ataACTION
Telehealth Policy to Transform Healthcare

April 6, 2026

The Honorable Mehmet Oz
Administrator Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

RE: ATA Action Recommendations for CY 2027 Physician Fee Schedule

On behalf of ATA Action, the advocacy-focused affiliate of the American Telemedicine Association, we commend the Centers for Medicare and Medicaid Services ("CMS" or the "Agency") for its continued efforts to modernize Medicare, and we thank the Agency for its continued efforts to support the delivery of virtual care. Below, we have outlined ATA Action's recommendations for the Agency for consideration in advance of the CY 2027 Physician Fee Schedule (PFS). We hope this information is helpful and would welcome the opportunity to be a resource for the Agency as it evaluates its proposals for 2027.

Partner with Congress to Modernize Medicare

Telehealth Flexibilities

In February 2026, Congress reinstated key telehealth flexibilities for multiple years. The legislative package included several critical telehealth provisions, including:

- Extension of Medicare telehealth flexibilities through December 31, 2027;
- Five-year extension of the Acute Hospital Care at Home Program through September 30, 2030;
- Extension of in-home cardiopulmonary rehabilitation flexibilities through January 1, 2028; and
- Inclusion of virtual diabetes suppliers in the Medicare Diabetes Prevention Program through December 31, 2029.

ATA Action kindly requests CMS to work alongside Congress to make permanent or extend these flexibilities for as long as possible before these extensions expire.

New Benefit Categories for Innovative Products

CMS has long taken the position that there are limited avenues in which prescription digital therapeutics, as well as other innovative technologies, can be covered under existing Medicare benefits. ATA Action appreciates the significant efforts undertaken by the Agency to allow for such coverage under its existing legislative authority. We kindly request the Agency's assistance in explaining to Congress why Medicare benefits must be updated to include innovative technologies

and working with Congress to identify the legislative changes that are necessary to cover prescription digital therapeutics and other innovative technologies cleared or approved by the Food and Drug Administration. As part of this discussion, we urge CMS to explain the necessity of legislation like the Access to Prescription Digital Therapeutics Act (H.R. 3288/S. 1702) and the Health Tech Innovation Act (H.R. 6197/S.1399).

Congressional Telehealth Modifier Recommendations

In February 2026, Congress extended the Medicare telehealth flexibilities through December 31, 2027 and directed CMS to implement telehealth-specific modifiers or codes on certain claims beginning in 2027. ATA Action would have preferred a straightforward extension of the Medicare telehealth flexibilities rather than the addition of a new modifier requirement. We believe telehealth providers and platforms are already complying with federal and state laws, and existing oversight mechanisms and coding requirements are effectively identifying bad actors and clearly signaling when virtual care is taking place. Additional guardrails are therefore unnecessary.

As CMS looks to implement this provision, we urge caution and clarity to ensure the solution is not overly burdensome to providers or unintentionally disincentivizes telehealth utilization. To minimize administrative burden and ensure the modifier provides meaningful program-integrity insight, CMS should limit the modifier requirement to virtual-only providers and telehealth platform companies. Traditional providers who simply use telehealth as one modality should not be required to append a modifier, as this would create unnecessary complexity without improving oversight.

With that said, we urge CMS to clearly define the term "virtual platform" through the use of specific exceptions that indicate when the additional data captured by the telehealth modifier is not required. A precise and transparent definition is essential to avoid confusion, promote consistent compliance, and ensure accurate claims reporting.

Given statutory intent, we believe CMS should exempt the following care from this definition:

- Any telehealth services furnished by a clinician or provider organization capable of offering care in person (as these services represent a substitution for in-person care and not utilization growth).
- Any telehealth services furnished to an existing patient as follow-up care that includes in-person care (as these services represent a continuation of an existing care relationship and not new utilization).
- Any telehealth service furnished as the onboarding or initiation of treatment for an organization that has a contractual relationship with a related in-person or facility-based provider treating the same conditions (as this represents the creation of efficiencies for patients who would otherwise receive the same care).

