

March 20, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: ATA Action Comments on Telehealth in Advance of Calendar Year (CY) 2025 Physician Fee Schedule (PFS) Proposed Rule

On behalf of the American Telemedicine Association, the only organization focused on advancing telehealth, and ATA Action, the ATA's affiliated advocacy arm, we thank the Centers for Medicare and Medicaid Services (CMS) for its continued support of telehealth and work to expand access to care. This is one of the biggest years for telehealth to date, as many of the legislative and regulatory Medicare telehealth flexibilities expire at the end of this calendar year. It is imperative that CMS work alongside Congress to ensure that millions of patients and providers do not lose access to virtual care services post CY2024.

As you know, the COVID-19 pandemic afforded many policy flexibilities to allow for the use of telehealth. Some of these flexibilities must be updated in statute, such as changes to section 1834(m) of the Social Security Act, and some CMS has existing authority to allow to continue, such as policies around remote monitoring coverage. **Telehealth services have become essential for millions of Americans, particularly for the most vulnerable and underserved populations, significantly enhancing access to healthcare services.** We urge CMS to 1) make as many telehealth flexibility policies within existing jurisdiction permanent and 2) work with Congress to determine timing of their action on the policies that require statutory change. If Congress does not act, telehealth as we know it would not continue to be allowed in the Medicare program. Fortunately, Congress has indicated in a bipartisan manner that it does not intend to let that happen. However, Congress might not act on legislation until just before flexibilities expire at the end of this year. We urge CMS to relay the message of urgency to Congress given that the PFS is typically finalized in the fall and thus CY2025 policies need to be determined before December 2024. To the extent that clarity is not yet available from Congress before the CY2025 PFS is finalized, we urge CMS to anticipate updating policies immediately upon congressional action and outside the typical PFS process.

In the remainder of this letter, we detail our policy recommendations, distinguishing between those we believe CMS can implement through its rulemaking capabilities and those we hope to see Congress address through legislative action.

Below are telehealth policies that can be independently addressed by CMS under their existing authorities through the upcoming CY2025 PFS. To ensure continued telehealth access, we recommend CMS:

- **Make Medicare telehealth codes permanent:** Since the beginning of the COVID-19 Public Health Emergency (PHE), there have been 156 telehealth services codes added on a temporary basis to the Medicare program through CY2024. ATA Action is service agnostic meaning we believe any provider should be able to provide any type of medical service via telehealth, provided it meets the standard of care and is clinically appropriate. Therefore, we urge CMS to make these telehealth services codes a permanent part of the Medicare program.

- **Make Box 32 provider address flexibility permanent:** Since the beginning of the COVID-19 PHE, CMS has allowed providers across the country who render telehealth services to list a practice address rather than their home address on their Medicare enrollment and billing forms. We applaud CMS for extending this flexibility through CY2024 and strongly urge CMS to make it permanent. Workplace violence is a leading cause of job dissatisfaction among providers, particularly nurses.¹ Workplace violence incidents can lead to increased costs due to staff turnover, costs for treating injuries, and staff time away from work. One of ATA Action's top priorities is to ensure provider safety and security. A provider should not be required to list their home address on any Medicare form, especially one that will be published on a public facing platform. Additionally, if this flexibility were to revert back to the pre-pandemic policy there would be a tremendous influx of Medicare billing and enrollment forms that CMS may not have the resources or capacity to keep up with internally. Therefore, CMS should address this flexibility in the upcoming PFS. ATA Action looks forward to working alongside CMS to find a workable and feasible permanent solution. [See here](#) for our latest stakeholder letter with over 100 signees.
- **Allow virtual direct supervision indefinitely:** CMS has extended the virtual direct supervision flexibility through CY2024. The ATA and ATA Action continue to urge CMS to make direct supervision via telehealth a permanent option. Virtual direct supervision has been shown to be beneficial in many ways. For example, in a survey study with former psychology trainees (n = 12) at Veterans Affairs Health Care System site regarding their supervision experiences, telesupervision demonstrated the potential to contribute to the sustainability of rural health training programs, to increase access to needed mental health care in geographical areas of mental health shortage, and to allow trainees to receive supervision from supervisors who are culturally competent and expert in providing care to diverse patient populations.² The American Medical Association's position on virtual supervision was clear in their letter sent in May 2023 to the CMS Administrator. The association encouraged CMS to permanently allow residents in teaching settings to be supervised through audio/visual real-time communications technology regardless of where they live and work.³ As mentioned in previous comments⁴, we believe that CMS should collaborate with stakeholders to identify which services would be the most appropriate for direct supervision via telehealth, while taking into account patient safety. We believe physician and nonphysician providers should have the autonomy to determine when direct supervision via telehealth is clinically appropriate and in line with the relevant standard of care and that CMS should avoid adding additional provider requirements that do not otherwise exist for in-person services.
- **Remove telehealth visit frequency limitations:** The ATA and ATA Action are not supportive of limitations on the quantity of telehealth visits a practitioner can furnish over a period of time or any type of in-person requirement. These are arbitrary barriers that limit access to care. Ultimately, we want the practitioner to be able to practice at the top of their license and allow

