August 31, 2026

Submitted electronically via www.regulations.gov

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

RE: ATA Action Comments in Response to the CY 2027 Medicare Physician Fee Schedule Proposed Rule (CMS-1848-P); Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; 91 Fed. Reg. 43842 (July 16, 2026)

Dear Administrator Oz:

On behalf of ATA Action: Advocacy Shaping Virtual Care, the advocacy-focused affiliate of the American Telemedicine Association (ATA), we commend the Centers for Medicare & Medicaid Services ("CMS" or the "Agency") for its continued efforts to modernize the Medicare program through the CY 2027 Physician Fee Schedule ("PFS") proposed rule ("Proposed Rule"). We strongly support policies that leverage technology to improve health care quality, patient outcomes, and access to care, and we appreciate the Agency's ongoing work to modernize Medicare payment policy accordingly. As part of that effort, we urge CMS to continue expanding access to virtual care while withdrawing or substantially modifying several of its proposed changes to remote patient monitoring. Our comments below outline ATA Action's recommendations on these and other provisions of the Proposed Rule.

1. Maintain Access to Remote Patient Monitoring Services

ATA Action is extremely concerned by the CMS proposals for remote patient monitoring ("RPM") and remote therapeutic monitoring ("RTM") and urges the Agency to work with Congress and stakeholders to find solutions that preserve patient access to care and ensure that any changes to remote monitoring are implemented within a time frame that is feasible for the industry. RPM and RTM are a crucial part of the virtual care ecosystem that both the Agency and Congress are seeking to leverage for the benefit of Medicare beneficiaries through the Rural Health Transformation Program, the extension of the Acute Hospital Care at Home waiver, and the RPM Access Act. These services allow clinicians to identify deterioration between office visits, review changes in blood pressure, weight, oxygen levels, symptoms, and other measures, communicate with patients, and intervene before a condition becomes an emergency. Our members consistently report that established remote monitoring programs have prevented hospital readmissions, avoided emergency department visits, and sustained patient engagement over time. For example, a published evaluation of one member's neonatal RPM program for infants discharged with nasogastric tube feeding found a 53 percent reduction in unplanned hospital admissions and emergency department visits, improved weight gain at three and six months after discharge, and earlier discharge from the neonatal intensive care unit.[1] Members that furnish remote monitoring through virtual care management partners report similar results in adult populations: in one large specialty practice program, average systolic

[1] R.D. Henkel et al., Effects of Remote Patient Monitoring on Neonatal Intensive Care Unit Patients Discharged with Nasogastric Tube Feeding, Journal of Pediatrics, vol. 288 (2026).

blood pressure declined by approximately six percent, severe loss of blood pressure control events (systolic readings above 180) fell by 96 percent, long term patient retention approached 90 percent, and a member cardiology practice program reported comparable improvements across more than 1,300 enrolled patients.

While we appreciate the Agency's efforts to strengthen Medicare program integrity by going after fraud, waste, and abuse and support the objectives identified by CMS and the Office of Inspector General ("OIG") in its remote monitoring reports (the "OIG RM Reports"),[2] **ATA Action urges the Agency not to finalize its remote patient monitoring proposals and to consider a more targeted, data driven approach**. Otherwise, many physician practices and health systems will be forced to reduce enrollment, terminate existing programs, or discontinue remote monitoring altogether. As a result, patients could lose established connections with care teams for reasons unrelated to their clinical needs, and patients could face delays in enrollment following hospitalization, medication changes, new diagnoses, or worsening chronic conditions. The consequences would be particularly serious for older adults, patients with mobility or transportation barriers, and beneficiaries with heart failure, hypertension, diabetes, respiratory disease, and other complex chronic conditions. The breadth of patients served by ATA and ATA Action member programs illustrates who is affected. One member, a children's hospital, operates a remote monitoring department that manages approximately 300 patients each month across 17 programs and has served more than 1,200 children with conditions including congenital heart disease, heart transplantation, ventricular assist devices, peritoneal dialysis, cystic fibrosis and other respiratory diseases, type 1 diabetes, poor weight gain, and postoperative recovery.[3] In adult programs supported by member virtual care management organizations, individual specialty and cardiology practices each enrolled well over 1,000 patients within the first ten months of operation.

For rural providers, the problem is even more acute because the available clinical workforce is already limited. CMS's own proposed Rural Health Transformation Program emphasizes workforce development, sustainable access, innovative care, and technology innovation in rural communities. Through that program, the Agency is partnering with states to make historic investments in rural health technology, and rural providers in many states are planning to use those funds to deploy remote monitoring infrastructure. A federal policy that simultaneously encourages rural technology enabled care while making established remote monitoring partnerships unavailable would work against those objectives, leave rural providers with fewer tools to serve their patients, and push care back toward more costly emergency departments, hospitals, and institutional settings.

The remote monitoring proposals are also out of step with the direction set by Congress and the broader Administration. Last month, the House Ways and Means Committee advanced the RPM Access Act (H.R. 3108) by a unanimous, bipartisan vote of 39 to 0.[4] That legislation is designed to expand, or at the very least maintain, Medicare beneficiary access to remote monitoring, with a particular focus on rural communities. The unanimous action of the Committee reflects a clear congressional judgment that remote monitoring access should be strengthened, not curtailed, and it follows the Administration's own sustained emphasis on using health technology to improve access to care in the home and in rural America. We respectfully submit that finalizing the remote monitoring proposals as drafted would place Medicare

[2] See U.S. Department of Health and Human Services, Office of Inspector General, Additional Oversight of Remote Patient Monitoring in Medicare Is Needed (September 2024), and subsequent OIG reporting on remote patient monitoring and remote therapeutic monitoring (collectively, the "OIG RM Reports").