- Any telehealth service furnished as the result of a referral from an existing provider (as these services represent care decisions within an existing care relationship and not new utilization).
- Any telehealth service offering a "second opinion" in response to a patient's existing in-person care team (as this is a patient-initiated visit that is crucial for individuals with limited access or in areas with provider shortages).

Taken together, these recommendations will help CMS implement Congress's directive in a way that preserves program integrity while safeguarding patient access to high-quality virtual care.

Further Action Needed to Protect Virtual Only Providers

In our CY 2026 letter responding to the proposed rule ("CY 2026 Letter"), we asked the Agency to make permanent the COVID-19 pandemic flexibilities allowing telehealth providers to use an affiliated practice address rather than their home address on enrollment and billing forms.

We appreciate the significant progress that CMS has made on this issue with the FAQ explaining that going forward providers indefinitely use their physical practice location rather than their home address for purposes of enrollment and billing.

While this approach addresses concerns for practitioners that have a separate physical practice location, it continues to require providers that are virtual only (and therefore do not have a separately enrolled practice location) to provide their home address. While steps can be taken to suppress street details through PECOS, significant privacy and safety concerns remain when this information could still be obtained by the public through other means. We urge CMS to thoroughly evaluate the means in which a member of the public could obtain virtual only provider home address street details and if there is any potential for such a release to occur either legitimately or by mistake or due to a data breach. ATA Action believes such potential exists and strongly recommends the Agency work with stakeholders to develop an alternate method of determining location for the purposes of payment that does not require the reporting of a home address. One potential option would be to allow a business address to be reported for purposes of enrollment, and a geographic indicator such as a zip code be reported for payment adjustment by geographic cost and wage index.

Continue Innovating and Integrating Telehealth and Digital Health Tools

We applaud the Agency's efforts to modernize Medicare and understand how to facilitate access to virtual care, better treat and manage chronic conditions, and improve access to prevention and digital solutions for Medicare beneficiaries. We encourage CMS to continue development of innovative programs like CMMI ACCESS, ELEVATE, and LEAD and encourage further engagement with the health care industry to make these and other programs successful.

As CMS advances these models, it is critical to clearly differentiate FDA-authorized digital therapeutics (DTx), including Digital Mental Health Treatments (DMHTs), from other digital health technologies. DTx and DMHTs are prescribed therapeutic interventions that are clinically validated through rigorous trials and authorized by the FDA to directly deliver treatment, rather than tools used primarily for monitoring, care management, or wellness. As a result, these products raise distinct considerations for coverage authority, valuation, and provider involvement, and should be explicitly defined and preserved as a separate therapeutic category within both fee-for-service and model-based payment approaches.

CMS should continue to look for ways to expand its integration of telehealth and digital health tools across the Medicare program to better support the prevention, management, and self-management of chronic diseases. Chronic diseases like diabetes, hypertension, COPD, and heart failure account for the vast majority of Medicare spending and disproportionately impact older adults and underserved populations. Digital tools and other innovative prevention approaches offer a critical opportunity to address these conditions more proactively and efficiently.

Support Virtual Care Delivery and Foster Innovation Through Timely and Appropriate Reimbursement

As further explained in our CY 2026 Letter, there are many factors that deter providers from delivering innovative services including inconsistent coverage determinations, claims processing delays, and concerns about fair and accurate reimbursement. We urge CMS to continue to engage with all stakeholders to better understand what is necessary to incentivize innovation and foster adoption by health care providers. Additionally, we stress the importance of establishing and maintaining multiple reimbursement pathways under existing benefits for innovative products and providing clear guidance on evidence-based expectations and implementation of those products to promote consistent adoption across care settings.

Further recommendations and considerations for supporting virtual care and innovation are detailed below.

National Coverage Determination Establishing MAC Requirements for DMHTs.

