March 11, 2025

Stephanie Carlton
Acting Administrator
Centers for Medicare and Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Carlton,

On behalf of ATA Action, the American Telemedicine Association's affiliated advocacy organization, I would like to applaud the Centers for Medicare and Medicaid Services (CMS) for your continuous support for telehealth and commitment to advancing virtual care services. We appreciate the monumental strides CMS has made over the past few years through the annual Physician Fee Schedule (PFS) to expand access and reimbursement for virtual care services. As we look ahead to the upcoming CY2026 Physician Fee Schedule cycle, we are hopeful that many of the important virtual care provisions currently in place will be made permanent. Specifically, we request that CMS address the following key provisions:

1. **Collaborate with Congress to ensure continuation of Medicare telehealth flexibilities –** At the end of 2024, Congress extended the following flexibilities through March 31, 2025:

    - Waiving originating and geographic sites
    - Audio-only coverage
    - Expansion of Medicare telehealth list to include therapists
    - Allowing Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to serve as distant sites
    - Temporary waiver of telemental health in-person requirement
    - Continuation of Acute Hospital Care at Home Program

    ATA Action kindly requests CMS to work alongside Congress to make permanent or extend these flexibilities for as long as possible before the end of March. Following an extension, it is critical that CMS releases aligning regulatory guidance as soon as possible to reduce confusion amongst the industry.

2. **Extend Outpatient Therapists' Ability to Bill for Telehealth -** CMS extended the flexibility that allows hospital-employed physical therapists (PTs), occupational therapists (OTs), audiologists, and speech-language pathologists (SLPs) to continue billing for telehealth services through March 31, 2025. It is crucial for Congress to act to ensure that PTs, OTs, SLPs, and audiologists can continue providing telehealth services after the March deadline. Following congressional action, we urge CMS to align its payment policies accordingly to support these essential services

3. **Ensure permanency of the codes on the Medicare Telehealth Services List**– Currently, there are more than 250 codes on the Medicare Telehealth Services List that qualify for reimbursement. We urge CMS to retain all of the provisional codes in the upcoming PFS, should they not be made permanent, and consult with stakeholders to identify any important services that may be missing from the list.

4. **Remove telehealth frequency limitations** – ATA Action doesn't support arbitrary barriers that limit access to care such as telehealth frequency limitations, in-person, geographic proximity, or brick and mortar requirements. In last year's PFS, CMS removed the telehealth frequency limitations for subsequent hospital inpatient/observation care (99231, 99232, 99233), subsequent nursing facility visits (99307, 99308, 99309, 99310), and critical care consultation services (G0508, G0509), until the end of CY2025. We appreciate this extension but urge CMS to permanently remove these telehealth frequency limitations moving forward.

5. **Ensure that providers' home addresses remain confidential** – During the COVID-19 pandemic, CMS allowed providers who rendered telehealth services from their homes to utilize their practice address on their Medicare enrollment and billing forms instead of their home address. This flexibility has been extended through the end of CY2025. It is imperative that all provider home addresses remain confidential for safety purposes. Recent studies indicate, for example, that 44% of nurses reported experiencing physical violence and 68% reported experiencing verbal abuse during the COVID-19 pandemic.[1] A report from the Bureau of Labor Statistics found that even before the pandemic, amongst all industries, health care and social service industries have the highest rates of injury due to workplace violence.[2] In fact, health care workers were five times more likely to experience workplace violence injuries than all workers.[3]

   This is not only a safety concern, but also hospital systems and providers across the nation view this as an untenable administrative burden. ATA Action urges CMS to work with stakeholders on a long-term and permanent solution post CY2025. See here for a stakeholder letter with over 100 signees outlining potential viable solutions.

6. **Allow for direct virtual supervision** –ATA Action applauds CMS for extending the PHE definition of direct supervision, which allows a supervising provider to be considered "immediately available" through virtual presence, through the end of CY2025. We are also pleased that CMS made this definition permanent for a subset of low-risk, incident-to services typically performed entirely by auxiliary personnel. While these are steps in the right direction, ATA Action continues to urge CMS to make direct supervision via telehealth a permanent option across all scenarios. We recommend that CMS collaborate with stakeholders to identify the most appropriate services for this supervision method, with patient safety as the paramount concern. Providers should have the autonomy to determine when direct supervision via telehealth is clinically appropriate and consistent with the standard of care, and CMS should avoid imposing additional requirements for virtual supervision that do not apply to in-person supervision.

   Further, we support CMS's decision to continue to allow teaching physicians to have a virtual presence during a virtual, three-way telehealth visit, with the patient, resident, and teaching physician in separate locations through CY2025. Although, ATA Action asks CMS to permanently allow direct virtual supervision for teaching physicians during both virtual visits and non-virtual visits, specifically allowing in-person resident and patient visits to be supervised by a teaching provider who joins virtually.

