August 28, 2024

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1784-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Comments on the CY2025 Physician Fee Schedule proposed rule (CMS-1807-P)

Submitted electronically on regulations.gov

Dear Administrator Brooks-LaSure:

As the only organization completely focused on advancing telehealth, the American Telemedicine Association (ATA) and ATA Action, the ATA's advocacy arm, are committed to ensuring that everyone has access to safe, affordable and appropriate care when and where they need it, enabling the system to do more good for more people. The ATA and ATA Action appreciate CMS's continued work to expand access to care for all patients, and we are pleased to submit the following comments in response to the calendar year (CY) 2025 Physician Fee Schedule proposed rule (CMS-1807-P).

As the landscape of healthcare continues to evolve, telehealth plays a crucial role in ensuring timely, appropriate, and expanded access to care for millions of Americans. We applaud CMS for maintaining and extending as many of the Medicare telehealth flexibilities as possible within its regulatory authority. The ATA and ATA Action recognize that CMS is in a particularly challenging position this year, as the absence of an active Public Health Emergency (PHE) limits its ability to extend telehealth authorities independently. As a result, CMS now relies on congressional action to ensure clarity and continuity for statutory telehealth policies beyond CY2024. We urge CMS to join us in advocating for Congress to swiftly extend or make permanent the Medicare telehealth flexibilities, including:

- Waiving geographic and originating site restrictions.
- Maintaining coverage for audio-only services.
- Allowing Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to be reimbursed for providing telehealth services.
- Delaying the telemental health prior in-person requirement.
- Maintaining the expansion of the Medicare Telehealth Provider list to include physical therapy, occupational therapy, and speech therapy (PT/OT/ST) to ensure these providers can be reimbursed for telehealth services.

Given recent Congressional legislative movement on telehealth and conversations with committees of jurisdiction and leadership, we strongly believe that Congress will maintain the Medicare telehealth flexibilities after 2024. Once Congress officially enacts telehealth legislation, we urge the administration, in coordination with CMS, to quickly issue guidance to providers and others within the industry to eliminate confusion and ensure the smooth implementation of regulatory telehealth policies beyond 2024.

Changes to Medicare Telehealth Services List

We applaud CMS for adding 13 new codes to the Medicare Telehealth Services list, including Preexposure Prophylaxis (PrEP) of Human Immunodeficiency Virus (HIV) (G0011 & G0013) on a permanent basis, and Home International Normalized Ratio Monitoring (G0248) and Caregiver Training (97550-2, 96202-96203, GCTD1-GCTD3, GCTB1) on a provisional basis. These additions are a positive step forward, but we recognize that CMS has received requests to move several of the provisional codes to the permanent list for CY2025. CMS plans to complete a comprehensive analysis of all provisional codes before making final determinations. The ATA and ATA Action believe that any healthcare service that meets the standard of care should be deliverable virtually. We urge CMS to conduct a thorough and timely review of the provisional services, considering the growing demand for virtual care, and to make the necessary additions to the permanent list to ensure all beneficiaries have consistent and appropriate access to these essential services.

The ATA and ATA Action respectfully raise concerns about the proposed removal of radiation treatment management from the Medicare Telehealth Services list. This code has facilitated the continuous management of radiation therapy for patients. We believe that its removal could inadvertently disrupt patient care and access to vital services. We encourage CMS to carefully consider the potential impacts of this change on patient outcomes and provider efficiency.

Frequency Limitations on Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations

The ATA and ATA Action strongly oppose limitations on the quantity of telehealth visits a practitioner can furnish over a period of time or any type of in-person requirement. These are arbitrary barriers that limit access to care. Ultimately, we want the practitioner to be able to practice at the top of their license and allow them to use their clinical judgment to determine the type of visit, how many visits, and the type of treatment that is best fit for the patient so long as the standard of care is met. CMS proposes to temporarily remove the telehealth frequency limitations for subsequent hospital inpatient/observation care (99231, 99232, 99233), subsequent nursing facility visits (99307, 99308, 99309, 99310), and critical care consultation services (G0508, G0509), until the end of CY2025. We appreciate this extension but urge CMS to eliminate these barriers permanently.