As further described in our CY 2026 Letter, the Medicare Administrative Contractor (MAC) pricing process has been slow, and the MACs continue to question DMHT coverage. ATA Action and other stakeholders have sought to educate the MACs regarding DMHTs, with limited success and inconsistent results. We understand that the Agency's position is that there is insufficient data to support a national price, but it is clear these MAC problems will continue without clear guidance from CMS as to what is acceptable during the MAC coverage determination and pricing process.

To support consistent national coverage and avoid inappropriate cross-walks as CMS explores new payment models, CMS should clearly affirm that DMHTs represent the delivery of FDA-authorized,

clinically validated therapy, and are not substitutes for remote monitoring, data collection, or care coordination services. DMHTs should therefore not be cross-walked to RPM, RTM, or other monitoring codes, nor treated as ancillary software inputs to broader services. Clear guidance is necessary to ensure that ongoing model development does not inadvertently undermine established therapeutic pathways under the Physician Fee Schedule. ATA Action suggests issuing a National Coverage Determination stating the following:

- FDA clearance or approval under the specified DMHT classification establishes clinical effectiveness.
- Medical necessity for computerized behavioral therapy is established by a determination that the treatment delivered by the DMHT is indicated for the patient's condition.
- Remote monitoring pricing is not an appropriate benchmark or factor for DMHT pricing.
- Invoices paid by healthcare providers for DMHTs are to be used to establish the cost to the provider unless substantial evidence exists to show the invoice pricing is grossly misaligned with standard product pricing.

Remote Monitoring Recommendations

To reiterate comments in our CY 2026 Letter, to ensure continued access to high-quality care and support the long-term viability of remote monitoring, we urge CMS to update remote monitoring code valuations to align RTM and RPM reimbursement rates with those of CCM, given the comparable time, complexity, and value involved in delivering these services.

Facilitate Virtual Provider Diagnostic Testing

To further the significant progress made by the CMS in improving access to care for Medicare beneficiaries, we continue to suggest the Agency consider coverage and payment policies that enable a patient or their caregiver to collect specimens and perform diagnostic tests in their home. Further, we suggest that CMS appropriately reimburse for the time spent and cost incurred by health care providers in connection with a patient's in-home specimen collection and testing. Such changes would help facilitate diagnostic testing by virtual care providers, expanding access to care and addressing many of the barriers Medicare beneficiaries face when seeking care. For example, the PFS generally treats CPT Code 99000 Handling and/or conveyance of specimen for transfer from the office to a laboratory as a bundled service with no associated RVU time. For in-home testing, physicians may not be performing the other services that are bundled under CPT Code 99000. In order to ensure fair and appropriate reimbursement we suggest the Agency allocate separate RVU time to providers for CPT Code 99000 when a patient self-collect samples or performs a diagnostic test at home when provided by their health care practitioner.

Evaluate How Innovation Changes Clinical Practice

CMS should not assume that all uses of technology will always result in a decrease in clinician time, particularly when new technologies are being implemented. CMS could consider incorporating factors such as clinical workflow impact, level of ongoing practitioner involvement, and technology complexity when evaluating valuation for digital health technologies. Approaches that account for differences in data monitoring, patient engagement requirements, and integration into care delivery would better reflect the resources required to safely and effectively utilize these technologies.

For example, digital therapeutics used for behavioral health conditions such as substance use disorder or insomnia often require ongoing patient engagement, adherence monitoring, and integration with clinical care teams, which differ significantly from lower-complexity applications. Similarly, digital tools supporting diabetes management may incorporate continuous glucose monitoring data, medication titration support, and patient coaching, requiring ongoing clinical oversight and care coordination. Remote monitoring platforms that incorporate predictive analytics or AI-driven alerts may also require additional clinical review and data interpretation compared to more passive technologies. These differences in functionality and clinical workflow should be reflected in valuation approaches.

Address Complexity in Reimbursement Policies for Software

As further explained in our CY 2026 Letter, ATA Action does not support a "one size fits all" approach to reimbursement policies for digital technologies. We urge the agency to take a more nuanced approach focused on the functionality of the product, the complexity of the software, and the regulatory requirements applicable to the product, rather than focusing on the mode of delivery (e.g. SaaS).