[3] K. Denker et al., Using a Centralized Nursing Team to Implement Multi-specialty Pediatric Remote Patient Monitoring Programs, Journal of Pediatric Nursing, vol. 69 (2023).

[4] RPM Access Act, H.R. 3108, 119th Congress, favorably reported by the House Committee on Ways and Means in July 2026 by a vote of 39 to 0.

payment policy at odds with the expressed priorities of Congress, the Rural Health Transformation Program, and the Administration's health technology agenda, and we urge the Agency to resolve that inconsistency in favor of preserving patient access.

We also strongly recommend that CMS and OIG further analyze remote monitoring patient data to address several gaps in the current OIG RM Reports to better inform the industry regarding fraud, waste, and abuse concerns and allow for a more targeted approach by the agencies moving forward:

- Consider whether the pandemic and changes in policy contributed to increases in legitimate remote patient monitoring;
- Consider how remote patient monitoring is ordered and provided, for example, several related entities can be involved in remote patient monitoring services for the same patient;
- Determine whether an entity is prohibited from billing all remote monitoring services by Medicare billing rules, for example, the prohibition on billing separately for monitoring services that are provided within the global surgery billing period;
- Determine whether the use of multiple devices is influenced by medical necessity, not fraud; and
- Determine whether multiple practices billing for remote monitoring can be explained by unrelated practices ordering different types of patient monitoring.

The Direct Employment Requirement Is Overly Broad and Threatens Patient Access

CMS proposes to permit payment for RPM and RTM only when the clinical staff furnishing the services are direct employees of the billing practitioner or practice, effectively prohibiting contracted clinical staff effective January 1, 2027. The elimination of these partnerships was not recommended by the OIG RM Reports, nor does the Agency provide evidence to support such a broad approach with potentially devastating consequences for patients.

The OIG RM Reports recommended that CMS implement additional safeguards to ensure that remote monitoring is used and billed appropriately, require that claims identify the ordering provider, develop methods to identify the health data being monitored, conduct provider education on billing requirements, and identify and monitor the companies that bill for remote monitoring. The OIG did not contemplate changes to staffing structures as a means of addressing fraud, waste, and abuse, and nothing in the OIG RM Reports suggests that prohibiting contracted clinical staff would accomplish that goal. Indeed, the conduct that OIG highlighted, such as companies cold calling beneficiaries to solicit enrollment, has no connection to whether the clinical staff performing monitoring are directly employed by the billing practitioner or furnished through a clinically integrated partner under the general supervision of the billing practitioner. To the extent the Agency is relying on the OIG RM Reports as the justification for this proposal, the proposal reaches far beyond anything the OIG recommended.

The proposal would also reverse a deliberate policy choice that CMS made based on stakeholder experience. When the RPM codes were first implemented, monitoring was required to be furnished under direct supervision, and practices and health systems consistently reported that it was not feasible for their internal clinical staff to absorb monitoring responsibilities. In response, CMS moved these services to general supervision in 2020, which enabled the clinically integrated staffing arrangements in use today. Furnishing services through auxiliary personnel under general supervision is a longstanding and widespread feature of Medicare payment policy across care management and many other services, and the Agency has not explained why remote monitoring alone should now be subject to a categorical employment test.

Clinical partnerships for the delivery of remote monitoring services are widespread and involve a variety of relationships in which the clinical staff delivering care are employed by an entity other than the billing

provider. Many of our members report that most, and in some cases all, of their remote monitoring services are furnished through such partnerships. For example, one member children's hospital furnishes remote monitoring through a centralized nursing team that supports 17 programs across 10 specialties and monitors approximately 300 active patients per month, a model that has enabled monitoring of more than 1,200 pediatric patients while maintaining patient satisfaction scores of 9.1 out of 10 and a 98 percent recommendation rate.[5] Other members partner with virtual care management organizations that onboard patients during office visits, obtain consent, furnish connected devices and train patients in their use, provide clinical staffing scaled to the size of the program, and document all time spent, escalations, and care plan management, in every case under care plans, patient eligibility criteria, and escalation protocols approved by the billing provider. Even with that support, one participating practice estimates that its own physicians and staff devote more than 100 hours per month to the program. Many physician practices simply do not have the financial or human resources to provide remote patient monitoring services independently. High-quality RPM programs may draw on a range of clinical, operational, technical, and administrative capabilities. Depending on the program and patient population, these may include:

- Patient onboarding and education.
- Connected devices.
- Device logistics and replacement.
- Connectivity and data transmission.
- Secure software.
- EHR integration.
- Clinical data review.
- Patient engagement.
- Alert management.
- Escalation protocols.
- Documentation.
- Billing and compliance infrastructure.
- Technical support.

Importantly, the direct employment requirement would disqualify arrangements that no reasonable observer would describe as third party vendor relationships. At academic medical centers and other health systems, the billing practitioner is frequently a member of a faculty practice plan or medical group, while the nurses and advanced practice providers who perform the monitoring are employed by an affiliated hospital or medical center that operates under the same health system umbrella but a different taxpayer identification number. In these programs, the ordering practitioner selects the parameters to be monitored, monitoring data are integrated into the electronic health record and shared with the ordering practitioner and the patient's primary care and specialty care providers, and escalation occurs under provider approved protocols. These are precisely the clinically integrated programs the Agency should want to encourage, yet under the proposal they would be out of compliance on January 1, 2027. The same is true of the centralized virtual care centers and clinical call centers through which health system staff monitoring across multiple hospitals, states, and regions, each of which would apparently need to be restructured so that monitoring staff are employed by every individual billing provider.

5 J. Walters et al., Post-discharge Remote Patient Monitoring for Children Hospitalized with Acute Asthma Exacerbations, Academic Pediatrics (2024).

