ALLIANCE for CONNECTED CARE

September 4, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, D.C. 20201

Re: Comments on CY 2025 Physician Fee Schedule Proposed Rule (CMS-1807-P)

Dear Administrator Brooks-LaSure,

The Alliance for Connected Care ("the Alliance") welcomes the opportunity to provide feedback on the Centers for Medicare & Medicaid Services ("CMS") Medicare Physician Fee Schedule (PFS) proposed rule, which updates the schedule for Calendar Year 2025 (CY 25) and includes important proposals to lay the groundwork for future significant changes in telehealth Medicare policy. We look forward to working with you to continue efforts to ensure permanent access to services provided via telehealth.

The Alliance is dedicated to improving access to care through the reduction of policy, legal, and regulatory barriers to the adoption of telemedicine and remote patient monitoring. Our members are leading health care and technology innovators, and patient and provider groups, including many types of clinician specialty and patient advocacy groups who wish to better utilize the opportunities created by telehealth and remote patient monitoring.

As reflected in the comments below, the Alliance appreciates CMS for ensuring certainty to telehealth access to Medicare beneficiaries to the extent it could. The Alliance is committed to leveraging telehealth and remote patient monitoring to improve quality of care while also lowering costs and improving the clinician experience.

The Alliance would like to emphasize the following overarching priorities in advance of our more detailed response:

- **The Alliance supports the CMS proposal for a one-year extension to provide time to address provider enrollment and billing concerns related to the provision of telehealth services form a provider's home or non-clinical location**. The Alliance seeks clarification on specific requirements related to enrollment and billing of these providers.
- **The Alliance strongly supports the continued availability of direct supervision through telehealth for both the treatment of patients and the training of residents**. We urge CMS to consider additional clinical situations in which virtual direct supervision is also acceptable. We applaud CMS for permanently allowing virtual direct supervision for lower acuity health care services provided incident to a physician.

- **The Alliance applauds the CMS decision not to cover duplicative codes for telehealth services.** We believe that the adoption of these codes would undermine the broader efforts of the Administration to ensure equitable access to the full spectrum of Medicare services.
- **While reimbursement is a concern for many services, the Alliance is most concerned with the dramatic and continuing decline in reimbursement for remote patient monitoring**. We believe that this decline presents a significant barrier for most Medicare beneficiaries to receive services that both CMS and the Alliance believe are valuable for patients with chronic conditions.
- **The Alliance strongly supports permanent CMS action to protect and ensure access to audio-only telehealth** when clinically appropriate and needed by the patient.

The Alliance also appreciates CMS continuing to reimburse for telehealth services at the non-facility rate. As noted, through years of comments, the Alliance believes telehealth serves as another modality to same care services and should not be paid differently by the Medicare program. While the Alliance supports the non-facility rate payment, we urge CMS to alter its definition of what services are eligible for the non-facility rate. Rather than limiting this payment to the patient's home through POS 10, CMS should instead simply apply the non-facility rate for any telehealth service not offered from a facility.

Telehealth has become integrated into ongoing care plans for many of America's seniors, allowing individuals to remain in their home when appropriate. We appreciate CMS for ensuring, to the extent of its authority, Medicare beneficiaries continue to have access to telehealth and RPM. We understand that, without congressional action, CMS is limited in what it is able to do. We look forward to continued conversation around a temporary extension of current flexibilities, which will lay the groundwork for permanent telehealth policies.

Please find below specific comments in response to proposals in the CY2025 PFS. We look forward to meeting with you to discuss these items more in detail, as needed.

Changes to the Medicare Telehealth Services List

The Alliance is disappointed that CMS is has not made any determinations to recategorize provisional codes as permanent until CMS can complete a comprehensive analysis of all such provisional codes. In general, we believe sufficient evidence exists from the past four years of telehealth services to justify longer-term decision-making around Medicare telehealth services.

The Alliance urges CMS to clarify the process for provisional codes to be recategorized as permanent as soon as possible. Many health care practices and providers depend on certainty for continued investments around telehealth services. Without a clear path for provisional codes to become permanent, many practices and providers are reluctant to make system changes for continued access to these health care services.

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

CMS is proposing to delay implementation frequency limitations for codes related to subsequent inpatient visits, subsequent nursing facility visits, and critical care consultation services in CY2025. The Alliance and its members strongly support the removal of the frequency limitations for Subsequent Inpatient Visits, Subsequent Nursing Facility Visits, and Critical Care Consultation Services as these services are regularly performed within our member organizations by many specialties. This flexibility will allow specialists (examples include neurointensivists, infectious diseases, and pediatric subspecialists), who are unable to travel to rural hospitals, to treat patients in an ongoing manner. This policy will also be extremely beneficial to patients being treated through Hospital at Home and other home-based treatment programs. The Alliance supports CMS action to allow for an additional year of data to determine how practice patterns are evolving and changing.

