surgical and oncology practice. Surgeons do more than perform procedures. They evaluate, diagnose, counsel, coordinate care, assess risk, and develop treatment plans. Procedures are not performed on isolated anatomical findings; they are performed on patients. High-quality care often requires significant evaluation, clinical judgment, and coordination to occur during a single encounter.

By definition, an E/M service reported with modifier -25 is significant, separately identifiable, medically necessary, and distinct from the work associated with the procedure. CMS has provided no evidence demonstrating that these services are routinely overvalued or that current payment rates result in duplicate reimbursement. Existing Medicare valuation methodologies already provide mechanisms to identify and address overlapping physician work and practice expense where such overlap exists. **If CMS believes specific services remain misvalued, it should address those concerns through targeted, code-specific review rather than a uniform payment reduction.**

CMS previously examined and rejected a similar proposal in the CY 2019 PFS rulemaking. The agency proposed a 50 percent payment reduction for procedures furnished on the same day as a separately identifiable E/M service. Following significant stakeholder concerns regarding payment accuracy, care fragmentation, and the risk of discouraging medically appropriate same-day services, CMS chose not to finalize the policy. CMS specifically stated that it was not finalizing the proposal to reduce payment when E/M office/outpatient visits are furnished on the same day as procedures. The concerns that led CMS to withdraw the proposal in 2019 remain equally relevant today and weigh strongly against implementation of the current proposal.

Given the absence of evidence supporting a broad assumption of duplicative work and the availability of more targeted alternatives, The Network respectfully urges CMS to withdraw this proposal in its entirety.

Radiation Oncology Treatment Delivery (CPT codes 77402, 77407, and 77412) Radiation Oncology Payment Accuracy and Access Concerns

The Network remains concerned about the ongoing financial pressure facing community-based radiation oncology physicians following the significant payment changes finalized under the 2026 PFS and Hospital Outpatient Prospective Payment System (OPPS) final rules. While CMS intended these policies to modernize radiation oncology reimbursement and improve payment accuracy, the resulting reimbursement reductions for many community-based providers have been substantially greater than CMS anticipated.

In CY 2026, CMS fundamentally restructured payment for radiation treatment delivery services by replacing the longstanding G-code framework with a revised CPT-based payment methodology.



In doing so, CMS used the relative relationships among OPPS APCs 5621, 5622, and 5623 to establish practice expense values for CPT codes 77402, 77407, and 77412 under the PFS. Although intended to improve alignment between OPPS and PFS payment methodologies, the restructuring resulted in a significant redistribution of reimbursement among radiation treatment modalities.

In practice, the CY 2026 methodology produced substantial reimbursement reductions for disease sites where intensity-modulated radiation therapy (IMRT) represents the prevailing standard of care, including prostate, head and neck, lung, gastrointestinal, and brain cancers. By contrast, disease sites that rely more heavily on three-dimensional conformal radiation therapy (3D-CRT), most notably breast cancer, generally experienced more favorable reimbursement outcomes. As a result, many community-based radiation oncology practices have experienced reimbursement reductions that are disproportionate to changes in underlying resource utilization and inconsistent with contemporary treatment patterns.

The impact is particularly evident in prostate cancer treatment. Advances in image guidance, hypofractionation, stereotactic techniques, treatment planning, and IMRT have fundamentally changed both resource utilization and clinical practice patterns. However, payment methodologies driven by historical claims distributions and APC-based assumptions may not fully reflect the technology investments, staffing requirements, quality assurance activities, and infrastructure necessary to safely deliver modern radiation therapy. Consequently, reimbursement reductions may exceed any corresponding reduction in practice resources or clinical complexity.

The Network appreciates that CMS has acknowledged stakeholder concerns regarding the CY 2026 valuation methodology. In the CY 2027 proposed rule, CMS recognizes that the utilization assumptions used to establish relativity among CPT codes 77402, 77407, and 77412 did not accurately reflect actual treatment patterns and proposes to revise the valuation of these services using observed claims data from 2026. Specifically, CMS notes that utilization of CPT code 77412 was substantially lower than previously assumed and proposes to recalibrate payment within the treatment delivery code family accordingly. The Network's 2026 claims experience indicates that CPT code 77412 has been utilized substantially less frequently than CMS assumed when establishing CY 2026 payment rates.

While The Network appreciates CMS's willingness to revisit these assumptions, we remain concerned that the proposed refinements represent only a partial correction to the CY 2026 methodology and do not fully address the financial disruption experienced by community-based radiation oncology physicians. Based on analyses conducted by Network practices, the proposed CY 2027 revisions do not fully offset the reimbursement reductions that resulted from the CY 2026 restructuring and, for many physicians, are unlikely to produce meaningful overall reimbursement recovery.

These concerns are particularly significant in communities where radiation oncology services are integrated with medical oncology, patient navigation, supportive care, survivorship services, and multidisciplinary treatment planning. Continued reimbursement instability threatens the long-term viability of independent and community-based radiation oncology programs and may reduce patient access to local cancer treatment, particularly in rural and underserved areas where alternative treatment options may be limited.

The Network therefore urges CMS to:

- Use its existing administrative authority to address the structural payment deficiency resulting from the CY 2026 coding changes. CMS should use CY 2026 claims data that demonstrate that the utilization assumptions underlying the CY 2026 methodology materially differ from practice.
- Reevaluate the utilization assumptions and valuation methodology underlying radiation treatment delivery services, including CPT codes 77402, 77407, and 77412.
- Continue working with radiation oncology stakeholders to ensure claims-based utilization assumptions accurately reflect contemporary treatment patterns.
- Consider the cumulative impact of CY 2026 and CY 2027 payment policies on community-based radiation oncology physicians.
- Assess whether current payment methodologies appropriately recognize the capital investment, staffing requirements, quality assurance activities, and infrastructure necessary to furnish modern radiation therapy.
- Avoid payment policies that may accelerate consolidation, reduce competition, or shift care away from community-based cancer treatment settings.
- Monitor the impact of these policies on patient access to radiation therapy, particularly in rural and underserved communities.

As CMS continues to refine radiation oncology payment policy, we encourage the agency to work closely with stakeholders to ensure reimbursement accurately reflects contemporary clinical practice and supports continued access to high-quality cancer care in community settings. The Network is also concerned about the spillover effect this reimbursement changes have on commercial payer reimbursement methodologies, where substantial reductions have already been observed following the CY 2026 restructuring. CMS should consider these broader market impacts when evaluating future refinements to radiation oncology payment policy.



Proton Beam Treatment Delivery (CPT Codes 77520, 77522, 77523, and 77525A)

The Network supports CMS's goal of ultimately establishing a more consistent national payment methodology for proton beam treatment delivery services and reducing the geographic payment variation that exists under the current contractor-priced system. **However, we are concerned that the methodology proposed for CY 2027 may not adequately reflect the substantial resources required to furnish proton therapy and could create significant reimbursement reductions for community-based practices.**

In the CY 2027 proposed rule, CMS proposes to establish national payment rates for CPT codes 77520, 77522, 77523, and 77525 using a methodology based on historical Medicare allowed charges and the development of PFS practice expense RVUs for the proton therapy code family. CMS indicates that the proposal is intended to replace existing contractor pricing and create greater consistency in payment nationally.

Proton beam therapy is a highly specialized treatment modality that plays an important role in the treatment of pediatric cancers, tumors located near critical structures, reirradiation cases, and other clinically complex conditions. Through community-based proton therapy centers, Medicare beneficiaries can access this highly specialized cancer treatment closer to home and reduce travel burdens.

While The Network supports greater payment consistency, we are concerned that the proposed methodology may not fully capture the unique costs associated with furnishing proton therapy. Proton beam treatment requires substantial capital investment, specialized treatment equipment, sophisticated treatment planning systems, extensive quality assurance programs, ongoing facility maintenance, and a highly trained clinical workforce. These requirements exist regardless of whether proton therapy is furnished in a freestanding center or a hospital outpatient department.

The Network is particularly concerned that the proposed national rates may result in reimbursement reductions that do not reflect the actual resources required to safely furnish proton therapy in community-based settings. Because freestanding proton therapy centers and hospital-based proton therapy programs utilize fundamentally similar technology, infrastructure, and clinical expertise, Medicare payment policy should strive to avoid creating reimbursement disparities that favor one site of care over another.

For this reason, The Network urges CMS to not finalize the proposal for 2027 for further evaluation of whether the proposed national pricing methodology accurately reflects the costs of furnishing proton beam treatment delivery services and whether additional refinements are necessary to preserve beneficiary access. CMS should work closely with proton therapy physicians and radiation oncology stakeholders to ensure that any national payment methodology appropriately recognizes the capital investment, infrastructure, technology, and workforce requirements associated with proton therapy while supporting patient access across all sites of care.