Additionally, some clinical partnerships are borne out of legal compliance requirements. For example, hospitals in some states may employ nurses and other clinical staff for remote patient monitoring programs but are legally prohibited from employing physicians. The proposed direct employment requirement will therefore eliminate not only the use of legitimate third-party remote patient monitoring programs by providers who cannot offer them independently, but also many existing clinically integrated provider programs that exist because of these legal requirements.

The consequences of this proposal are not simply a change in billing. Because so many staffing structures rely on contracted and affiliated clinical staff, finalizing the direct employment proposal would mean that, for a large share of physician practices and health systems, RPM and RTM services could no longer be furnished in a manner that is reimbursable under Medicare at all. Practices that lack the financial or human resources to hire dedicated monitoring staff would be forced to end their programs entirely, and many other programs would require staffing, contracting, intake, scheduling, and revenue model changes that cannot feasibly be completed by January 1, 2027. The resulting loss of patient access to continuous clinical monitoring would be immediate and significant. At the member children's hospital described above, centralized staffing and shared remote monitoring infrastructure support monitoring for hundreds of medically complex children each month, including patients with feeding tubes, congenital heart disease, dialysis dependence, transplantation, respiratory disease, and poor growth. Limiting these staffing models would jeopardize access for the approximately 300 children actively monitored each month and reduce the capacity of programs that have collectively served more than 1,200 patients.[6]

We also caution that this proposal would create costs rather than savings. Clinically integrated partners achieve economies of scale by keeping specialized clinical staff fully and efficiently utilized across programs. Requiring each billing practice to directly employ its own monitoring staff would either overburden existing clinical staff or create underutilized positions that most practices cannot sustain, raising the cost of furnishing these services precisely as the Agency proposes to reduce payment for them. And where monitoring programs end, clinical deterioration that is identified early today will instead present in emergency departments and hospitals, increasing total Medicare spending. Because state Medicaid programs and commercial payers frequently follow Medicare's remote monitoring constructs, these effects would extend well beyond the Medicare program. A proposal advanced in the name of burden reduction and cost savings would, in practice, be cost creating for providers, for patients, and for the Medicare program itself.

Rather than prohibiting widely used clinical partnerships, we recommend that CMS work with responsible industry stakeholders to establish measurable guardrails that identify and eliminate bad actors while allowing legitimate, clinically integrated arrangements to continue. Informed by input from our members, these guardrails could include:

1. Medical necessity and provider initiation.
2. Documented patient consent and onboarding.
3. Provider approved clinical and escalation protocols.
4. Documentation of abnormal findings and clinical response.
5. Auditable patient data showing device use, transmission, review, communication, and treatment management.
6. Identification of the ordering provider and the health data being monitored.

6 C. Sump et al., Outcomes Associated with Remote Patient Monitoring for Poor Weight Gain, Hospital Pediatrics, vol. 15 (2025).

7. Qualified and accountable RPM and RTM clinical partners.
8. Billing only when required services are delivered.
9. CMS monitoring of organizations with anomalous billing patterns.

The Reduction in Payment Is Premature and Could Make RPM and RTM Unaffordable for Health Care Providers

ATA Action has repeatedly suggested that CMS update remote monitoring code valuations to align RTM and RPM reimbursement rates with those of chronic care management ("CCM"), given the comparable time, complexity, and value involved in delivering these services. We are therefore deeply concerned by the proposed payment methodology changes, which the Agency has acknowledged are largely unsupported by actual expense data. Creating and maintaining a high-quality remote patient monitoring program requires substantially more than the cost of the device. The economics include the device, connectivity, software, EHR integration, technical support, patient education, clinical staff, data review, patient engagement, escalation, documentation, compliance, and administration.

The proposed valuations do not reflect these realities. The proposed supply valuation is anchored to devices comparable to blood pressure cuffs available off the shelf at a pharmacy, which include no cellular connectivity, no data transmission, no software or electronic health record integration, no device logistics or replacement, and no technical support. That comparison is inapt for the connected devices that Medicare's remote monitoring requirements contemplate, and it disregards higher cost specialty devices used for certain patient populations, as well as the tablets and cellular hubs that providers must supply when patients lack broadband access. Members estimate that the proposed changes would reduce payment for remote monitoring services to a small fraction of current levels. Similarly, the proposal to remove clinical staff time from the valuation of the treatment management codes is internally inconsistent with the proposed requirement that this very clinical staff be directly employed by the billing practice, and it would pay practices less for the staff the Agency would simultaneously require them to hire.

As a result, even modest reductions in payment could make continuing RPM and RTM services financially unsustainable for many practices, which will significantly impact patient access to care, and the loss of that access is likely to increase, rather than decrease, total program costs. Published evidence from member programs bears this out. Children actively engaged in an asthma remote monitoring program following hospital discharge experienced no hospital readmissions, fewer emergency department and urgent care visits, and fewer rescue inhaler refills.[7] Among infants hospitalized for poor weight gain, remote monitoring improved attendance at recommended well child visits from 50 percent to 80 percent while reducing Child Protective Services involvement from 53 percent to 28 percent, suggesting improved engagement with preventive care and reduced need for costlier downstream interventions.[8] For this reason, we urge CMS to reconsider making any of the proposed changes relevant to payment for remote patient monitoring services until the Agency has had the opportunity to collect and analyze actual device, technology, clinical labor, and program delivery costs. At a minimum, we suggest the Agency await the results of the upcoming RUC review of the remote monitoring code family, which we understand has been accelerated to January 2027, rather than adopt new valuations only months before that data driven review concludes. Moreover, given that CMS is asking for information in the broader context of virtual care management, we suggest that any valuation changes to remote monitoring be considered as part of that effort rather than reviewed in isolation.

[7] J. Walters et al., Post-discharge Remote Patient Monitoring for Children Hospitalized with Acute Asthma Exacerbations, Academic Pediatrics (2024).
[8] C. Sump et al., Outcomes Associated with Remote Patient Monitoring for Poor Weight Gain, Hospital Pediatrics, vol. 15 (2025).