Valuation Considerations for Digital Tools

For FDA-authorized digital therapeutics, valuation should reflect the substantial investment required to generate clinical evidence demonstrating safety, efficacy, and cost-effectiveness, including randomized controlled trials, post-market evidence generation, and ongoing compliance with FDA requirements. These factors distinguish DTx from non-regulated digital tools and should serve as primary inputs into coverage and payment decisions across both fee-for-service and alternative payment models.

We believe that digital therapeutics (DTx) and other forms of software as a medical device ("SaMD"), as federally regulated medical devices, should be coded and reimbursed separately and appropriately because they meet an evidence threshold above and beyond mobile health products. While the agency has acknowledged this distinction in previous comments, concerns remain on this point. For example, there does not seem to be any differences in reimbursement under the CMMI Model between care delivered using devices that have obtained the necessary approvals

from the Food and Drug Administration and those that have not incurred the expense to complete those processes, including those made available under the FDA TEMPO program.

As further discussed in our CY 2026 Letter, there are multiple factors that should play into valuation of digital tools which is why using a single formula for valuating all SaMD and other digital tools is not appropriate. We encourage CMS to consider consulting with third party experts and utilizing existing frameworks to develop flexible methodologies that recognize these variations and allow for tailored payment approaches based on regulatory burden, functionality, clinical utility, and ongoing support needs. As previously recommended in our CY 2026 Letter, the Agency should also consider establishing a dedicated group focused on AI and SaMD payment.

Expand Coverage and Coding for Prescription Digital Therapeutics

Expand DMHT Codes

The DMHT codes will continue to be crucial to health care innovation. We applaud the Agency's decision to expand the DMHT codes to include devices treating ADHD classified under 21 C.F.R. 882.5803 for CY 2026. As further explained in our CY 2026 letter, ATA Action supports the expansion of DMHT coverage to include a broader range of devices.

While we appreciate the Agency's reasoning in expanding the DMHT codes to other classes of devices with the same special controls as existing DMHT devices under 21 C.F.R. 882.5801 (specifically, clinical performance testing of the behavioral therapy in general and as delivered by the device, software description and software verification, validation, and hazard analysis, and patient and physician labeling requirements) and agree that DMHTs should be FDA classified devices, we note that similar controls exist under the following classifications:

- Computerized Behavioral Therapy Device for Treating Symptoms of Gastrointestinal Conditions classified under 21 C.F.R. 879.5960 requires clinical data demonstrating the model of therapy delivered by the device and any adverse events, Software verification, validation, and hazard analysis, software usability assessment, and physician and patient labeling requirements.
- Digital Therapy Device to Reduce Sleep Disturbance for Psychiatric Conditions (e.g., nightmare disorder, PTSD, etc.) classified under 21 C.F.R. 882.5705 requires clinical performance testing and validation of the device's ability to provide therapy and the worsening of any symptoms, software description and software verification, validation, and hazard analysis, and patient and physician labeling requirements.
- Computerized Behavioral Therapy for the Treatment of Fibromyalgia Symptoms classified under 21 C.F.R. 882.5804 requires clinical data demonstrating an improvement of symptoms and any adverse events, software description and software verification, validation, and hazard analysis, and patient and physician labeling requirements.

While the above-described controls are not exactly the same, they are substantially similar to 21 C.F.R. 882.5801.

ATA Action strongly encourages the Agency to administratively manage and evaluate the DMHT supply codes by FDA classification and expand the supply codes to include the above FDA device classifications for CY 2027. These additions are critical, as they reflect the growing clinical evidence supporting the effectiveness of DTx across a broader range of chronic and comorbid conditions.

Expanding DMHT coding across additional FDA-authorized therapeutic categories will help ensure beneficiary access to evidence-based digital therapies and provide CMS with the data needed to evaluate utilization, outcomes, and appropriate pricing, while avoiding pressure to collapse distinct therapeutic services into more generalized monitoring or wellness constructs.