Any transition to national pricing should be implemented carefully to avoid disruptions in patient access or physician participation.

RFI: Payment for Physician-Patient Clinical Trial Discussions

The Network supports CMS's consideration of a dedicated HCPCS code for clinical trial counseling. Identifying appropriate clinical trial opportunities and counseling patients on participation requires significant clinical effort that is not adequately recognized under current payment policies. Additional payment recognition could help support research infrastructure and encourage greater clinical trial participation, particularly in community oncology settings.

CMS should recognize that clinical trial counseling is rarely a single physician-patient conversation. Rather, it is an iterative process that often involves physicians, advanced practice providers, research nurses, clinical research coordinators, and other qualified professionals. Accordingly, "clinical trial counseling" should be defined broadly and reflect the multidisciplinary nature of research operations.

The Network believes a 20-minute threshold is generally reasonable but recommends allowing qualifying time to be aggregate time across multiple encounters within a defined period established by CMS. CMS has recognized similar approaches in other care management services, where cumulative time may be counted toward monthly billing thresholds. Clinical trial participation decisions often occur over time as patients review treatment options, consider risks and benefits, engage caregivers, and undergo eligibility evaluation. Allowing cumulative time would more accurately reflect real-world research workflows and promote appropriate utilization of the service. CMS should also consider whether future code levels may be warranted to account for varying levels of complexity across different trial types and patient populations.

Documentation requirements should be streamlined and leverage existing medical record workflows rather than creating a new administrative process. At a minimum, documentation should include confirmation that a clinical trial discussion occurred, the patient's potential eligibility for study participation, the topics discussed, and the total qualifying time. CMS should avoid overly prescriptive requirements regarding specific trial protocols or a patient's ultimate enrollment decision.

The Network strongly recommends that valuation of the service include activities performed outside the direct patient discussion, including chart review, eligibility screening, protocol review, review of biomarker and genomic testing results, coordination with research personnel, patient education, and related documentation. Much of the work associated with clinical trial participation occurs before a patient ultimately enrolls in a study. Therefore, payment should not be contingent on actual enrollment, as substantial clinical resources are expended even when patients are determined ineligible or elect not to participate.

The Network also supports making the service available via telehealth, as many clinical trial discussions involve review of complex information and shared decision-making that can be conducted effectively through virtual platforms.

Finally, CMS should provide clear guidance regarding the relationship between this service and existing E/M services to avoid duplicate billing concerns. CMS should also minimize administrative burden and avoid documentation requirements that necessitate significant workflow changes, as research operations vary substantially across practice settings.

The Network supports creation of a clinical trial counseling code and encourages CMS to adopt a flexible approach that allows aggregation of time across encounters, includes pre- and post-service activities in valuation, recognizes the multidisciplinary nature of research operations, and ensures payment is available regardless of whether a patient ultimately enrolls in a clinical trial.

Clinical Laboratory Fee Schedule (CLFS) Payment Reductions Under PAMA

While we recognize that this proposal largely reflects requirements established by Congress, we remain deeply concerned about cumulative payment reductions of up to 40% percent under the Clinical Laboratory Fee Schedule (CLFS) beginning in CY 2027 and their potential impact on patient access to critical diagnostic services and follow-on treatment.

Laboratory testing is foundational to modern healthcare and increasingly central to oncology care. Cancer patients rely on laboratory services throughout the continuum of care, from diagnosis and biomarker identification to treatment selection, toxicity monitoring, disease surveillance, and assessment of therapeutic response. Access to timely, accurate, and innovative diagnostic testing is essential to delivering high-quality, evidence-based cancer care.

The scheduled CLFS reductions raise significant concerns for laboratories, particularly independent, community-based, and rural laboratories that play a critical role in ensuring patient access to diagnostic services. Repeated reductions over multiple years may erode the financial sustainability of laboratory operations, limit investment in new technologies, and reduce access to testing for Medicare beneficiaries.

These concerns are particularly acute as oncology becomes increasingly dependent on precision medicine. Molecular diagnostics, genomic profiling, and biomarker testing now drive many treatment decisions and often require substantial investments in specialized equipment, laboratory personnel, quality systems, informatics infrastructure, and ongoing scientific validation. Sustained reimbursement pressure may make it more difficult for laboratories to maintain and expand these capabilities, potentially limiting patient access to innovative diagnostic technologies.

A significant concern is patient access to STAT testing, as PAMA payment cuts can significantly threaten access at point of care. STAT laboratory testing is often clinically required before a patient can receive treatment.



In oncology, timely laboratory results are often essential to determining whether a patient is eligible to proceed with a therapy, adjust treatment, or safely receive an infusion. If PAMA cuts make it unsustainable for laboratories to maintain STAT testing capacity at or near the point of care, patients may face additional delays, travel, and potentially missed treatment opportunities.

Importantly, laboratory testing represents a relatively small share of overall healthcare spending but has a disproportionate impact on clinical decision-making and patient outcomes. Diagnostic information guides treatment selection, identifies complications, helps avoid unnecessary procedures, and supports more effective use of healthcare resources. In oncology, reductions in reimbursement for diagnostic testing may generate modest program savings while increasing the risk of delayed diagnoses, less-informed treatment decisions, treatment delays, and higher downstream healthcare costs.

As CMS implements the statutory CLFS reporting and rate-setting requirements, The Network encourages the agency to carefully monitor the impact of resulting payment rates on beneficiary access, laboratory sustainability, and diagnostic innovation. CMS should analyze whether the reported data accurately reflect current market conditions and continue evaluating the real-world effects of PAMA-based payment updates on laboratories furnishing services to Medicare beneficiaries. The Network remains concerned that payment rates established under the PAMA framework may not fully reflect the diversity of the laboratory sector. Although CMS has taken steps to broaden reporting participation over time, stakeholders have continued to raise concerns regarding whether the reported data adequately represent the full range of laboratories serving Medicare beneficiaries. To the extent payment rates are derived from data that do not fully capture the laboratory market, reimbursement levels may not accurately reflect the resources required to maintain access to high-quality diagnostic services.

Ultimately, laboratory services are not ancillary to patient care; they are foundational to diagnosis, treatment, and disease management. This is particularly true in oncology, where diagnostic testing increasingly determines treatment selection and guides ongoing clinical management.

Policies that result in substantial reductions in laboratory reimbursement risk undermining access to essential services while producing savings that may be outweighed by downstream costs associated with delayed diagnosis, treatment inefficiencies, avoidable complications, and poorer patient outcomes.

Additionally, The Network appreciates CMS's efforts to establish a consistent payment framework for Software as a Medical Service (SaMS) technologies and recognizes the agency's rationale for treating algorithmic analyses performed on previously generated laboratory data differently from clinical diagnostic laboratory tests. Many of the affected codes, however, describe oncology-related services that inform diagnosis, prognosis, treatment selection, recurrence risk, and other clinically significant decisions.



While CMS proposes to remove these services from the CLFS and pay them under the MPFS through contractor pricing, the Network is concerned that localized MAC pricing may not achieve CMS's stated goals of payment stability and predictability. Community oncology practices rely on reimbursement certainty when evaluating and adopting innovative precision oncology tools that increasingly support personalized cancer care.

CMS specifically seeks comment on alternatives to contractor pricing, including potential alignment with the proposed OPPS payment approach for these services. The Network believes a nationally consistent payment methodology would better support transparency, predictability, and access than jurisdiction-specific contractor determinations. Payment variation across geographic regions could create uncertainty for clinicians, technology developers, and Medicare beneficiaries seeking access to emerging oncology diagnostic technologies.

If CMS finalizes removal of these services from the CLFS, the Network urges CMS to establish a nationally standardized payment methodology under the PFS rather than rely on contractor pricing. CMS should consider an evidence-based national payment approach, including consideration of the proposed OPPS framework, to promote predictable reimbursement, encourage continued innovation, and support access to precision oncology technologies.

RFI: Duplicate Laboratory Testing, Imaging, and Result Sharing and Interoperability

The Network appreciates CMS's focus on reducing unnecessary duplicate laboratory testing and imaging while improving interoperability across the healthcare system. We agree that incomplete access to diagnostic information can contribute to fragmented care, delayed decision-making, and avoidable repeat testing. Improving the exchange and usability of laboratory and imaging data should remain a priority.