The Established Patient and Initiating Visit Requirements Create Operational Burdens

The proposed established patient and separately billable initiating visit requirements would create operational burdens and duplicative services for many well-functioning programs, particularly those launched at hospital discharge. Remote monitoring is frequently ordered when a patient is discharged from an inpatient stay or an emergency department visit. In these settings, the discharging physician, hospitalist, or surgeon evaluates the patient, determines that remote monitoring is medically necessary, initiates the order, and refers the patient to a primary care physician or the monitoring program to manage the patient's care after discharge. Some health systems have implemented bedside kit deployment programs in which patients are educated, consented, and equipped with connected devices before they leave the hospital so that monitoring begins immediately during the highest risk period following discharge.

Requiring a separate billable initiating visit with the billing practitioner in these circumstances would duplicate clinical work that has already been performed and documented, delay the start of monitoring during the period when patients are most vulnerable to readmission, add cost to the program without adding clinical value, and, in many cases, be operationally infeasible where the billing practitioner is not the clinician who identified the need for monitoring. If the Agency nonetheless finalizes an initiating visit requirement in some form, we urge CMS to recognize a qualifying hospital discharge, emergency department discharge, or other documented clinical encounter, including the discharge summary, as satisfying the requirement, to confirm that an inpatient visit furnished by a physician from the department leading the monitoring program qualifies, and to confirm that the required relationship may be established through an evaluation and management encounter furnished via telehealth. The Agency should also clarify how these requirements interact with global surgery billing rules, under which certain monitoring related services cannot be separately billed.

Consolidation of Remote Monitoring Codes Creates Unnecessary Burdens for Providers

The proposal to replace the existing remote monitoring code set with a small number of consolidated, Medicare specific monthly codes would complicate rather than streamline remote monitoring billing. First, the consolidated codes assume that every component of the service is furnished and billable every month, which is not how these services work. Device setup and patient education are furnished once at the outset of an episode of monitoring, so a patient appropriately monitored over multiple years would rarely, if ever, generate that component after the first month. Similarly, Medicare billing rules themselves prohibit separate billing of certain monitoring services furnished during a global surgery period. Under the proposal, a month in which any required element is absent for entirely legitimate reasons would apparently be unbillable, even though medically necessary monitoring and management were furnished in good faith. We note that this same misunderstanding -- the assumption that a beneficiary only benefits when every code in the family is billed -- underlies portions of the OIG RM Reports, and we urge the Agency not to embed it in the payment system.

Second, the consolidated codes would require that the same entity furnish all components of the bundle, which may not be operationally feasible where, for example, a hospital and a medical group operate under a single health system umbrella but bill under different entities. Third, creating Medicare specific G codes would fragment coding across payers. The current CPT code set, which was expanded as recently as CY 2026 to add codes for two to 15 days of data and 10 to 19 minutes of management time, provides granularity that clinicians, state Medicaid programs, and commercial payers rely upon. Replacing it for Medicare purposes only would force providers to maintain parallel billing systems and would discard granular utilization data at exactly the moment the Agency says it wants better information about how these services are furnished. Finally, we note that RTM adoption remains nascent, with only a small share of eligible allied health professionals billing the codes today because of workflow complexity. Layering new consolidated codes and reduced payment on top of that complexity would likely end allied health participation in remote therapeutic monitoring altogether.

Each of the remote monitoring proposals described above is an operational change, not merely a payment change. Together they would affect staffing models, patient intake, scheduling, vendor contracts, electronic health record builds, and program economics. If the Agency finalizes any changes to remote monitoring, it must provide an adequate phase in period, well beyond January 1, 2027, and should evaluate remote monitoring within the broader context of care management rather than in isolation.

In conclusion, we respectfully suggest that CMS take the following approach to its remote patient monitoring proposals:

1. Do not finalize the direct employment restriction, and instead address fraud, waste, and abuse concerns through targeted safeguards based on the OIG's observations and recommendations, including requiring ordering provider information on claims, requiring billing provider review and approval of clinical and escalation protocols, developing methods to identify and monitor companies providing remote patient monitoring, including whether the company is an independent third party vendor, developing methods to identify the health data being monitored, developing methods of auditing required communication and documentation, and continuing billing audits that identify concerning billing patterns.
2. Allow qualified and accountable clinical partners to support RPM and RTM under provider oversight.
3. Base any payment changes on actual device, technology, clinical labor, and program delivery costs, and defer valuation changes at least until the upcoming RUC review and the broader technology enabled care management effort conclude.
4. Do not finalize the established patient and initiating visit proposals as drafted, and, at a minimum, recognize hospital discharge encounters, emergency department discharge encounters, and telehealth encounters as qualifying events.
5. Do not finalize the consolidation of the remote monitoring codes.
6. Provide an adequate phase in period, well beyond January 1, 2027, for any remote monitoring changes that are finalized, and evaluate remote monitoring within the broader context of care management rather than in isolation.

2. Care Management Request for Information

The Proposed Rule includes a request for information ("RFI") on the care management code family as part of the Agency's broader effort on redesigning primary care, including questions regarding whether care management services should be furnished by directly employed clinical staff and whether initiating visit requirements should apply. We appreciate the Agency's interest in gathering information before making changes to these important services. We are concerned, however, that the RFI asks the very questions that the Proposed Rule appears to have already answered for remote monitoring. Care management services, including chronic care management, principal care management, behavioral health integration, and advanced primary care management, rely on the same general supervision framework and the same clinically integrated staffing arrangements as remote monitoring. Extending an employment restriction or new visit requirements across the care management family would multiply the access harms described above across an even larger population of Medicare beneficiaries.