Audio-Only Communication Technology

The Alliance applauds CMS for its action to ensure access to widespread audio-only telehealth services. While we do believe that audio-video communication is the preferred modality for most telehealth, the Alliance strongly supports continued access for audio-only telehealth – when clinically appropriate and when meeting the need or request of the patient. We believe that this proposal will reduce the care gaps that disproportionately affect the Medicare population. We encourage CMS to ensure that any steps around documentation of patient need for audio-only telehealth represent as small of a burden on providers as possible.

Deletion of Telephone E/M Services

With CMS recognizing interactive telecommunications system to include two-way, real-time audio-only communication, it is understandable that the telephone E/M CPT codes are unnecessary. The Alliance has long believed that CMS was able to cover audio-only telehealth under the same authority it has used to cover other communications technology-based services, such as virtual check-ins and remote technology.

We also believe that the coding alignment of audio-only telehealth services and audio-video telehealth services will make it easier to capture data and research the efficacy and outcomes of telehealth services. It will also simplify billing for services. For example, aligned codes for audio-only telehealth will be extremely helpful in circumstances where a telehealth visit becomes and audio-only visit because of a technical difficulty or broadband outage. The patient will continue to receive care, and the visit will continue to be documented for the service being provided.

The Alliance continues to support data collection through CPT modifiers documenting audio-only services. It is important to collect data on audio-only telehealth in order to support high-quality, permanent telehealth policies that allow for appropriate use of audio-only services.

Distant Site Requirements – Provider Location

The Alliance for Connected Care thanks CMS for allowing a one-year extension to permit the distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services from their home. The Alliance and its members have met with CMS for several years

about the importance continuing this flexibility for health care professionals and we look forward to working with the Administration on permanent policy.

The Alliance is concerned that failure to resolve this concern will tarnish one of the greatest silver linings of the past few years – the increased flexibility that has allowed many health care providers to better support patients while also better managing their own stress and burnout. Allowing the billing of services while offering more flexible care from remote locations such as the home has enabled telehealth to expand provider capacity, supported patient access to after-hours care from their existing clinicians, and has been a determining factor in the decision of many health care practitioners to remain in the workforce.

The administrative burdens associated with home address reporting for billing purposes are significant. Clinicians change their home addresses far more frequently than their practice location. The process to set up a new address for Medicare enrollment forms include registering the clinician's location with Medicare as Group B enrollment, registering the clinician under the health system's taxpayer identification number (TIN), with a practicing address as their Group B enrollment address, and configuring a new EHR location for the individual provider's home address. The administrative burden of changing the current management of Medicare billing and enrollment addresses would substantially increase the burden on both health systems and payers, including Medicare.

In a recent letter to CMS, the Alliance and its members reported that a change in the current status quo would result in 40 times increase in the number of billing addresses tracked and reported to CMS by a health system. Multiple health system members estimated the resulting operational costs of this change at approximately $1 million in labor costs. It is important to note that CMS itself would also have significant operational costs related to the processing the additional documentation that would be submitted to the agency.

For most providers, the logistical processes related to supporting telehealth services are generally the same as in-person services – as the majority of telehealth services are scheduled, managed, and supported by the same support staff working in the facility or medical practice. As telehealth becomes integrated into everyday care, CMS will need to update its management of Medicare billing and enrollment addresses to reflect the real-world application of telehealth. **We respectfully request that CMS make permanent its existing policy allowing a practitioner to bill from a location in which they can practice in-person**.

With respect to CY2025, we request that CMS issue clarification that a provider who has enrolled via P.O. box as per the guidance offered earlier this year, can report that currently enrolled location as per the flexibility outlined in the proposed rule. These flexibilities, taken together, do enable fully remote virtual care, but there remains significant confusion about this flexibility – including from Medicare Administrative Contractors.

Concerns related to fully remote practitioners

While the Alliance deeply appreciates CMS's actions to preserve flexibility around location reporting for those practitioners with an in-person enrolled location, we believe the continued delay in creating a clear

enrollment and billing pathway for fully remote practitioners to be extremely harmful for patient access. There are many practitioners working fully remotely who share the same safety, privacy, and operational concerns as those helped by this flexibility. Many practitioners have shifted to fully virtual practice to better meet patient needs and offer care across wider geographies – meeting national access needs. A particular area of concern is mental health and substance use disorder services, as telehealth utilization is extremely high for this care – with 37 percent of mental health services continuing to be offered remotely. These practitioners also have significant incentives to protect security of their home addresses when practicing from that location.