As CMS considers potential payment and program integrity policies related to duplicate testing, it is important to distinguish unnecessary duplicate services from clinically appropriate repeat testing. This distinction is particularly important in oncology, where ongoing laboratory monitoring and diagnostic imaging are integral to patient care.

Patients receiving cancer treatment routinely undergo repeated testing to monitor treatment response, assess toxicity, evaluate disease progression or recurrence, investigate new symptoms, and determine eligibility for ongoing therapy. The fact that a similar test was recently performed does not, by itself, indicate that a subsequent test is unnecessary.

For this reason, The Network urges CMS not to adopt a uniform temporal definition of a "duplicate" laboratory or imaging test. As CMS recognizes in the RFI, there is no single timeframe within which a test should automatically be considered duplicative across all clinical scenarios. In oncology, patients receiving chemotherapy, immunotherapy, targeted therapy, radiation therapy, or treatment for therapy-related complications may require repeat testing within hours, days, or weeks to support safe and effective treatment decisions. Claims data alone cannot adequately capture these clinical circumstances.



A subsequent laboratory or imaging service should not be considered duplicative when it is ordered to evaluate a change in clinical status, monitor treatment response or toxicity, assess disease progression or recurrence, inform a new treatment decision, or obtain clinically necessary information that is not available in a timely and usable form.

The following oncology scenarios illustrate why the same or similar laboratory service may be appropriately repeated within a relatively short period. In each example, the subsequent test addresses a new clinical circumstance or treatment decision and should not be classified as duplicative solely based on claims history or the elapsed time since the prior service.

Vignette 1: Treatment Safety Monitoring

A patient receiving chemotherapy with a bispecific develops acute vomiting, fever, rigors, and acute mental status changes at the end of infusion. Prior to therapy, a AMP was normal and the CBC showed borderline low but adequate counts to receive therapy. The oncologist repeats a complete blood count with differential (CBC with differential) and comprehensive metabolic panel (CMP). The new results show neutropenia and new electrolyte abnormalities, prompting immediate intervention. Although the same tests were recently performed, the repeat testing captures a significant change in clinical status and is essential to preventing potentially serious harm.

Vignette 2: Molecular Testing at Disease Progression

A patient with advanced non-small cell lung cancer initially responds to targeted therapy but later develops disease progression. Repeat tissue next-generation sequencing (NGS) or a plasma circulating tumor DNA (ctDNA) assay is ordered to evaluate an acquired resistance mechanism and other actionable alterations, including EGFR, ALK, ROS1, BRAF, KRAS, MET, RET, and ERBB2 (HER2). The earlier molecular profile guided the original treatment; the repeat test addresses a new clinical question and may directly determine the next therapy.

Vignette 3: Unavailable or Clinically Unusable Prior Results

A patient with metastatic non-small cell lung cancer transfers care and requires a prompt treatment decision, but the prior pathology and molecular reports cannot be obtained in a timely, complete, and clinically usable form. The oncologist orders PD-L1 immunohistochemistry and a tissue NGS panel, or a plasma ctDNA assay when clinically appropriate, to assess EGFR, ALK, ROS1, BRAF, KRAS, MET, RET, and ERBB2 (HER2). Delaying testing could delay treatment, while proceeding without the results could lead to a less-informed therapy choice. A prior claim alone does not provide the clinical information needed to treat the patient.

The Network is also concerned about potential approaches outlined in the RFI that would deny payment, reduce payment, recoup payment, or apply automated edits based solely on the identification of a potentially duplicate test. Such policies risk retrospective second-guessing of clinical decision-making and may create barriers to medically necessary care.

The Network further notes that laboratories already face significant reimbursement pressures under the CLFS. CMS should avoid policies that create additional financial disincentives for furnishing medically necessary diagnostic services.

Efforts to reduce avoidable repeat testing should focus on improving information sharing and interoperability rather than imposing additional payment restrictions that could further strain access to laboratory services.

Similarly, CMS should exercise caution before expanding frequency limitations on laboratory testing or imaging services. While such limitations may be appropriate in narrowly defined circumstances, broad application could inadvertently restrict access to medically necessary services. Any future frequency-based policies should include clear and flexible exceptions that preserve physician discretion and account for individual patient circumstances.

The Network agrees with CMS that interoperability challenges remain a significant contributor to unnecessary repeat testing. Patients with cancer frequently receive care across multiple physicians, hospitals, imaging centers, pathology laboratories, and treatment settings that may not share information seamlessly. When prior diagnostic information cannot be accessed in a timely and usable manner, clinicians may have little practical choice but to repeat testing to make safe treatment decisions.

This issue is particularly important as oncology becomes increasingly dependent upon molecular diagnostics, genomic profiling, biomarker testing, and other precision medicine tools. Improving the availability and usability of these results through interoperable data exchange may offer greater opportunities to reduce unnecessary repeat testing than payment restrictions directed at clinicians who are attempting to make informed treatment decisions with incomplete information.

Accordingly, the most effective and sustainable solution to avoidable repeat testing is not payment denials, recoupments, automated edits, or frequency limitations, but improved interoperability and reliable access to previously generated diagnostic information. When physicians can readily obtain laboratory results, pathology reports, molecular testing data, and diagnostic imaging studies from other care settings, the need for repeat testing naturally declines without creating barriers to medically necessary care.

The Network supports CMS's efforts to promote standardized exchange of laboratory and imaging information through existing interoperability standards, trusted exchange networks, and incentive-based approaches that encourage adoption. Any future requirements should build upon existing national standards and avoid creating duplicative administrative burdens.



Finally, CMS should ensure that any future policies related to duplicate testing are grounded in clear evidence that testing was unnecessary, avoid retrospective second-guessing of clinical decision-making, and appropriately account for the role that incomplete interoperability plays in driving repeat services. Oncology demonstrates why claims-based assessments of duplicate testing must be avoided. What may appear administratively to be a duplicate service is often a medically necessary component of treatment monitoring, disease surveillance, and toxicity management.

The Network therefore encourages CMS to focus primarily on improving interoperability and access to diagnostic information rather than relying on payment restrictions that may inadvertently limit beneficiary access to essential laboratory and imaging services. We appreciate the opportunity to comment and look forward to working with CMS to advance interoperability while preserving timely access to medically necessary care for Medicare beneficiaries.

Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM)

We support CMS's goal of ensuring that Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) services remain clinically integrated, appropriately supervised, and centered on longitudinal practitioner-patient relationships. We recognize and support CMS's efforts to address concerns identified by the Office of Inspector General regarding vendor-driven remote monitoring programs that may lack sufficient practitioner oversight, clinical integration, or accountability.

However, we respectfully encourage CMS to distinguish among three separate functions that are often combined under the broad term "third-party services":

- Third-party technology and operational vendors;
- Independent vendor-operated clinical monitoring programs; and
- Clinically integrated care team partners contracted directly by the practice and operating as an extension of the practice's care team under practitioner supervision.

Technology Enablement Should Remain Permissible

We encourage CMS to clarify that technology partners providing platforms, devices, electronic patient-reported outcome (ePRO) solutions, workflow automation, analytics, interoperability services, documentation support, reporting tools, and operational infrastructure are not furnishing billable clinical RPM or RTM services. These capabilities enable physician-directed care but do not replace the practitioner-patient relationship, clinical decision-making responsibility, or supervision requirements associated with furnishing remote monitoring services.



Preserve Access to Clinically Integrated Contracted Care Teams

We are concerned that a strict "direct employee only" standard may unintentionally limit patient access to clinically appropriate monitoring services, particularly for community-based specialty practices and independent physician practices that may lack the scale required to employ dedicated remote monitoring clinicians.

We recommend that CMS permit practices to contract directly with licensed clinical care team organizations that furnish RPM and RTM support under the supervision of the billing practitioner, provided that such clinicians function as an integrated extension of the practice care team and satisfy all applicable Medicare supervision, documentation, and accountability requirements.

Under this approach:

- The billing practitioner retains responsibility for patient selection, enrollment, care planning, supervision, and clinical oversight.
- The contracted clinicians operate exclusively on behalf of the practice and support practitioner-directed care.
- Clinical activities are documented within the practice's clinical workflow and medical record.
- The contracted care team maintains ongoing communication with the billing practitioner and practice staff.
- The practice remains fully accountable for compliance, medical necessity, quality oversight, and billing requirements.
- The contracted clinical support organization is distinct from and independent of any technology vendor supplying ePRO, RPM, RTM, device, or software infrastructure.

This model preserves the practitioner accountability and care coordination objectives articulated by CMS while allowing practices to access specialized nursing, symptom management, navigation, and monitoring expertise needed to effectively close the loop on patient-reported symptoms, physiologic alerts, treatment adherence concerns, and other clinically actionable findings.