We urge the Agency to allow the record developed through this RFI to inform its remote monitoring policies as well, rather than finalizing for remote monitoring in CY 2027 the very restrictions on which it is simultaneously seeking comment for care management. Our members are continuing to develop detailed feedback on the RFI's questions regarding primary care payment, intensity of services, care coordination,

patient monitoring, treatment, diagnostics, and approaches to valuation, and we look forward to sharing that feedback with the Agency.

Finally, we note that the Proposed Rule contains an unusually large number of substantive proposals alongside several significant RFIs, including the care management, technology enablement, artificial intelligence, and Current Procedural Terminology RFIs. Because stakeholders have necessarily devoted the sixty-day comment period to the substantive proposals with immediate operational consequences, we respectfully request that the Agency provide an additional opportunity to respond to the RFIs, whether by extending the response window applicable to the RFIs, issuing a supplemental RFI, or convening structured listening sessions with stakeholders.

3. Implement Proposals Supporting Virtual Care and Innovation

In February 2026, Congress reinstated key telehealth flexibilities for multiple years. The legislative package incorporated several critical telehealth provisions, including: extension of the Medicare telehealth flexibilities through December 31, 2027; a 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 thanks the Agency for its continued support of these flexibilities and kindly requests that CMS work alongside Congress to make permanent or extend these flexibilities for as long as possible before these extensions expire.

We applaud the efforts made by CMS in its CY 2027 proposal to support beneficiary access to virtual care, including:

- Adding five new HCPCS codes to the Medicare Telehealth Services List (advance care planning, speech language services for children, vaccination side effect management, and shared medical appointments for group education, counseling, and peer support);
- Allowing teaching physicians to bill for services involving residents when either the teaching physician or the resident is in the same room as the beneficiary; and
- Clarifying the critical care telehealth consultation descriptors.

ATA Action also applauds the Agency's two new proposals to support the use of digital tools in clinical care by creating two new Merit Based Incentive Payment System ("MIPS") improvement activities, Clinician Use of Artificial Intelligence to Improve Patient Care and Use of Decision Support for interoperable clinical decision support and encourages the Agency to continue to find avenues to support clinician implementation and use of innovative technologies. We note that digital therapeutics ("DTx"), which were not otherwise addressed in this year's proposals, can deliver therapeutic interventions through artificial intelligence. We urge the Agency to clarify that AI-enabled DTx may be used to meet the Clinician Use of Artificial Intelligence improvement activity by specifically mentioning DTx in the list of activity examples.

<u>Support Online Suppliers in the Medicare Diabetes Prevention Program</u>

ATA Action also thanks the Agency for the improvements made to the Medicare Diabetes Prevention Program ("MDPP") in last year's rule, including the ability of Online, virtual only suppliers to participate in the program through December 31, 2029. We remain concerned, however, that Online sessions are paid at $18 per core or core maintenance session compared with $25 for sessions furnished in person, which is 28 percent less per lesson completed and lowers the maximum program payment by 21 percent. Online suppliers carry substantial upfront fixed costs, including technology development and the provision of

cellular connected weight scales, which our members report are central to participant engagement, accountability, and outcomes. CMS's own data show stronger results among beneficiaries who attend sessions virtually, with average weight loss of 5.3 percent compared with 4.6 percent for those attending primarily in person, so the lower Online rate is difficult to justify and the resulting downstream savings likely exceed anything saved by paying Online suppliers less.

We urge CMS, at a minimum, to establish payment parity across delivery modalities during the Online Test period by compensating HCPCS Code G9871 (Online) at the same $25 rate as HCPCS Codes G9886 (In Person) and G9887 (Distance Learning). If the Agency prefers an alternative structure, our members have suggested weighting Online payment more heavily, or even entirely, toward weight loss outcomes, or adopting a milestone-based approach, similar to the model used by the Maryland Medicaid program, that provides a larger initial payment recognizing upfront device and enrollment costs while preserving the outcome-based bonus payments.

Finally, because the Online modality and virtual only supplier participation are authorized only through a testing period ending December 31, 2029, inadequate payment risks suppressing supplier participation and beneficiary enrollment, leaving CMS to evaluate the modality on artificially low utilization rather than its true potential. We recommend that CMS correct the Online payment rates as soon as possible, extend the Online modality and virtual only supplier participation policies for as long as possible beyond 2029, and establish a pathway toward permanent adoption, so that suppliers can invest with confidence and the Agency can assess the modality using a meaningful volume of real-world utilization and outcomes data.

4. Telehealth Modifiers Should Be Limited to Virtual Only Providers

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 and does not unintentionally disincentivize 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. In addition, it is not clear from the Proposed Rule which arrangements would qualify under the proposed BB and BC modifier definitions, and we urge the Agency to provide a detailed explanation, with examples, of the arrangements each modifier is intended to capture. We further 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; and

- 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.

5. Protect the Home Address Privacy of Virtual Only Providers (Box 32)

In our CY 2026 letter responding to last year's proposed rule (our "CY 2026 Letter"), we asked the Agency to make permanent the pandemic era 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 through the FAQ explaining that, going forward, providers may 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 how a member of the public could obtain the home address street details of a virtual only provider and whether there is any potential for such a release to occur either legitimately, by mistake, or through 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, with a geographic indicator such as a zip code reported for payment adjustment by geographic cost and wage index.

6. Clinical Software Generally

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. 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 appear to be any difference 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 the valuation of digital tools, which is why using a single formula for valuing all SaMD and other digital tools is not appropriate.