Audio-Only Communication Technology to Meet the Definition of "Telecommunications System"

We support revising § 410.78(a)(3) to include two-way, real-time audio-only communication technology for any telehealth service provided in a beneficiary's home and appreciate CMS for covering such services. However, we urge CMS to not restrict audio-only services to specific circumstances, such as the unavailability of video technology or requiring explicit patient consent for video visits. Such limitations create unnecessary burdensome barriers and can complicate audio-only services, especially for on-call providers who conduct audio-only emergency services. The draft rule restricts audio-only services to cases where patients lack access to video technology, disregarding scenarios where providers might also face limitations. We believe it is essential to allow providers and patients the flexibility to determine the most appropriate modality for their care, without imposing restrictive conditions that could undermine the effectiveness and accessibility of telehealth services.

Telehealth Reimbursement

We appreciate that CMS continued to reimburse telehealth services provided in the home at the higher non-facility rate in CY2024, but we are disappointed that this rate was not extended or mentioned in this year's rule. Without fair payment, current utilization levels and upticks of telehealth will be disincentivized, negatively impacting patients' access to care.

As outlined in previous comments, we support the principle of fair payment for telehealth services. The time a clinician spends with a patient typically does not vary whether the service is provided in-person or virtually. However, other factors, such as infrastructure costs (whether for physical facilities or technology) and administrative time, can differ significantly. Virtual options can offer savings by reducing administrative burdens and time. We are concerned that reductions in payment rates under the fee schedule could inadvertently disincentivize the adoption of telehealth and hinder providers' ability to adequately invest in the necessary technological infrastructure or incorporate it into their workflow. Fair payment should consider these varying factors. Therefore, we respectfully urge CMS to continue engaging with stakeholders on telehealth reimbursement rates in future fee schedule rules, ensuring that these rates remain appropriate as technology and healthcare delivery continue to evolve.

Extending Outpatient Therapists' Ability to Bill for Telehealth

CMS did not extend the flexibility that allows hospital-employed physical therapists (PTs), occupational therapists (OTs), and speech-language pathologists (SLPs) to continue billing for telehealth services beyond CY2024. It is crucial for Congress to act to ensure that PTs, OTs, SLPs, and audiologists can continue providing telehealth services. Following congressional action, we urge CMS to align its payment policies accordingly to support these essential services.

Virtual Direct Supervision

The ATA and ATA Action support CMS's proposal to extend the PHE definition of direct supervision, which allows a supervising provider to be considered "immediately available"

through virtual presence, through the end of CY2025. We are also pleased that CMS proposes to permanently define this standard for a subset of low-risk, incident-to services typically performed entirely by auxiliary personnel. While these are steps in the right direction, the ATA and ATA Action continue to urge CMS to make direct supervision via telehealth a permanent option across all scenarios. We recommend that CMS collaborate with stakeholders to identify the most appropriate services for this supervision method, with patient safety as the paramount concern. Providers should have the autonomy to determine when direct supervision via telehealth is clinically appropriate and consistent with the standard of care, and CMS should avoid imposing additional requirements for virtual supervision that do not apply to in-person supervision.

Direct Supervision for Teaching Physicians

We are pleased to see that CMS is continuing its current policy through 2025 to allow teaching physicians to have a virtual presence during a virtual, three-way telehealth visit, with the patient, resident, and teaching physician in separate locations. We would appreciate CMS considering the extension of this policy to include non-virtual visits, specifically allowing in-person resident and patient visits to be supervised by a teaching provider who joins virtually.