The Network supports CMS's efforts to prevent fragmented, vendor-driven monitoring models that lack practitioner accountability. At the same time, we encourage CMS to distinguish between technology enablement, independent outsourced monitoring programs, and clinically integrated contracted care teams that operate under practitioner supervision. Allowing practices to contract directly with licensed clinical and certified care team partners functioning as an extension of the practice care team would preserve access, maintain accountability, and better support the goals of coordinated, patient-centered remote monitoring.



Initial Visit Requirements for RTM and RPM

The Network recommends that RTM and RPM programs remain reliant on a clinician order rather than requiring an initiating visit to allow ease of patient access to remote monitoring. Remote monitoring orders stemmed from a past OIG review of program utilization and are well warranted. An order allows clinicians to initiate patient access to monitoring without an existing patient needing to travel to a practice and potentially incur additional visit cost.

Scalp cooling (CPT code 97007, 97008, 97009)

The Network appreciates CMS's continued efforts to establish Medicare reimbursement for mechanical scalp cooling services through implementation of CPT® codes 97007, 97008, and 97009. We support CMS's recognition that mechanical scalp cooling is a practice-delivered clinical service that can significantly improve quality of life for patients undergoing chemotherapy by reducing treatment-related alopecia.

In our comments on the 2026 PFS proposed rule, The Network urged CMS to ensure that payment for mechanical scalp cooling appropriately reflect the clinical and operational resources required to furnish these services. We remain concerned that the current valuation of CPT codes 97007, 97008, and 97009 does not adequately account for the staff time, equipment utilization, and operational costs associated with delivering scalp cooling in community oncology practices.

Community oncology practices continue to report that the clinical staff time assumptions underlying the current payment rates do not accurately reflect real-world service delivery. Specifically, practice-reported data that previously submitted to CMS indicate that furnishing mechanical scalp cooling requires substantially greater clinical staff time than is reflected in the current valuation, including approximately 100 minutes for CPT 97007, 50 minutes for CPT97008, and 20 minutes for CPT 97009. These services require patient education, treatment preparation, equipment setup and monitoring, patient assessment, and ongoing clinical oversight throughout the treatment process.

Because CPT codes 97007, 97008, and 97009 do not include physician work RVUs and are valued primarily through practice expense inputs, accurate recognition of clinical labor, equipment, and operational costs is particularly important. If the underlying practice expense assumptions do not reflect actual resource utilization, payment will not adequately support delivery of these services.

These reimbursement challenges have important implications for patient access. Inadequate payment may make it difficult for practices to furnish scalp cooling through routine reimbursement pathways, limiting availability despite increasing patient demand and clinical adoption. Such outcomes would be inconsistent with CMS's goals of supporting patient-centered cancer care and improving access to supportive oncology services.



Accordingly, The Network urges CMS to re-evaluate the valuation of CPT codes 97007, 97008, and 97009 to ensure that Medicare payment appropriately reflects the true resources required to furnish mechanical scalp cooling services. A reassessment should incorporate real-world utilization data and operational experience from clinicians currently furnishing mechanical scalp cooling services. An accurate valuation will help preserve patient access, support broader adoption of this important supportive care intervention, and ensure that beneficiaries can continue to receive these services in community oncology settings where most cancer care is delivered.

Current Procedural Terminology (CPT) Request for Information

The Network appreciates CMS's interest in evaluating the coding and valuation systems that support Medicare physician payment. While the RFI raises important questions regarding CPT governance, valuation methodology, transparency, and alternative coding approaches, we believe it is important to distinguish between the CPT coding system itself and the processes used to establish Medicare payment rates. Many of the concerns identified in the RFI relate primarily to valuation methodology rather than coding nomenclature.

CPT Remains the Appropriate Coding Standard

The Network does not believe CMS should replace CPT as the national coding standard for physician services. CPT is deeply integrated throughout the healthcare system and serves as the common language used by physicians, payers, electronic health records, quality reporting programs, researchers, and public health agencies.

While CMS appropriately seeks input on potential alternatives, including ICD-10-PCS and other classification systems, we have not seen evidence that replacing CPT would meaningfully improve payment accuracy, transparency, or patient outcomes. Such a change would create significant operational disruption while leaving many of the same valuation and payment policy questions unresolved.

CPT Is Distinct from Medical Necessity

CMS asks whether CPT code creation is linked to medical necessity. In our view, CPT functions primarily as a clinical nomenclature and reporting framework. The existence of a code does not establish medical necessity, coverage, or clinical appropriateness. Those determinations are made through separate Medicare coverage, payment, and clinical review processes.

Accordingly, concerns regarding utilization or coverage should not be viewed as deficiencies in the CPT coding structure itself.

Opportunities to Improve Valuation

The Network agrees that CMS should continue evaluating opportunities to strengthen valuation governance and improve transparency.

We support efforts to supplement existing valuation recommendations with additional objective data sources, including claims analyses, practice cost surveys that are comprehensive and include data and cyber security costs, electronic health record workflow data, clinical registries, and independent validation of selected recommendations.

Broader stakeholder participation and increased transparency may further strengthen confidence in the valuation process while preserving the benefits of a stable coding framework.

Recognizing Longitudinal and Preventive Care

CMS also asks whether current coding and valuation structures adequately support prevention and long-term care management. The Network agrees that Medicare payment policy should continue evolving to recognize services such as care coordination, symptom management, patient education, navigation, survivorship care, and other longitudinal care activities that are increasingly important in oncology and other specialties.

However, this challenge is fundamentally one of valuation and payment policy rather than CPT nomenclature. CMS can better support these services through targeted valuation reforms without replacing the underlying coding system.

Future focus on valuation governance, transparency, and payment methodology

The Network believes the central issues raised in this RFI are questions of valuation governance, transparency, and payment methodology rather than shortcomings of the CPT coding framework itself. We support efforts to strengthen the valuation process and ensure that preventive, cognitive, and longitudinal care services receive appropriate recognition. However, we have not seen evidence that replacing CPT, adopting ICD-10-PCS for physician services, or implementing facility-style grouping methodologies would address the concerns identified by CMS. Instead, CMS should pursue targeted improvements to valuation processes while preserving the stability, consistency, and interoperability that CPT provides throughout the healthcare system.

Quality Payment Program (QPP): Merit based Incentive Payment System (MIPS)/MIPS Value Pathways (MVPs)

Full Transition to MVPs and Sunset of Traditional MIPS

CMS proposes to phase out traditional MIPS reporting for MIPS eligible clinicians not participating in the APP beginning with the CY 2029 performance period/2031 MIPS payment year, leaving MVPs and the APP as the two remaining reporting options.

The Network opposes the proposed CY 2029 sunset of traditional MIPS. The current MVP catalog does not adequately cover oncology and hematology subspecialties, including hematologic malignancies, rare and subspecialized solid tumors, radiation and surgical oncology, and pediatric and adolescent/young adult oncology. Large, multi-site oncology networks also continue to face subgroup reporting limits across disparate technology platforms, creating risk that practices are penalized for health IT constraints rather than care quality.

The Network urges CMS to suspend the CY 2029 sunset date until objective readiness benchmarks are met, including full subspecialty coverage, mature EHR capability for automated subgroup data aggregation, a QCDR-to-MVP innovation pathway, and transparent measure mapping developed with specialty societies.

Measure Inventory Contraction vs. Specialty Coverage

The Network is concerned that CMS is moving in two directions at once: sunsetting traditional MIPS on the premise that MVPs are more clinically meaningful, while narrowing the inventory MVPs draw from.

Removals such as Measure 143 widen a gap that already leaves 35 to 45 percent of the oncology and hematology workforce without condition-specific measures. The Network recommends that CMS add subspecialty measures before removing existing ones, report annually on coverage by specialty, and confirm that no MVP becomes mandatory while a material share of its clinicians lack applicable measures.

Transparency in Measure Evaluation and MVP Composition

CMS has not published the criteria used to evaluate measure relevance, determine MVP composition, or designate MIPS Core Measures, nor any target number of measures and improvement activities per MVP. The Network recommends that CMS publish the evaluation framework and inclusion criteria, disclose those targets and their basis, identify the clinical experts and specialty measure stewards involved, and provide a formal public comment opportunity on MVP composition before measure sets carry scoring consequences.

Advancing Cancer Care MVP: Retention of Measure 143 and Core Designation of Measure 144

CMS proposes to remove Q143, Oncology: Medical and Radiation - Pain Intensity Quantified, from the MIPS quality measure inventory on the basis that the measure has reached the end of the topped-out lifecycle, while retaining and proposing core designation for Q144, Oncology: Medical and Radiation - Plan of Care for Pain.