In evaluating the valuation, coding, and payment of clinical software, we encourage the Agency to consider at least three dimensions. First, clinical functionality, drawing on frameworks such as the American Medical Association's taxonomy distinguishing assistive, augmentative, and autonomous software functions. Second, risk and regulatory burden, recognizing meaningful differences among products marketed under FDA enforcement discretion, products cleared through the 510(k) pathway, and products subject to premarket authorization. Third, the fit of alternative payment approaches for a given product type, including fee for service and direct expense approaches, such as per use versus monthly licensing, capitation approaches with their benefits and limitations, and value based or outcomes-based payment with its benefits

and limitations. We would welcome the opportunity to work with the Agency on how these dimensions could be operationalized in valuation policy.

Finally, 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 artificial intelligence 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.

7. Artificial Intelligence in Virtual Care

ATA Action thanks the Agency for the thoughtful requests for information regarding artificial intelligence ("AI") throughout the Proposed Rule, including the questions regarding changes to primary care and care management due to technology and clinical AI, technology and AI augmentation in primary care through the Medicare Annual Wellness Visit, and the proposed Clinician Use of Artificial Intelligence improvement activity. Our responses below are anchored in the ATA's published AI Policy Principles,[9] which support policies, practices, and regulatory frameworks that keep patients and providers at the center of care and that promote trust, safety, transparency, explainability, accountability, appropriate human oversight, data privacy and security, and the integration of AI into clinical workflows in ways that preserve the patient and provider relationship and applicable standards of care.

We also want to make the Agency aware that ATA Action and its members are actively engaged in a comprehensive AI in Virtual Care Policy Initiative, through which member workgroups spanning state policy, federal legislative policy, and federal regulatory policy are developing consensus recommendations on the responsible deployment, oversight, valuation, and reimbursement of AI-enabled virtual care. We would welcome the opportunity to collaborate with CMS and HHS as these recommendations are finalized and to work with the Agency on incorporating them into future rulemaking. We would be pleased to brief the Agency on this work at its convenience.

<u>AI's Impact on Care Delivery and Clinician Workflows</u>

The components of health care delivery that AI can already make more efficient are those involving high volume, information dense work: clinical documentation and ambient scribing, synthesis of patient chart trends, inbox management, patient communication and triage, risk stratification, remote monitoring data review, and longitudinal care management. AI can also support clinical decision making, imaging interpretation, and the identification of patients who need intervention. At the same time, the Agency should recognize that the initial implementation period involves a learning curve during which clinician workload increases rather than decreases, due to the need to build clinician trust and adoption, learn new technologies

[9] American Telemedicine Association, Artificial Intelligence Principles, available at https://www.americantelemed.org.

and workflows, review and validate outputs, address unexpected issues, and monitor AI performance. Payment policy should not assume immediate efficiency gains from AI adoption.

Evaluating the Value of AI Tools

We believe AI should be evaluated using the same quadruple aim lens applied to other care innovations: quality outcomes, patient experience, cost and return on investment, and clinician experience. Many current AI tools show promise in documentation, ambient scribing, patient triage, risk stratification, and remote patient monitoring, but their value should be measured beyond simple efficiency gains. In connection with coverage decisions, CMS should consider improvement in patient outcomes, reduction in avoidable utilization, expanded access to care, patient and clinician experience, clinician time saved and reductions in clinician workload and burnout, total cost of care, and interoperability and workflow integration. Reimbursement models should reward technologies that produce measurable improvements in these domains rather than simply paying for technology adoption itself. Future payment frameworks should also recognize that the value of AI often comes from augmenting care teams and enabling proactive, continuous care rather than replacing clinician services. As Medicare increasingly supports home-based and virtual care models, AI should be viewed as a tool that enhances the reach and effectiveness of clinicians while maintaining appropriate human oversight and accountability.

Measuring Outcomes

Outcomes associated with AI-enabled technologies should be assessed at three complementary levels. First, clinical outcomes, including safety, effectiveness, quality, and relevant health outcomes. Second, patient centered outcomes, including experience, satisfaction, access, timeliness, continuity of care, and participation in decision making. Third, health system outcomes, including costs, productivity, and utilization. CMS should encourage the collection of data related to safety, access, clinician workload and burnout reduction, patient engagement, and longitudinal outcomes.

Frameworks for Valuation, Coding, and Payment

We encourage CMS to adopt a multidimensional and adaptive framework for the valuation, coding, and payment of AI-enabled services. Such a framework should consider functionality and clinical purpose, level of autonomy, clinical risk, regulatory requirements, evidence of effectiveness, workflow impact, need for professional oversight, intensity of services, interoperability, integration with electronic health records, and demonstrated impact on clinical and patient centered outcomes.

Reimbursement Approaches for Innovative Technologies

For AI-enabled services, reimbursement should consider the type and intensity of the service, the role of the health care professional, the clinical purpose of the technology, the level of risk, the resources required, and the quality and outcomes of care achieved. Fee for service mechanisms may be appropriate for specific AI supported services that can be clearly identified and coded, particularly when professional involvement and service intensity can be adequately established. Prospective payment mechanisms may be particularly relevant when AI is integrated into broader models of care, population management, remote monitoring, follow up, or longitudinal care. In these cases, AI may contribute to the organization and efficiency of care without necessarily constituting a separate technology-based service requiring separate reimbursement. At the same time, payment mechanisms should evolve as evidence regarding the clinical and economic impact of AI becomes available. Rather than creating a separate payment category simply for the use of AI, reimbursement should focus on the health care service provided, the professional responsibility involved, the resources required, the level of risk, and the value generated for patients and health systems.

8. Software as a Medical Service

We applaud the Agency for moving away from general terms when discussing software used in clinical care by defining Software as a Medical Service ("SaMS"). We view this as a crucial step in taking the functionality of clinical software into account in establishing Medicare payment policy.