Expand Coverage to More Digital Therapeutics

While there are a small number of DTx available in the U.S., they already cover many different therapeutic categories including diabetes, musculoskeletal, respiratory, mental and behavioral health, women's health, oncology, and more will continue to enter the U.S. market. ATA Action strongly supports CMS expanding Medicare coverage for DTx under existing benefit categories (including but not limited to the Physician Fee Schedule) and evaluating new coverage and reimbursement models through CMMI. As further explained in our CY 2026 Letter, there are a wide range of health conditions (which have varying degrees of patient risk associated with them) and the products designed to treat them may have varying levels of software complexity (ranging from simple analytics to artificial intelligence), different mechanisms of action, and variations in hardware requirements (e.g. nothing required beyond a smartphone, to software connected to or incorporated into a sensor or other devices such as wearables and VR/AR headsets which can vary greatly in terms of functionality and cost). ATA Action agrees and recommends that CMS consider ways to differentiate between DTx products that have substantially different practice expense inputs, clinical applications and hardware types as it expands Medicare coverage for DTx. As discussed above with respect to DMHTs, creating new codes for new classifications of devices (preferably with condition specific modifiers as necessary) to further specify the type of devices and treatments involved could allow the Agency to describe and price different classifications of DTx products with more specificity.

Expand Coding for Digital Therapeutics

In addition to expanding coverage, ATA Action recommends CMS develop more codes to better support more specific analyses of treatments and pricing. In the near term, as further explained in our CY 2026 Letter we strongly urge CMS to create new supply codes for the four additional FDA device classifications discussed above and that the Agency consider modifiers for such codes if necessary to distinguish between mental health conditions treated by the same device class to

allow for more specific analyses of treatments and pricing. In the longer term, ATA Action urges CMS to pursue a coding structure that supports differential pricing primarily by therapeutic indication, consistent with regulatory and clinical practice frameworks.

While recognizing that variation in complexity and return on investment can exist within indications, indication-based categorization provides a transparent and practical foundation. Within each indication, CMS may incorporate secondary adjustments to reflect substantial differences in development complexity, evidence base, or treatment models, thus balancing clarity and flexibility while avoiding overly burdensome complexity metrics.

Create Separate Coding and Payment to Support Virtual Foodcare

ATA Action strongly supports CMS's exploration of separate coding and payment for medically tailored foods (Medically Tailored Meals and Medically Tailored Groceries), particularly when integrated with virtual care and remote patient support services. Access to medically appropriate nutrition plays a crucial role in sustainably improving health outcomes in the short and long-term, especially for individuals with chronic illnesses, recent hospitalizations, high-risk pregnancy, or food insecurity. MTFs can serve as a powerful complement to medical nutrition therapy (MNT) and digital health tools by supporting care plan adoption and adherence, improving medication effectiveness, reducing hospital readmissions, and sustaining better health outcomes.

ATA Action encourages CMS to create HCPCS codes (akin to those S and B codes used for medical foods) for MTMs and Medically Tailored Groceries (MTG) and allow flexibility for providers (e.g., PCPs, Registered Dietitians, and other specialty care providers) to be eligible to bill for the services separately. Clear coding distinctions would differentiate medically tailored food interventions from general nutrition services and other bundled care services, improving consistency in billing and program implementation. This would support an increase in accuracy for utilization tracking which enables evaluation of clinical outcomes and total cost of care. This strengthens CMS's ability to assess the impact of these services across patient populations.

CMS should also allow for the inclusion of virtual foodcare services, such as digital screening for adequate access to food, personalized foodcare plans, personalized meal planning, remote medical nutrition therapy, and meal tracking via patient apps. These services may be particularly impactful for patients with chronic conditions and those transitioning from acute care settings, where nutrition plays a key role in recovery and readmission reduction.

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Telehealth Policy to Transform Healthcare

Thank you for your consideration. We look forward to continuing our work together to ensure that innovation remains at the forefront of federal healthcare policy and that America continues to lead the world in advancing high-quality care.

Kind regards,

Alexis Apple
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ATA Action