[1] Fact-Sheet-Workplace-Violence-and-Intimidation-and-the-Need-for-a-Federal-Legislative-Response.pdf
[2] Workplace Violence in Healthcare, 2018 : U.S. Bureau of Labor Statistics
[3] ibid

7. **Expand the Medicare Diabetes Prevention Program (DPP)** – The Medicare Diabetes Prevention Program is a Medicare-covered initiative designed to help prevent or delay the onset of Type 2 diabetes in individuals at high risk. MDPP suppliers are organizations or entities that are approved by CMS to deliver the Diabetes Prevention Program (DPP), which typically involves group-based coaching, education, and support in areas such as nutrition, physical activity, and weight management.

   Currently, the MDPP has a restriction on the types of suppliers that can participate, excluding virtual only suppliers. We urge CMS to expand this program and allow all CDC-recognized delivery modalities, including virtual diabetes prevention platforms and suppliers, to participate in the Medicare Diabetes Prevention Program.

8. **Adopt new remote monitoring codes and ensure fair payment –** A critical issue for the remote monitoring industry has been the arbitrary 16-day data requirement for remote physiologic and remote therapeutic monitoring devices over a 30-day period. This restriction lacks clinical relevance, and industry feedback indicates that in some cases, 16 days of data can lead to inaccurate or misleading diagnoses and treatments. ATA Action has long urged CMS to address this limitation. In late 2024, the American Medical Association's CPT panel accepted a proposal to create two distinct device supply codes: one for 2-15 days of monitoring and another for 16 or more days. ATA Action strongly urges CMS to adopt these new codes and establish fair reimbursement rates. Since the introduction of RPM codes in 2019, average Medicare reimbursement for these services has decreased by between 7% and 28%, outpacing overall reductions in the Physician Fee Schedule conversion factor.[4] This trend has led to significant challenges for providers, particularly those in rural areas, as geographic adjustments intended to align payments with local costs of living further reduce reimbursement. If CMS continues to decrease reimbursement rates, hospital systems and providers will not continue to utilize these critical technologies, and many RM organizations will shut down.

9. **Further expand access to audio-only services** – ATA Action applauds CMS for previously updating its definition of interactive telecommunications system to include audio-only for any telehealth service provided in a beneficiary's home, if the distant site physician or practitioner is technically capable of using an interactive telecommunications system, but the patient is not capable of, or does not consent to, the use of video technology. Although, we urge CMS to not restrict audio-only services to specific circumstances, such as the unavailability of video technology or requiring explicit patient consent for video visits.

10. **Address Digital Mental Health Treatment (DMHT) Device Criteria** – Last year, CMS established the first-ever reimbursement for DMHT devices and services, setting an encouraging precedent for broader reimbursement of digital therapeutics. While this marks significant progress, CMS's criteria for qualifying devices are quite stringent, potentially excluding emerging devices that don't have specific FDA clearances. CMS determined that DMHT devices "must be cleared under section 510(k) of the FD&C Act or granted De Novo authorization by the FDA, and in each case, must be classified under 21 CFR 882.5801 for mental or behavioral health treatment." This strict standard could exclude promising devices that lack the required FDA clearances but are

[4] Maximizing the Value of Remote Patient Monitoring | Bipartisan Policy Center

recognized under alternative FDA pathways, such as 510(k) exempt status or the FDA's enforcement discretion. Similarly, devices already available on the market with FDA clearances classified under regulations other than 882.5801 will be excluded from the new DMHT codes and may need to reassess their regulatory strategies to align with these updates. ATA Action supports these new codes but encourages CMS to broaden its definition to encompass a wider range of devices, ensuring more efficient and affordable care for all patients.

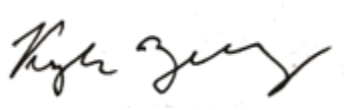
11. **Provide a reimbursement pathway for home health agencies** – Home health agencies (HHAs) use telehealth to provide care to patients in their homes. Telehealth can include video visits, remote patient monitoring, and other forms of technology. Currently, home health agencies lack the ability to bill directly when rendering telehealth services. We urge CMS to consider a permanent pathway for home health agencies to be able to be covered and reimbursed for providing telehealth services.

12. **Expansion of Advanced Primary Care Management (APCM) Codeset** – ATA Action appreciates CMS for establishing coding and payment under the CY2025 PFS for a new set of APCM services described by three new HCPCS G-codes. However, we would ask that CMS consider expanding this code set to allow for other specialties and renaming these codes as "Advanced Specialty Care Management Codes." As a simple solution, we recommend that CMS make HCPCS code G0556 available to all healthcare providers, rather than restricting it solely to primary care providers. This would ensure a more inclusive approach to managing advanced specialty care.

The ATA and ATA Action deeply appreciate all that CMS has done to advance telehealth and expand access to care for beneficiaries. We look forward to working closely with you and want to emphasize that ATA Action is committed to being a resource for CMS on all aspects of telehealth and virtual care policy, including the 2026 Physician Fee Schedule and beyond.

We are available at your convenience to discuss any of these comments in further detail and provide additional support. Thank you for considering our comments, and we stand ready to support your efforts in any way we can. If you have any questions or would like to further discuss our recommendations, please contact Kyle Zebley, Executive Director, ATA Action at kzebley@ataaction.org.

Kind regards,



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