CMS has proposed to define SaMS as "software-based technologies that support clinical decision making through algorithmic analysis, including those that provide clinical or diagnostic functionality." As the Agency finalizes this definition, we request additional clarity regarding its intended scope, including whether digital therapeutics and digital mental health treatment devices are included. We note that the proposed definition does not expressly address monitoring functions, even though software supported monitoring raises many of the same coverage and pricing questions discussed elsewhere in this letter and it would be helpful for CMS to clarify which specific supply codes, including CPT, that CMS is proposing that this definition applies. The Agency should ensure that the SaMS definition is clear and does not create obstacles to differentiated pricing among these distinct categories of devices and services.

CMS has proposed that SaMS be contractor priced, consistent with its approach for other new technologies reimbursed under the PFS. As further discussed below, physicians are experiencing significant difficulties in obtaining payment for Digital Mental Health Treatment claims through the Medicare Administrative Contractors ("MACs"). While ATA Action understands the reasoning for contractor pricing SaMS, we urge the Agency, if it proceeds with this proposal, to provide substantial guidance to the MACs with respect to the following by January 1, 2027:

- Recognize the applicable FDA pathway and discourage MACs from unnecessarily duplicating evidence review FDA has already undertaken.
- How medical necessity is established for SaMS and what must be documented in the record; and
- Invoices paid by health care providers for SaMS are to be used to establish the cost to the provider unless substantial evidence exists to show that the invoice pricing is grossly misaligned with standard product pricing.

We also encourage the Agency to clarify the intended scope of the SaMS definition and how the new category will interact with existing services and pathways, including remote monitoring, digital mental health treatment, digital therapeutics, and laboratory analyses, so that established therapeutic and diagnostic pathways are not inadvertently cross walked into, or displaced by, the new category. Some stakeholders have raised questions regarding the definition and payment parity for health care innovations in connection with the Agency's SaMS proposal, and we look forward to sharing additional detail with the Agency as our members further develop those comments.

9. Digital Mental Health Treatment

<u>Reimbursement and MAC Implementation Issues</u>

We were disappointed that CMS did not address continued refinement of the digital mental health treatment ("DMHT") services in the Proposed Rule, after the Agency stated in last year's rule that further clarification on scope and pricing would be issued. We greatly appreciated the opportunity to collaborate with CMS in the development of the DMHT codes, which provide critically important recognition for evidence based, FDA cleared therapies that can be delivered remotely. DMHT services immediately help to address the longstanding and worsening shortage of mental health professionals in the United States, providing convenient, proven treatment options for Medicare beneficiaries in remote locations or with limited access to mental health practitioners.

As CMS is aware from prior discussions, many providers continue to experience severe challenges in establishing consistent reimbursement and recognition for DMHT services through the MACs, especially for the G0552 service that includes the cost of the DMHT device. Recent experience has included claim denials, rejections, and significant underpayments as compared to the costs practitioners must incur to deliver DMHT services. Current MAC determined rates are insufficient to support provider adoption and patient access. For example, HCPCS Code G0552 has been reimbursed by at least one MAC at far below the typical acquisition pricing seen in U.S. commercial markets and other developed countries, resulting in a significant disincentive for adoption. We urge CMS to direct the MACs to establish rates that reflect true acquisition costs and to collect and analyze manufacturer invoice data. Critically, CMS should commit now to transitioning to national payment rates no later than CY 2028, informed by that data and robust stakeholder collaboration. As further described in our CY 2026 Letter, the 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 also note that the Agency indicated it would provide guidance to the MACs on these issues, and our members have not yet observed any improvement. 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. We urge CMS to take immediate action to resolve these barriers to patient access, either through direct instruction to the MACs on appropriate recognition and payment for DMHT services or through better recognition at the national level of the resources needed to deliver DMHT.

To support consistent national coverage and avoid inappropriate crosswalks 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 PFS. 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;
- An appropriate national pricing structure for product or product category pricing, accurately reflecting the variation in eligible DMHTs, will be established based on learnings from the short-term period of contractor pricing; and
- Invoices paid by health care providers for DMHTs are to be used to establish the cost to the provider unless substantial evidence exists to show that the invoice pricing is grossly misaligned with standard product pricing.

<u>Expand the DMHT Codes to Additional FDA Device Classifications</u>

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 while we 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, which requires clinical data demonstrating the model of therapy delivered by the device and any adverse events, software verification, validation, and hazard analysis, a software usability assessment, and physician and patient labeling requirements;
- Digital Therapy Device to Reduce Sleep Disturbance for Psychiatric Conditions (for example, nightmare disorder and posttraumatic stress disorder), classified under 21 C.F.R. 882.5705, which 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; and
- Computerized Behavioral Therapy for the Treatment of Fibromyalgia Symptoms, classified under 21 C.F.R. 882.5804, which 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.

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 DMHT Coding

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 additional FDA device classifications discussed above, and we ask 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.

10. Coverage of Other Digital Therapeutics

While there are a small number of DTx available in the United States, they already cover many different therapeutic categories, including diabetes, musculoskeletal, respiratory, mental and behavioral health, women's health, and oncology, and more will continue to enter the United States market. ATA Action strongly supports CMS expanding Medicare coverage for DTx under existing benefit categories, including but not limited to the PFS, 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, from nothing required beyond a smartphone to software connected to or incorporated into a sensor or other devices such as wearables and virtual and augmented

reality headsets, which can vary greatly in terms of functionality and cost. ATA Action 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. In addition, as the Agency implements new models and programs involving digital therapeutics, including the ACCESS Model and products made available under the FDA TEMPO program, we urge CMS to ensure that these initiatives complement, rather than displace, the established PFS codes for DMHTs and other DTx. Stable coverage and payment pathways under the PFS are essential to give providers and beneficiaries confidence that products reimbursed today will remain available as new models develop.

11. Facilitate In Home Diagnostic Testing

To further the significant progress made by 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 costs 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, particularly in rural communities where patients may live several hours from the nearest specimen collection site. As a general principle, we believe reimbursement for a diagnostic test performed by a laboratory should be indifferent to the location or method of specimen collection, so long as the test is performed lawfully and accurately.