¹ [Addressing Workplace Violence and Creating a Safer Workplace | PSNet \(ahrq.gov\)](#)

² Jordan, S. E., & Shearer, E. M. (2019). An exploration of supervision delivered via clinical video telehealth (CVT). *Training and Education in Professional Psychology, 13*(4), 323–330. <https://doi.org/10.1037/tep0000245>

³ Henry, T.A. (2023, June 26). Virtual supervision of resident physicians should be here to stay. American Medical Association. <https://www.ama-assn.org/medical-residents/residency-life/virtual-supervision-resident-physicians-should-be-here-stay>

⁴ [ATAPFSCY2024CommentLetter8.28-FINAL.pdf \(americantelemed.org\)](#)

them to use their clinical judgment to determine the type of visit, how many visits, and the type of treatment that is the best fit for the patient so long as the standard of care is met. CMS temporarily removed the telehealth frequency limitations for the codes 99231-3, 99307-10 that pay for telehealth services in skilled nursing facilities as well as nixing telehealth frequency limitations for critical care consultation services, G0508-9, until the end of CY2024. We appreciate this extension but urge CMS to eliminate these barriers permanently.

- **Allow hospital-employed Physical Therapists (PTs), Occupational Therapists (OTs), and Speech-Language Pathologists (SLPs) to continue billing for telehealth services:** CMS extended the flexibility in last year's PFS that would allow hospital-employed PT, OT, and SLP providers to continue billing for telehealth services through the end of 2024, aligning with the other main telehealth flexibilities and providing much needed clarity. Telehealth services are comparable to in-person in terms of satisfaction and treatment outcomes for these professionals. For example, in a study that surveyed patients who received in-person physical therapy and telehealth evaluations, the ratings for satisfaction in achieving treatment goals were 4.7 for in-person and 4.6 for telehealth patients on a five-point scale.⁵The ATA and ATA Action applaud CMS for extending this flexibility but urge CMS to allow this service permanently.
- **Allow Centers for Disease Control and Prevention (CDC) -defined online providers of Diabetes Prevention Recognition Program (DPRP)-recognized programs to apply to become suppliers in the Medicare Diabetes Prevention Program (MDPP) and remove the requirement to maintain in-person recognition.** The ATA and ATA Action strongly support continuing the current flexibility that MDPP suppliers have the option to continue delivering their programs through distance learning/synchronous telehealth sessions. We urge CMS to further expand on this proposal by removing the requirement to maintain in-person recognition for distance learning-only MDPP suppliers and allowing CDC-defined online providers of DPRP-recognized programs to apply to become suppliers in the MDPP. The CDC's NDRP standards already recognize four standard modes of delivering the service, including distance learning, online, and combination in addition to in-person, and recognizes program delivery organizations that deliver via all these modalities, including virtual-only providers. We encourage CMS to consider adopting these same definitions to its own MDPP, which would create further alignment between the two programs and reduce barriers to entry into the MDPP, increasing the number of MDPP suppliers and advancing CMS' goal of increasing access to and utilization of the MDPP benefit by Medicare beneficiaries.
- **Make the MDPP a permanent Medicare covered benefit.** Doing so could entice more potential suppliers to create their own diabetes prevention programs, seek CDC DPRP recognition, and apply to be MDPP suppliers, because such suppliers would know the tremendous efforts involved in establishing a program and becoming an MDPP supplier would be an investment in what could be a long-term MDPP product.
- **Ensure access to critical remote monitoring services by removing the 16-day data collection requirement:** A significant concern for many in the healthcare industry, including ATA Action, is the restriction imposed by the 16-day data collection requirement for remote monitoring. Since its

⁵ Eannucci EF, Hazel K, Grundstein MJ, Nguyen JT, Gallegro J. Patient Satisfaction for Telehealth Physical Therapy Services Was Comparable to that of In-Person Services During the COVID-19 Pandemic. *HSS J.* 2020 Nov;16(Suppl 1):10-16. doi: 10.1007/s11420-020-09800-5. Epub 2020 Oct 19. PMID: 33100933; PMCID: PMC7571303.

reinstatement at the conclusion of the Public Health Emergency (PHE) on May 11, 2023, this mandate has hindered patients from receiving the necessary remote monitoring services that do not meet the arbitrary 16-day data threshold, despite such monitoring being vital for their diagnosis and treatment. This limitation not only restricts patient access to essential care but also contributes to confusion among providers regarding billing for remote monitoring services that fall short of the 16-day criteria, thereby reducing the effective utilization of remote healthcare solutions. It is our hope that CMS will act to eliminate this barrier by permanently reducing the data collection requirement, thereby enhancing patient access to these critical services in the upcoming PFS.