The Network recommends that CMS retain Q143 alongside Q144 until a patient-reported outcome performance measure for pain has been fully developed, validated through the Measures Under Consideration process, and is ready for implementation. The two measures operate as a paired clinical workflow: clinicians must first quantify pain intensity to identify the patients who require a documented plan of care. Removing Q143 leaves that workflow unchanged while eliminating reporting credit for the assessment step.



The Network adds three considerations from network experience.

- First, Q143 is currently included in the Enhancing Oncology Model quality measure set and contributes to the Aggregate Quality Score used to determine performance-based payment adjustments, so its removal from MIPS has consequences beyond the MIPS program itself.
- Second, removal reduces the number of quality measures available within the Advancing Cancer Care MVP at the same time CMS is narrowing measure choice, which creates additional difficulty for MVP participation and measure selection; if CMS retains Q143, we recommend that it also be designated a MIPS core measure, consistent with the proposal for Q144.
- Third, The Network encourages CMS to evaluate the inclusion of PIMSH4: Patient-Reported Pain Improvement Within 30 Days in a future version of the Advancing Cancer Care MVP. As a patient-reported outcome measure, PIMSH4 directly assesses whether patients experience meaningful improvement in cancer-related pain following clinical intervention. Inclusion of a validated oncology-specific PRO measure would strengthen the MVP's patient-centered focus, complement existing process measures, and align with CMS's continued movement toward outcome-based quality assessment.

Antiemetic QCDR Measures (PIMSH19 and PIMSH20)

The Network recommends that CMS finalize PIMSH19, Antiemetic Therapy for Low- and Minimal-Emetic-Risk Antineoplastic Agents - Avoidance of Overuse, and PIMSH20, Appropriate Antiemetic Therapy for High- and Moderate-Emetic-Risk Antineoplastic Agents, for addition to the Advancing Cancer Care MVP. Management of chemotherapy-induced nausea and vomiting is central to patient safety, symptom control, and treatment adherence.

MIPS Core Measure Designation, Small Practices, and Core Measure Scoring

The Network is concerned that a mandatory core measure requirement will be adopted without transparent selection criteria, and questions the designation itself: measures selected for an MVP should already be the specialty's most clinically relevant, high-value indicators, which makes a separate classification largely redundant. The Network recommends that CMS refine MVP measure sets and publish clear clinical, scientific, and operational selection criteria rather than create a core designation. If CMS proceeds, it should publish the criteria for core status, take public comments on each core set before scoring consequences attach, recognize specialty stewards and QCDRs in identifying core measures, and let practices without an applicable core measure report an alternative high-value specialty measure without penalty.

The small practice exemption does not address insufficient case volume. Many oncology measures apply only to narrow populations defined by tumor type, biomarker status, stage, or line of therapy, so small and subspecialized practices often cannot reach benchmarked scores.



CMS should expand MVP measure inventories and confirm the exemption does not disadvantage those practices in scoring or feedback. The Network also opposes the proposed zero-point penalty for failing to report a core measure or complete a non-applicability attestation, which emphasizes reporting compliance over care quality.

Topped-Out Measure Benchmarks

The Network supports applying the defined topped-out benchmark to Q144 MIPS CQM for the CY 2027 performance period/2029 payment year, which removes an arbitrary point cap on a measure medical oncologists rely on, and supports scoring MIPS core measures in their second or later consecutive topped-out year from one to ten achievement points rather than under the seven-point cap; capping a required measure penalizes compliance.

Sustained high performance on MIPS 143 and 144 also signals that oncology may be ready for more advanced measures, such as PIMSH4 (Pain Improvement), that assess whether interventions produce meaningful improvement rather than whether a process was completed.

Measure 134: Preventative Care and Screening: Screening for Depression and Follow-Up Plan

The Network is concerned that differences between the eCQM and CQM numerator criteria for Measure 134 create confusion for clinicians, practices, and reporting entities. The eCQM allows an active depression medication or an active depression management intervention to satisfy the follow-up requirement, while the CQM accepts only documentation of a follow-up plan. As a result, comparable patient care activities are treated differently depending on the collection type selected.

Patients who screen positive for depression are frequently already engaged in treatment through pharmacologic therapy, psychotherapy, behavioral health services, or other interventions. Requiring a separately documented follow-up plan in these circumstances does not accurately reflect the care being delivered and adds documentation burden without improving outcomes. Differences in measure logic across collection types also produce variation in reported performance that reflects documentation requirements rather than differences in the quality of care. The Network recommends that CMS align the eCQM and CQM numerator criteria by allowing documented active depression medication or an active depression management intervention to satisfy the numerator in addition to a documented follow-up plan.

The Network is also concerned that the MIPS CQM specification requires depression screening to be documented by the individual clinician reporting the measure, even when a valid screening has already been completed elsewhere in the practice during the same patient encounter.



As a result, patients seen by multiple clinicians on the same day may be subjected to repetitive screening solely to satisfy documentation requirements. In contrast, the eCQM permits use of information contained within the medical record and recognizes screenings previously completed for the patient, regardless of which clinician documented the assessment. This distinction shifts the focus of the measure from evaluating whether appropriate patient care occurred to evaluating whether duplicate documentation was generated. Alignment across collection types would reduce reporting complexity, improve consistency, and better reflect legitimate clinical pathways for managing patients with depression.

Measure 457: Treatment of the Revised Measure for PY 2027

While The Network supports efforts to encourage timely hospice enrollment and improve end-of-life care, we are concerned that the proposed revisions to Measure 457 are substantial enough to limit comparability with historical performance. The proposal changes the measure name, the measure type, the denominator specifications, the denominator exceptions, and the measure directionality; the measure would no longer be an inverse measure. Collectively these changes alter how performance is interpreted, scored, benchmarked, and communicated to clinicians.

Practices have built workflows, educational materials, dashboards, and quality improvement initiatives around the current specifications and will require meaningful transition planning. Year-over-year trend analysis will also be affected, making it difficult to determine whether a change in performance reflects actual improvement or a change in measure design.

The Network recommends that CMS treat Measure 457 as a new measure for Performance Year 2027 and apply the corresponding new measure policies for benchmarking and scoring, recognizing the limited availability of historical performance data under the revised specifications.

QCDR and Qualified Registry Performance Feedback and DVER Timing

CMS proposes to require QCDRs and qualified registries to provide feedback at the level at which data was or will be submitted. Practices use feedback throughout the year to compare reporting strategies, and those decisions evolve with subgroup formation, APM participation, QP status, and organizational change - often unresolved early in the year because QP snapshots are unavailable. Registries neither make nor are always told of the eventual submission decision, so the requirement would hold them responsible for a determination outside their control. The Network recommends that CMS continue to allow group-level feedback or, in the alternative, confirm that a registry satisfies the requirement by providing feedback at the level the participant identified when the feedback was generated.

The same applies to Data Validation Execution Report (DVER) timing. Registries often do not know the eventual participation pathway at the time of audit, and the underlying clinical data is identical whether the participant reports as an individual, group, subgroup, or APM Entity. The Network recommends that CMS allow DVER audits based on anticipated participation at execution and clarify that registries are not responsible for later reporting strategy changes.



Application of QP and Partial QP Determination at the TIN/NPI Level

CMS proposes to apply QP and Partial QP determinations at the TIN/NPI level rather than the NPI level. The Network appreciates the goal but opposes implementation for CY 2027: clinicians furnishing services under multiple TINs or changing organizations mid-year could attain QP status under one TIN/NPI combination and not another, creating uncertainty about MIPS obligations, reporting requirements, and Advanced APM eligibility.

The Network recommends maintaining the current methodology for Performance Year 2027 and delaying implementation by at least one year. If CMS proceeds, PY 2027 should serve as a transparency and education year in which clinicians receive both their official determination under the current APM entity methodology and informational TIN/NPI-level percentages, so practices can assess the operational impact and build provider-level tracking before eligibility, incentives, or reporting obligations are affected.

QPP: Advanced APMs

QP and Partial QP Thresholds for the CY 2027 Performance Period

The Network recommends that CMS apply the lower restored threshold percentages to the CY 2027 performance period rather than carrying forward the elevated levels. The higher thresholds were established when a lump sum APM Incentive Payment was available; that payment is no longer available, so clinicians who meet them now receive only the higher qualifying APM conversion factor, a materially smaller benefit.