Medicare Provider Address

We fully support CMS's current proposal to continue allowing the use of practice locations instead of home addresses for Medicare enrollment and claim forms. Ensuring that addresses of providers who render telehealth services from their home residences remain confidential from the public has been a top priority for stakeholders, including the ATA and ATA Action. This year, CMS has proposed to continue allowing the distant site practitioner to use their currently enrolled practice location instead of their home address on their Medicare enrollment and claim forms when providing telehealth services from their home. We applaud CMS for this extension but urge CMS to work with stakeholders on a long term and permanent solution post CY2025. See here for a stakeholder letter with over 100 signees outlining potential viable solutions.

Rural Health Clinics and Federally Qualified Health Centers

Direct Supervision

The ATA and ATA Action support CMS maintaining the virtual presence flexibility for direct supervision for 2025. However, we advocate for making this policy permanent and not to exclude audio-only as an option.

Payment

The ATA and ATA Action strongly advocate for the permanent continuation of payments for RHC and FQHC services delivered via telehealth. Given the critical role these entities play in delivering care to Medicare beneficiaries—particularly in underserved and rural areas—it is essential that telehealth services continue to be covered and reimbursed. Telehealth ensures that vulnerable populations have consistent access to healthcare, reduces barriers related to distance and transportation, and allows for timely, high-quality care.

Permanently maintaining telehealth payments for RHCs and FQHCs is vital to ensuring that these services remain accessible and inclusive for all Medicare beneficiaries.

Telemental health in-person requirement

The ATA and ATA Action support the continuation of delaying the in-person visit requirement for telemental health services by RHCs and FQHCs to beneficiaries in their homes until January 1, 2026. However, we would like this policy made permanent.

Remote Monitoring

Remote monitoring technologies are crucial for improving patient outcomes, and any reduction in reimbursement risks undermining their adoption and sustainability. We respectfully express our concerns over CMS's proposed reduction in reimbursement for remote therapeutic monitoring (RTM) and remote physiologic monitoring (RPM), which continues a concerning multiyear trend. RTM and RPM treatment management codes are significantly undervalued relative to similar codes and should be updated. RTM and RPM are demonstrating positive clinical outcomes but have not benefited from an upward adjustment like the similar Chronic Care Management codes upon which their valuation was based. This change is necessary to enable continued access to high-quality services and ongoing reduction of risks undermining the adoption and sustainability of remote monitoring technologies, which are critical for patient care. Additionally, we are deeply concerned that CMS has not addressed the significant issues raised by digital health stakeholders regarding the 16-day data reporting requirement for billing RPM and RTM codes, as well as other restrictive billing conditions. These arbitrary data requirements place unnecessary burdens on providers and can hinder patient access to these valuable services. We strongly urge CMS to reconsider and reduce the 16-day data reporting requirement permanently to better support the integration of digital health technologies into patient care.

Opioid Treatment Programs

The ATA and ATA Action applaud CMS for permitting OTPs to conduct periodic assessments using audio-only on a permanent basis beginning January 1, 2025. We also commend CMS for allowing the OTP intake add-on code (HCPCS code G2076) to be used with two-way audio-video technology for initiating methadone treatment, provided this use is authorized by DEA and SAMHSA at the time of service. However, it is crucial to emphasize that this progress does not diminish the urgent need for DEA to establish workable post-pandemic rules for the remote prescribing of controlled substances. These rules are crucial not only for Medicare beneficiaries but for all Americans who rely on telehealth for critical care. We continue to urge DEA to expedite the release of revised regulations to ensure uninterrupted access to care, particularly as the current flexibilities are set to expire at the end of this year.

Medicare Diabetes Prevention Program (MDPP)

Expanding the Medicare Diabetes Prevention Program (MDPP) to include virtual-only suppliers is a top priority for the ATA and ATA Action. We are once again disappointed that CMS did not address this critical barrier, which limits the number of suppliers available to beneficiaries within

the program. This program is crucial, having demonstrated a 70 percent reduction in the incidence of new-onset type 2 diabetes among adults aged 60 and older with overweight or obesity and prediabetes (CMS Diabetes Strategy — Impact Report 2024). We strongly urge CMS to allow virtual-only suppliers to participate in the MDPP, as this would expand access to care and further improve health outcomes.