- **Expand Remote Monitoring Flexibility:** CMS should reconsider allowing multiple providers to report RPM codes in contrast to current policy that only allows one provider, in a 30-day billing period, to bill RPM for one patient. It is not uncommon for multiple specialists and providers to be remotely monitoring a single patient, with separate episodes of care. CMS should allow physicians to separately report RPM during a global surgical period when it is related to the global surgical event because these are separate services from the surgical event.
- **Clarify Remote Therapeutic Monitoring (RTM) Guidelines:** CMS should definitively clarify whether RTM is allowed for patients with acute and chronic conditions, or if RTM requires an established provider patient relationship, and the allowable method for obtaining patient consent. CMS should also clarify which non-physician providers may bill and report RTM services which are considered “General Medicine” and are not Evaluation and Management services. CMS should also clarify if RTM may be billed in conjunction with 99091, and how “interactive communication” is defined for purposes of RTM services specifically.
- **Define Coverage for RTM Supply of Cognitive Behavioral Therapy:** CPT Code 989X6 (now 98978) was assigned to “contractor pricing” in the 2023 Physician Fee Schedule Final Rule (<https://www.federalregister.gov/d/2022-23873/p-1954>). However, as of the 2024 Physician Fee Schedule 2024 Final Rule, CMS has given no indication on whether any Medicare Administrative Contractor has provided much needed coverage and payment for CPT code 98978. The country and this Administration have been key to deal with the well documented and unprecedented behavioral and psychological needs post covid PHE. These software as a medical device tools may be able to address those most in need. Stakeholders deserve to know whether CPT Code 98978 has been covered and paid – or not – and what has driven either decision.
- **Broaden RTM Conditions:** CMS should clarify that any condition requiring therapy adherence, therapy response, and the collection of subjective inputs by a patient through the use of a medical device as defined by FDA may be used to address the services of RTM work codes 98980 and 98981 – beyond musculoskeletal, respiratory, and cognitive behavioral therapy – as enumerated by the RTM supply codes 98976, 98977, and 98978. Any therapeutic medical condition (acute or chronic, when reasonable and necessary) should be allowed to be remotely monitored by a provider through 98980 and 98981.
- **Allow Concurrent Reporting of RTM Services:** Similar to what is being requested for Remote Physiologic Monitoring, CMS should allow multiple providers the ability to concurrently report RTM services, for the same patient, within a 30-day period.

- **Recognize Artificial Intelligence (AI) Software as a Medical Device (SaMD) as Direct Practice Expense:** CMS should recognize that Software as a Medical Device “SaMD” should be considered a direct practice expense (PE) and not indirect PE as merely “computer software” which is currently non-allocable.

Below are legislative flexibilities that we urge CMS to work alongside Congress to permanently address well in advance of the current expiration date, December 31, 2024.

- Remove the outdated and arbitrary geographic and originating site restrictions;
- Maintain ability for CMS to allow for audio coverage; between the summer and fall of 2020 the majority (56%) of Medicare beneficiaries who had a telehealth visit, reported accessing care using a telephone only⁶;
- Ensure Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) are able to cover and be reimbursed for rendering telehealth services;
- Expand the Medicare list of eligible telehealth practitioners to ensure Physical Therapists (PTs), Occupational Therapists (OTs), Speech-Language Pathologists (SLPs), and Audiologists are able to render telehealth services;
- Remove the telemental and behavioral health six month in-person requirement; and,
- Maintain the acute hospital care at-home program in which over 129 systems, and 300 hospitals in 37 states are currently participating.

We understand that Congress might not act on telehealth before the CY2025 PFS final rule is released. Therefore, it is imperative that CMS:

- **Work closely in the upcoming months with Congress to align both regulatory and legislative telehealth policies post CY2024.** In previous years, there have been many different deadlines for different sets of telehealth policies making it confusing for patients and providers, disincentivizing many from utilizing the services. We hope both agencies will work together in coordination to implement a seamless and straightforward pathway. The ATA and ATA Action are also here as a resource and can help relay important information to CMS and Congress.
- **Share relevant data with Members of Congress, their staff, and other agencies to provide them with the information they need as they contemplate permanency and urge Congress to act sooner rather than later to provide certainty for providers and patients.** By supplying this crucial information, CMS can underscore the urgency of the situation, encouraging Congress to expedite their decision-making process, ensuring timely and informed legislative action. The U.S. healthcare system, particularly its telehealth and virtual care infrastructure, cannot adapt instantaneously to changes in regulation and policy.

⁶ <https://www.kff.org/medicare/issue-brief/medicare-and-telehealth-coverage-and-use-during-the-covid-19-pandemic-and-options-for-the-future/>

This inherent inertia necessitates that policymakers provide clear, actionable guidance well ahead of the expiration of telehealth flexibilities, ensuring that the healthcare sector can continue to deliver uninterrupted, high-quality care to all Americans.

Early action by Congress is crucial to avoid disruption and maintain the momentum of telehealth advancements that have become a lifeline for millions.

- Continue engaging with stakeholders through public calls on pertinent telehealth issues ahead of the PFS proposed rule, preparing the healthcare community for upcoming changes and maintaining the continuity of care for millions of Americans reliant on telehealth. **CMS's preparation and foresight are critical in ensuring a smooth transition for all involved, safeguarding the advancements in telehealth that have become indispensable.**

Again, we thank CMS for its critical work and commitment to telehealth. We look forward to working with you over the next few months to find an appropriate path forward for these telehealth policies. If you have any questions, please reach out to Kyle Zebley (kzebley@ataaction.org).

Kind regards,



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