Elevated thresholds make QP status substantially harder to attain while reducing what attainment is worth, a meaningful disincentive for community oncology practices weighing Advanced APM participation. Relatedly, The Network recommends that CMS explore exempting clinicians participating in an Advanced APM Entity from MIPS reporting for the current performance year based on prior-year QP status, rather than same year QP determinations that force practices to maintain parallel MIPS performance and reporting readiness as a contingency in case QP is not achieved during the performance year.

Transition to Digital Quality Measures (dQMs/eQMs)

We appreciate CMS's continued efforts to advance interoperability and modernize quality measurement through the transition to digital quality measures and FHIR-based reporting. We support the long-term goal of reducing burden through greater automation, standardized data exchange, and more timely access to quality information.

However, we are concerned that the proposed pace of transition may outpace the current maturity of the underlying standards needed to support complex specialty care measurements. While standardized data elements and code sets may exist for many primary care and preventive services, significant gaps remain for specialty measures, including oncology measures that rely on nuanced clinical decision-making, detailed treatment information, longitudinal care processes, and patient-centered outcomes.



Many clinically meaningful specialty measures currently depend on data elements that are not consistently captured in structured formats across certified health IT products. In addition, there are not yet universally adopted specialty-specific value sets, terminologies, or implementation standards that allow complex measures to be calculated reliably and consistently across organizations. As a result, an accelerated transition to mandatory digital reporting could unintentionally reduce measure validity, limit available specialty measures, and create barriers to accurately representing quality performance.

We encourage CMS to take a measured approach and establish objective readiness criteria before requiring widespread adoption of digital quality measures. Specifically, CMS should:

- Ensure core clinical data standards, value sets, and implementation guidance are sufficiently mature for specialty care workflows before requiring digital reporting.
- Collaborate with specialty societies, measure stewards, EHR vendors, QCDRs, and registries to identify gaps in standardized data capture and coding.
- Pilot and validate specialty-focused digital measures across diverse practice settings before implementation in accountability programs.
- Maintain flexible reporting pathways, including QCDRs and other specialty-specific reporting mechanisms, until equivalent digital measures are available and proven reliable.

Without these foundational standards, there is a risk that the transition to digital measurement could prioritize what is easily captured electronically rather than what is most clinically meaningful to patient care. CMS should ensure the infrastructure required to support specialty measurement is in place before establishing mandatory digital reporting requirements.

Conclusion

On behalf of The US Oncology Network, thank you for the opportunity to provide comments on 2027 PFS proposed rule. We welcome the opportunity to discuss the issues outlined above and any other critical issues impacting community cancer care with you and your staff. Should you have any questions, please contact Ben Jones, SVP, Government Relations at Ben.Jones@usoncology.com.

Sincerely,

Les Busby, MD
Chief Medical Officer
The US Oncology Network

Appendix: Detailed Quality Payment Program (QPP) and Remote Monitoring Considerations for CMS

This appendix expands on the comments above and sets out, topic by topic, the specific factors The Network asks CMS to weigh, the criteria we believe should govern each policy, and the questions that remain unanswered in the proposed rule. It is intended to give CMS the operational detail behind our recommendations rather than to introduce new positions.

A. Readiness Criteria for Any Future Sunset of Traditional MIPS

The Network's opposition to the CY 2029 sunset is not an objection to MVPs as a reporting model. It is an objection to setting a date before the conditions that make MVP reporting viable for oncology have been met. We ask CMS to replace a fixed sunset date with published, measurable readiness gates, assessed annually and reported publicly, so that the transition is driven by demonstrated capability rather than by calendar. We recommend that CMS define and report against the following:

- Subspecialty coverage. The share of clinicians in each specialty who have a sufficient number of applicable, scoreable measures within their MVP - reported by subspecialty, including hematologic malignancies, rare and subspecialized solid tumors, radiation oncology, surgical oncology, and pediatric and adolescent/young adult oncology - together with the threshold CMS considers adequate and the year each subspecialty is projected to reach it.
- Subgroup data capability. Evidence that certified health IT can reliably aggregate and segment performance data at the subgroup level across the disparate platforms that large, multi-site networks operate, so that subgroup reporting reflects care quality rather than the maturity of a practice's technology stack.
- A QCDR-to-MVP innovation pathway. A defined route by which a QCDR measure that has been field-tested and shown to perform can enter an MVP inventory, so that specialty measurement continues to develop during and after the transition rather than freezing at the current inventory.
- A published measure mapping process. A transparent, collaborative crosswalk developed with specialty societies showing, for each traditional MIPS measure a specialty relies on, where that measure lands in the MVP structure or why it does not carry forward.

The Network also asks CMS to state explicitly what happens to a clinician who, at the point of sunset, has no MVP that fits their practice. Absent an answer, the proposal transfers the risk of an incomplete inventory from CMS to the clinician. A commitment that no MVP becomes mandatory for a specialty while a material share of its clinicians lack applicable measures would resolve much of our concern with the timeline itself.



B. Measure Inventory Contraction and Specialty Coverage

The proposed rule narrows the measure inventory at the same time it proposes to make a narrower reporting model mandatory. The Network asks CMS to consider that the oncology inventory is not oversupplied. Subspecialties are underserved because relevant measures were never developed, not because too many exist, and removal policies calibrated to a large, general inventory produce a different result when applied to a small specialty one.

We ask CMS to consider adopting a net-coverage test before finalizing any removal: before a measure is retired from a specialty inventory, CMS would confirm that the affected specialty retains a sufficient number of applicable, scoreable measures afterward, and would publish that determination alongside the removal. Where the test fails, the removal would be deferred until a replacement is available. We further ask CMS to publish an annual specialty coverage report and to sequence additions ahead of removals, so that inventory growth and contraction are visible to the practices that must plan around them.

CMS should also weigh what the topped-out designation actually signals in a specialty context. A topped-out measure reflects a care process clinicians have standardized. Treating high performance as grounds for removal, without a successor measure in place, retires the measurement while leaving the clinical workflow and its documentation burden intact.

C. Transparency in Measure Evaluation and MVP Composition

Practices are being asked to build multi-year reporting strategies around measure sets whose basis has not been disclosed. The proposed rule identifies which measures are added, removed, or designated as core, but not how those determinations were made, who participated, or what evidence was considered. The Network asks CMS to publish the following in advance of the year in which measure sets carry scoring consequences:

- The evaluation framework and inclusion criteria used to select measures for an MVP and to designate MIPS Core Measures, including how clinical relevance, validity, reliability, and specialty endorsement are weighed against one another.
- Whether CMS has set a target number of quality measures and improvement activities for each MVP, what that target is, and the basis on which it was determined.
- The clinical experts, specialty measure stewards, and organizations who participated in each determination, so that specialty societies can identify where their input was sought and where it was not.
- A formal public comment opportunity on MVP composition itself, distinct from comment on the rule, before a measure set is used for scoring.

Publishing this information would let practices, clinicians, and specialty societies plan with confidence and would strengthen, rather than delay, the transition CMS has proposed.

D. Measures 143 and 144: Paired Workflow, Cross-Program Effects, and a PRO Successor

The Network asks CMS to weigh four considerations before finalizing removal of Q143, Oncology: Medical and Radiation - Pain Intensity Quantified.

- The measures are a single workflow, not two independent processes. Clinicians must quantify pain intensity in order to identify the patients who require a documented plan of care. Removing Q143 does not remove the assessment step from practice; it removes reporting credit for it while Q144 continues to depend on it. CMS should consider whether retiring the upstream half of a paired workflow produces any reduction in burden at all, or simply reduces what is measured.
- The effect extends beyond MIPS. Q143 is included in the Enhancing Oncology Model (EOM) quality measure set and contributes to the Aggregate Quality Score used to determine performance-based payment adjustments. CMS should consider how removal from the MIPS inventory interacts with EOM scoring, and confirm what happens to EOM participants who have built collection and reporting around the measure.
- Removal compounds inventory contraction in the Advancing Cancer Care MVP. Practices are being asked to select from a smaller set at the moment measure choice is narrowing. If CMS retains Q143, The Network recommends it also be designated a MIPS core measure, consistent with the proposal for Q144, so that both halves of the workflow are treated alike.
- A patient-reported outcome successor should be developed before, not after, retirement. The Network encourages CMS to evaluate PIMSH4: Patient-Reported Pain Improvement Within 30 Days for a future version of the Advancing Cancer Care MVP. PIMSH4 assesses whether patients experience meaningful improvement in cancer-related pain following intervention, providing insight into outcomes that matter most to patients. Sequencing the PRO measure ahead of the removal would let CMS advance outcome-based measurement without a gap in which neither the process nor the outcome is measured.