For example, the PFS generally treats CPT Code 99000, handling and/or conveyance of a 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, while incurring real costs for validated collection kits, packaging and instructions designed to support proper collection and return, and round-trip shipping. To ensure fair and appropriate reimbursement, we suggest the Agency allocate separate RVU time to providers for CPT Code 99000 when a patient self collects samples or performs a diagnostic test at home as provided by their health care practitioner.

We also suggest two complementary steps. First, CMS should recognize the administrative cost of laboratory requisitions associated with in-home collection through a nominal payment, which would meaningfully support adoption without materially increasing program costs. Second, CMS should consider an outreach code or other incentive to support physician outreach to patients who are not compliant with recommended or guideline directed testing. Many Medicare beneficiaries, particularly in rural areas, have never received guideline recommended screenings, such as hepatitis C screening, despite the availability of curative treatment, simply because they rarely present for in person care. In home specimen collection paired with an outreach incentive would allow clinicians to close these gaps, identify disease earlier, and avoid far more costly downstream care.

12. Support Virtual Foodcare Through Nutrition, Coaching, and Medically Appropriate Food

ATA Action supports policies that integrate evidence-based nutrition care, medically appropriate food interventions, and virtual care to expand access and improve chronic disease prevention and management. We applaud the Agency's efforts to improve access to the services of dietitians and wellness coaches, including the proposals to increase access to diabetes self-management training and medical nutrition therapy services in rural health clinics and federally qualified health centers and to establish payment for

health coaching services (CPT Codes 0591T, 0592T, and 0593T). We suggest that CMS clarify that these services may be provided virtually in order to promote patient access.

Given the Agency's interest in preventing disease and better managing chronic conditions, ATA Action was surprised that this year's proposal did not include efforts to create new codes addressing medically appropriate nutrition or otherwise propose changes to improve access to medically tailored meals and other "food is medicine" interventions for Medicare beneficiaries. We note that CMS has specifically requested information regarding intensive lifestyle interventions to slow the progression of Alzheimer's disease. A growing body of peer reviewed evidence indicates that diet and lifestyle influence the development and progression of Alzheimer's dementia,[10] and virtual care tools, including remote coaching, digital screening, personalized meal planning, and remote medical nutrition therapy, make intensive lifestyle interventions scalable to beneficiaries wherever they live. Consistent with ATA Action's Virtual Foodcare Policy Principles[11], we encourage the Agency to include nutrition and virtual lifestyle supports in any framework that emerges from this RFI.

As ATA Action has previously recommended, we support CMS's exploration of separate coding and payment for medically tailored food interventions, including Medically Tailored Meals ("MTMs") and Medically Tailored Groceries ("MTGs"), particularly when integrated with virtual care and remote patient support. For individuals whose health conditions require nutrition tailored to specific clinical needs, these interventions can be an important component of care. Access to medically appropriate nutrition can support better outcomes, particularly for individuals managing chronic illness, transitioning from a hospitalization, experiencing a high-risk pregnancy, or facing barriers to accessing nutritious food.

Medically tailored food interventions can also complement medical nutrition therapy and digital health tools by supporting care plan adoption and adherence, complementing clinical treatment, reducing avoidable hospital readmissions and other health care utilization, and improving health outcomes. ATA Action therefore encourages CMS to establish distinct HCPCS codes for MTMs and MTGs, similar to existing coding approaches for medical foods, and to provide appropriate flexibility for primary care physicians, registered dietitians, specialty care providers, and other qualified practitioners to bill separately for these services. Distinct coding would help differentiate medically tailored food interventions from general nutrition services and bundled care management services, improve consistency in billing and program implementation, and allow CMS to better identify the type and duration of nutrition interventions and the populations receiving them. This, in turn, could improve CMS's ability to evaluate utilization, clinical outcomes, avoidable health care utilization, and total cost of care.

CMS should also support the integration of virtual foodcare services, including digital screening for food access needs, personalized foodcare and meal planning, remote medical nutrition therapy, and meal tracking

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[10] Livingston, G., Huntley, J., Liu, K. Y., et al. (2024). Dementia prevention, intervention, and care: 2024 report of the Lancet standing Commission. *The Lancet, 404*(10452), 572–628. https://doi.org/10.1016/S0140-6736(24)01296-0
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Arora, S., Santiago, J. A., Bernstein, M., & Potashkin, J. A. (2023). *Diet and lifestyle impact the development and progression of Alzheimer's dementia*. *Frontiers in Nutrition, 10*, Article 1213223.

[11] American Telemedicine Association's Virtual Foodcare Policy Principles
https://info.americantelemed.org/hubfs/ATA%20Action/Virtual-Foodcare-Policy-Principles.pdf

through patient-facing digital tools. These services may be particularly valuable for individuals with chronic conditions and those transitioning from acute care, where nutrition can play an important role in recovery and reducing avoidable readmissions. While we appreciate CMS's efforts through initiatives such as ACCESS and ELEVATE to use technology to support healthier lifestyles, these programs do not directly address access to food itself. Virtual coaching and nutrition recommendations are most effective when patients also have access to the nutritious and, where clinically indicated, medically appropriate food needed to put those recommendations into practice.

ATA Action appreciates CMS's continued commitment to advancing virtual care and innovation within the Medicare program. We believe this Proposed Rule takes important steps toward modernizing Medicare payment for technology enabled care, and, with the changes described above, particularly with respect to remote monitoring, the final rule can strengthen rather than diminish beneficiary access to high-quality care. We look forward to working together to ensure that Medicare beneficiaries can continue to benefit from safe, effective, and innovative virtual care. Please do not hesitate to reach out to me with any questions.

Sincerely,

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