The ATA and ATA Action do, however, applaud CMS for two proposals that would:

- Update the term "online delivery" to "online" to align with both the MDPP "distance learning" term and the CDC DPRP "online (non-live)" term.
- Revise the definition of the MDPP "online" delivery mode to specify that sessions delivered entirely through the internet via phone, tablet, or laptop in an asynchronous (non-live) format, where participants engage with the content at their own pace without a live component.

Advancing Access to Behavioral Health Services

Post-Discharge Telephonic Follow-up Contacts Intervention (FCI)

The Follow-up Contacts Intervention (FCI) involves a series of 10-20 minute phone calls between a provider and a patient after discharge from the emergency department. These calls aim to support the use of the Safety Plan, provide psychosocial support, and facilitate follow-up care. Since FCI is delivered via audio-only calls and is not a substitute for in-person services, it falls outside Medicare telehealth restrictions. The ATA and ATA Action support CMS proposing a new HCPCS code, GFCI1, for billing monthly follow-up contacts, which would cover four calls per month.

Digital Mental Health Treatment

We appreciate CMS for proposing the creation of three new HCPCS codes for Digital Mental Health Therapy (DMHT) devices, modeled on the coding for Remote Therapeutic Monitoring (RTM) services. CMS indicates that these proposed codes and payments will apply only to FDA-cleared devices, a measure designed to protect consumers. However, we hope the FDA clearance requirement is broad enough to include products that have received FDA approval, have undergone appropriate regulatory pathways, and include low-risk devices exempt from 510(k) clearance. The term "FDA cleared" specifically refers to devices that have completed the 510(k) premarket submission process. Limiting the DMHT codes to these devices could inadvertently exclude those that fall under different regulatory pathways based on the risk they pose to patients or the novelty of the technology involved. Since the FDA determines the appropriate regulatory pathway for a device, limiting reimbursement eligibility to just one pathway could unnecessarily restrict access to important DMHT devices, potentially misaligning with CMS's intent.

Additionally, it's important to note that the current RPM and RTM device requirements do not mandate FDA clearance, thereby deferring to the FDA's definition of a device and allowing the FDA to determine the appropriate regulatory pathway without CMS's intervention. We are concerned that the current wording of the rule might inadvertently limit DMHT codes to devices related to substance use disorder, insomnia, depression, and only those cleared through the 510(k) process. In the final rule, it would be helpful for CMS to clarify its intent and specify the types of

products it aims to include within this expansion, ensuring alignment with the intended goals.

Advanced Primary Care Management Codes

We commend CMS for this new code set as a great way to expand access and increase patient engagement. This provides enhanced opportunities for the beneficiary and any caregiver to communicate with the care team/practitioner regarding the beneficiary's care through the use of asynchronous non-face-to-face consultation methods other than telephone, such as secure messaging, email, internet, or patient portal, and other communication- technology based services.

Conclusion

The ATA and ATA Action deeply appreciate all that CMS has done to advance telehealth and expand access to care for beneficiaries. Your continued efforts have played a pivotal role in shaping a more inclusive and accessible healthcare system. As we move forward, we want to emphasize that the ATA and ATA Action are committed to being a resource for CMS on all aspects of telehealth and virtual care policy, including the 2025 Physician Fee Schedule and beyond.

We are available at your convenience to discuss any of these comments in further detail and provide additional support. We look forward to continuing our collaboration to ensure that these policies meet the evolving needs of providers and patients alike.

Thank you for considering our comments, and we stand ready to support your efforts in any way we can. If you have any questions or would like to further discuss our recommendations, please contact Kyle Zebley, Senior Vice President, Public Policy at kzebley@americantelemed.org.