More broadly, The Network asks CMS to treat topped-out status as a signal of readiness for more advanced measurement rather than as a trigger for removal. Measures such as MIPS 143 and 144 have been part of federal quality reporting since the PQRS and Meaningful Use era and represent widely accepted standards of oncology practice. Where a specialty has standardized a process, the productive response is to introduce a measure that evaluates whether the intervention improved the patient's condition, not to leave the specialty with fewer measures than it started with.

E. Measure 134: Alignment Across Collection Types

Two distinct problems in Measure 134 produce the same result: performance that reflects documentation rules rather than the care delivered. CMS should consider both. Measure 134 involves screening for depression and providing a follow-up plan when warranted.



First, the numerator criteria diverge. The eCQM allows an active depression medication or an active depression management intervention to satisfy the follow-up requirement; the CQM accepts only documentation of a follow-up plan. Patients who screen positive are frequently already engaged in treatment through pharmacologic therapy, psychotherapy, or behavioral health services, and requiring a separately documented plan in those circumstances adds documentation without changing care. CMS should align the CQM numerator with the eCQM by accepting an active medication or active management intervention in addition to a documented follow-up plan.

Second, the CQM attributes screening to the individual clinician reporting the measure, even when a valid screening was completed elsewhere in the practice during the same encounter. Patients seen by multiple clinicians on the same day may therefore be screened repeatedly to satisfy documentation rules. The eCQM, by contrast, permits use of information in the medical record regardless of which clinician documented the assessment. CMS should consider that the CQM specification, as written, can penalize the coordinated, team-based care the program otherwise seeks to encourage, and should permit recognition of a valid screening completed elsewhere in the practice during the same encounter.

Alignment across collection types would reduce reporting complexity, make performance comparable regardless of the pathway a practice selects, and remove an incentive for redundant screening that burdens patients without improving outcomes.

F. Measure 457: Why New-Measure Treatment Is Warranted

The Network supports the clinical intent behind the revisions. Our concern is comparability. The proposal changes the measure name, the measure type, the denominator specifications, the denominator exceptions, and the measure directionality - the measure would no longer be an inverse measure. A revision of that scope does not adjust an existing measure so much as replace it, and benchmarking the revised measure against historical performance would compare results generated under materially different specifications.

The practical consequences fall in three places. Practices have built workflows, educational materials, dashboards, and quality improvement initiatives around the current specifications and will need lead time to rebuild them. Year-over-year trend analysis will be unreliable, making it difficult for a practice - or for CMS - to distinguish real improvement from an artifact of measure design. And clinicians receiving feedback on a directionally reversed measure may reasonably misread their own performance during the first year.

USON recommends that CMS treat Measure 457 as a new measure for Performance Year 2027 and apply the corresponding new measure policies for benchmarking and scoring, recognizing the limited availability of historical performance data under the revised specifications. We further ask CMS to state clearly in guidance that the revised measure is not comparable to prior-year results, so that practices and the public interpret any change in performance correctly.

G. MIPS Core Measure Designation, Scoring, and Small Practices

The Network's central question for CMS is what the core designation adds. If MVP measure sets are intended to represent the most clinically relevant, evidence-based, high-value indicators within a specialty, then a second classification layered on top of them is redundant. If they are not, the more productive fix is to improve MVP measure selection rather than to designate a subset as mandatory. The Network asks CMS to explain what problem the designation solves that better measure selection would not.

There is also limited evidence that requiring participation in or reporting of a particular measure independently drives improvement in patient outcomes or population health. Quality programs are most effective when measures are clinically relevant, actionable, and aligned with genuine improvement opportunity, not when compliance with a specific reporting requirement is mandated. The Network therefore recommends that CMS prioritize refinement of MVP measure sets and publish clear clinical, scientific, and operational selection criteria rather than implement a separate core measure designation.

If CMS proceeds with the designation notwithstanding these comments, we ask that it be implemented with the following safeguards:

- Published criteria. The clinical, operational, and statistical criteria used to assign core status, released before the designation carries scoring consequences.
- Specialty input. Formal public comment on the core measure set for each specialty and MVP, with an explicit role for specialty stewards and QCDRs in identifying which measures warrant core designation.
- A workable alternative. A practice with no applicable core measure should be able to attest and report an alternative high-value specialty measure without a scoring penalty, and the attestation process should be simple enough that it does not become its own compliance exercise.
- An educational first year. Informational feedback for CY 2027 without scoring consequences, and in any event at least a one-year grace period with clear guidance on measure applicability, attestation requirements, and audit processes before penalties apply.

On scoring specifically, The Network does not support the zero-point penalty for failure to report a core measure or complete a non-applicability attestation. The penalty places disproportionate weight on compliance with a reporting requirement rather than on the quality of care delivered, and a missed submission may result from operational, technical, or workflow issues that have no bearing on patient care. A scoring methodology that can zero out a category for a procedural omission does not distinguish a practice delivering poor care from one that filed incorrectly.



The proposed small practice exemption is welcome but addresses eligibility rather than the underlying constraint. Many oncology measures apply only to narrow populations defined by tumor type, biomarker status, disease stage, or line of therapy, and small or subspecialized practices frequently lack the eligible cases to reach a benchmarked score - which effectively reduces the number of usable measures below the number nominally available. The constraint is amplified within MVPs, where inventories are intentionally narrower. The Network asks CMS to consider case-volume realities when setting MVP inventory size, to confirm that the exemption does not disadvantage small practices in scoring or performance feedback, and to continue technical assistance and educational resources supporting their transition.

H. Topped-Out Benchmarks and Measure Evolution

The Network supports applying the defined topped-out benchmark to Q144 MIPS CQM for the CY 2027 performance period and 2029 MIPS payment year, and supports scoring MIPS core measures in their second or later consecutive topped-out year from one to ten achievement points rather than under the seven-point cap. The principle underlying both is straightforward: a clinician required to report a measure should not be capped for reporting it. Applying a point cap to a mandatory measure penalizes compliance and produces a score that reflects the measure's maturity rather than the practice's performance.

Beyond scoring mechanics, The Network asks CMS to develop an explicit policy on measure evolution. When a measure demonstrates sustained high performance across a specialty, CMS should evaluate whether it has achieved its intended purpose and whether a more advanced measure could better drive continued improvement - and should do that evaluation before removal is proposed, with the specialty and the measure steward at the table. In oncology, PIMSH4 (Pain Improvement) illustrates the progression: it evaluates change in patient-reported pain outcomes over time rather than whether pain was assessed or documented. Treating topped-out status as a prompt for advancement rather than retirement would align the removal policy with the patient-centered direction of MVPs.

I. MVP Scoring Methodology

MVPs vary widely in measure composition, benchmark difficulty, and the number of available measures, so any normalization across MVPs risks producing comparisons that are not clinically meaningful - a particular concern for oncology practices caring for high-acuity patients with significant social risk, where measured performance is influenced by factors risk adjustment does not fully capture. The Network asks CMS to orient MVP scoring toward intra-specialty, longitudinal improvement rather than cross-MVP ranking, and to give practices the tools to understand and anticipate their scores:

- Plain-language methodology guides describing the formulas, weighting, and benchmark adjustments actually used.
- An interactive scoring calculator practices can use to model measure selection before the performance year begins.



- A penalty-free shadow reporting year before any new scoring methodology takes effect, so that practices and CMS can observe the methodology's behavior on real data before it determines payment.

On extreme and uncontrollable circumstances, The Network supports using the most current and reliable data available through a dual-source approach rather than replacing PECOS outright, and supports extending the deadline for clinicians to request reweighting of the quality, improvement activities, and Promoting Interoperability categories when a third party intermediary does not submit data on their behalf. A clinician should not lose reweighting relief because of a submission failure outside their control.

J. Third Party Intermediaries: Performance Feedback and Validation

The proposal at 414.1400(b)(3)(iii) would require QCDRs and qualified registries to provide performance feedback at the level at which data was or will be submitted. The Network shares the goal of meaningful, actionable feedback but asks CMS to consider how reporting decisions are actually made during a performance year.

Practices use QCDR feedback throughout the year precisely because they have not yet decided. Reporting strategy evolves with organizational structure, subgroup formation, Alternative Payment Model participation, changes in QP status, and mergers and acquisitions. In the first and second quarters especially, many practices cannot determine a final strategy because information such as QP snapshots is not yet available. Feedback delivered in a projected reporting format during that window is less useful, not more, because it forecloses the comparison the practice is trying to make.

Registries also do not control the determination. They are not the parties that decide whether a clinician or practice submits as an individual, group, virtual group, subgroup, or APM entity, and they are not always informed of that decision when feedback is generated. A requirement to align feedback with an eventual submission pathway assigns the registry responsibility for a fact outside its knowledge. The Network recommends that CMS maintain the current approach and continue to allow feedback at the group level, or in the alternative confirm that a registry satisfies the requirement when it provides feedback at the reporting level the participant identified at the time the feedback was generated, and that registries are not held responsible for later changes not communicated to them.

The same reasoning applies to Data Validation Execution Report timing. At the time a DVER is completed, registries often do not know how a clinician or practice will ultimately participate: final decisions may turn on MIPS eligibility determinations, QP status, Partial QP elections, subgroup formation, organizational changes, and performance analyses that occur well after audits are conducted, and practices may not decide until shortly before the submission deadline.

More fundamentally, the clinical data being audited is the same regardless of submission type. Quality measures, Promoting Interoperability data, and Improvement Activities documentation derive from the same source records and supporting evidence whether the participant reports as an individual, group, subgroup, or APM Entity. Auditing a specific submission type does not improve the accuracy of audit findings or provide additional assurance about the validity of the underlying data. What it does produce is additional sampling, duplicate audit activity, and revision of completed validation work when a participant changes strategy, which is burden and cost without a corresponding program integrity benefit. The Network recommends that CMS allow DVER audits and related validation to be conducted based on anticipated participation at the time of audit execution, and clarify that registries are not responsible for subsequent reporting strategy changes made by clinicians or practices.

K. Advanced APMs: TIN/NPI Determinations, Thresholds, and Dual Reporting

On TIN/NPI-level QP determinations, The Network asks CMS to consider the operational picture in a multi-site network. Many clinicians furnish services under multiple TINs or move between organizations during a performance year. Under the proposed methodology a clinician could attain QP status under one TIN/NPI combination and fail under another, leaving the practice uncertain about that clinician's MIPS participation requirements, reporting obligations, and eligibility for Advanced APM incentives. Practices rely on timely, predictable QP determinations for operational planning, clinician education, and financial forecasting, and the change would require substantially more provider-level tracking than organizations have built.

The Network recommends maintaining the current methodology for Performance Year 2027 and delaying TIN/NPI-level determinations by at least one year. If CMS determines it must proceed, we urge a one-year transparency and education period rather than immediate application for eligibility purposes: during that year CMS would provide each clinician and organization with both the official QP or Partial QP determination under the current APM entity methodology and informational TIN/NPI-level percentages showing how the clinician would have performed under the proposed approach. Side-by-side results for a single year would let practices, APM entities, and CMS evaluate the operational impact before the methodology determines eligibility, incentives, or reporting obligations, and would give organizations time to build the tracking the change requires. At the close of that year CMS could assess results, solicit stakeholder feedback grounded in actual data, and decide whether the change should take effect in a later performance year.

On thresholds, The Network asks CMS to weigh the incentive structure as it now stands. The elevated thresholds were established when a lump sum APM Incentive Payment was available to clinicians who attained QP status. That payment is no longer available, so a clinician who meets the threshold now receives only the higher qualifying APM conversion factor, a materially smaller benefit than the structure the elevated thresholds were designed to accompany. Maintaining elevated thresholds without the lump sum makes QP and Partial QP status harder to attain while reducing what attainment is worth. Applying the lower restored thresholds to CY 2027 would keep Advanced APM participation attainable and better reflect the incentives currently available under the statute.

The Network also asks CMS to consider a structural fix to dual reporting. Because final QP and Partial QP determinations are not known until late in the performance year, practices participating in Advanced APMs must simultaneously fund Advanced APM requirements and contingency MIPS reporting, maintaining parallel infrastructures despite a demonstrated commitment to value-based care. Prior-year participation in an Advanced APM is a reasonable and predictable indicator of continued engagement, and CMS could use it as the basis for a prospective MIPS exemption for the following performance year. For practices in models such as the Enhancing Oncology Model, the relief would support greater investment in patient navigation, symptom management, and care coordination rather than in duplicative reporting.

L. Digital Quality Measures and FHIR: Readiness Detail

The Network supports the destination. Automation, standardized data exchange, and more timely access to quality information would reduce burden and improve the usefulness of measurement. Our concern is sequencing: the pace of the proposed transition may outpace the maturity of the standards that specialty measurement depends on, and a mandate that arrives before the infrastructure does will degrade the measures rather than modernize them.

The specific gaps CMS should assess before setting a mandatory date are these. Standardized data elements and code sets exist for many primary care and preventive services, but oncology measures rely on nuanced clinical decision-making, detailed treatment information, longitudinal care processes, and patient-reported outcomes that are not consistently captured in structured formats across certified health IT products. There are not yet universally adopted specialty-specific value sets, terminologies, or implementation standards that allow complex measures to be calculated reliably and consistently across organizations. Where those elements are missing, a digital calculation does not produce a more accurate result than the current one; it produces a different result whose variation reflects data capture rather than care.

The Network asks CMS to publish objective readiness criteria and to report against them annually before requiring widespread adoption. At minimum, those criteria should address:

- Standards maturity by specialty. Whether core clinical data standards, value sets, and implementation guidance are sufficiently developed for specialty care workflows, assessed specialty by specialty rather than in aggregate.
- Structured capture in certified health IT. Whether the data elements a specialty's measures depend on are actually captured in structured form in the products that specialty uses, as distinct from being theoretically expressible in the standard.
- Calculation consistency across organizations. Evidence from testing that the same measure, calculated from the same patient population by different organizations and vendors, yields the same result.
- Availability of digital equivalents. Confirmation that a digital equivalent exists and performs reliably for each specialty measure before the non-digital pathway is withdrawn, so that the transition does not reduce the number of measures a specialty can report.



Alongside those criteria, CMS should collaborate with specialty societies, measure stewards, EHR vendors, QCDRs, and registries to identify gaps in standardized data capture and coding; pilot and validate specialty-focused digital measures across diverse practice settings before they are used in accountability programs; and maintain flexible reporting pathways, including QCDRs and other specialty-specific mechanisms, until equivalent digital measures are available and proven reliable. Without these foundations, digital measurement risks prioritizing what is easily captured electronically over what is most clinically meaningful to patient care.

M. RPM and RTM: Distinguishing Technology, Outsourced Monitoring, and Integrated Care Teams

The comments in the body of this letter set out The Network's position in full. This appendix adds only the distinction we believe should govern the regulatory test. The three functions grouped under the term third-party services carry different risk profiles, and a rule written for the second should not sweep in the first and third.

- Technology and operational vendors supply platforms, devices, ePRO solutions, workflow automation, analytics, interoperability services, documentation support, and reporting tools. They enable physician-directed care and furnish no billable clinical service, so they present no practitioner-accountability risk of the kind the Office of Inspector General identified.
- Independent vendor-operated clinical monitoring programs enroll and manage patients with limited practitioner involvement. These are the arrangements that raise the fragmentation and accountability concerns prompting the proposal.
- Clinically integrated contracted care teams are licensed clinicians engaged directly by the practice, operating under the billing practitioner's supervision within the practice's workflows and medical record. Functionally they are indistinguishable from employed staff; only the employment classification differs.

The Network asks CMS to consider that an employment-status test does not separate the second category from the third, while a clinical-integration test does. The factors that determine whether monitoring is practitioner-directed are observable and auditable: an established patient relationship with the billing practitioner, active clinical oversight, integration of monitoring into the plan of care, timely follow-up when a clinical need is identified, and documentation supporting medical necessity and practitioner involvement. A rule built on those factors reaches the arrangements CMS is concerned about without foreclosing access for community-based specialty practices and independent physician practices that lack the scale to employ dedicated remote monitoring clinicians.



N. Cross-Cutting Request: Predictability for the Practices That Must Implement These Policies

A theme runs through each of the comments above. Several proposals in this rule assign consequences to practices for determinations they cannot make, information they do not yet have, or infrastructure that does not yet exist: a sunset date set before the MVP inventory covers the specialty, a core measure penalty imposed before selection criteria are published, submission-type-specific validation required before the submission type is known, TIN/NPI determinations applied before organizations can track them, and digital reporting mandated before specialty standards mature.

The Network asks CMS to apply a consistent sequence to each: publish the criteria, provide an informational or shadow year, evaluate the results with stakeholders, and only then attach payment consequences. That sequence costs CMS a year in each case. It saves practices from building operations around policies whose effects neither they nor CMS can yet predict, and it produces better evidence about whether each policy achieves what it was designed to achieve. We welcome the opportunity to provide further detail on any of these comments and to work with CMS as these policies are finalized for the CY 2027 performance period.