For those providers without a physical practice location, we request that CMS develop an alternate method of reporting geographic location. One suggestion would be to allow a business address to be reported for purposes of enrollment, and a geographic indicator such as a zip code be reported for appropriate payment adjustment by geographic cost and wage index. An alternate option would be for CMS to identify a population of provider organizations at higher risk of "gaming" the system and leverage CMS claims data to monitor for unexpected geographic distribution of services related to enrolled location of those providers.

We strongly encourage CMS to push forward with its planned development of permanent policy to address these concerns and we request that CMS ensure adequate stakeholder input is incorporated into this effort.

Direct Supervision

The Alliance applauds CMS for continuing to define direct supervision to permit the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2025. Virtual direct supervision through telehealth can support innovative home-based models, can expand workforce capacity, and will of course have utility in any future outbreak or public health emergency situation. We urge CMS to consider additional clinical instances in which virtual direct supervision may be plausible and strengthen the capabilities of the direct care workforce.

Additionally, the Alliance and its members appreciate CMS recognition that practitioners and health systems require time to reorganize practice patterns established during the PHE. While the Alliance does not support a return to the pre-PHE approach, we agree this transition period would be necessary.

Permanent Direct Supervision for "Incident to" Services

The Alliance applauds CMS for its proposal to allow the definition of direct supervision to permit virtual presence for services that are inherently lower risk, including services that do not ordinarily require the presence of the billing practitioner, do not require direction by the supervising practitioner to the same degree as other services furnished under direct supervision, and are not services typically performed directly by the supervising practitioner.

The Alliance highlight in its comments to the CY 2024 Medicare PFS proposed rule, that, given the drastic workforce shortages that exist, the opportunity for a Medicare-billing practitioner to supervise care being offered by a non-billing practitioner in the home is a monumentally large opportunity to transform the delivery of health care in the United States to better meet patient needs when and where they are. As its becomes more common that patients are treated remotely, we do not believe that it makes sense to require that the supervising clinician to be in the physical room. It should be fully adequate or the supervising clinician to have virtual access to the patient-practitioner interaction, as this is the same level of access that the patient has to the care being offered.

We encourage CMS to consider additional use cases in which a service might benefit from the immediate availability of the supervising practitioner through real-time audio and visual interactive telecommunications is adequate.

Teaching Physician Billing for Services Involving Residents with Virtual Presence

The Alliance applauds CMS and its proposal to continue its current policy to allow teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings when the service is furnished virtually. The Alliance and its members believe virtual supervision of residents by teaching physicians provides an opportunity for residents to assist them with meeting the rapidly-growing demand for telehealth and prepare them for diverse job opportunities.

As noted, in the Alliance's CY 2024 Medicare PFS proposed rule comments, the Alliance and its members urge CMS to make this policy permanent. In a pilot program, a majority of residents noted the value of having a telehealth rotation in the curriculum, citing that "it prepared them for telehealth in the specialty program."

The Accreditation Council for Graduate Medical Education (ACGME) recognizes the benefits for allowing virtual supervision of residents and recommends this as a best practice in its Common Program Requirement. Many residents starting their first year of postgraduate training are unlikely to have been exposed to telehealth training. Familiarizing the next generation of health care providers with the knowledge of telemedicine serves as a valuable skill to serve populations that do not have more direct access to quality medical care. Without allowing virtual supervision, residents and attending physicians may not acquire valuable skills in their ability to consult and treat patients remotely.[1]

The Alliance urges CMS to additional clinical scenarios where it may be appropriate to permit the virtual presence of the teaching physician. For example;

- Medical teaching hospitals have seen a growing number of requests from its providers to leverage the efficiencies of virtual modalities to supervise residents who may be physically co-located with a patient at facility while the attending is off-site. For example, at some of these hospitals, a resident might be on site and speak with and examine a patient in person, while the teaching physician offering supervision over video. When the attending physicians bill for this interaction, they will do so using the appropriate telehealth billing information (as they are seeing the patient

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9756963/

over telehealth) and they should be allowed to include the information they obtained from the resident provider in their medical decision making.

- Virtual direct supervision of residents providing in-person care could create additional opportunities to address care shortages and expand training. For example, virtual supervision would expand opportunities for residents to obtain experience in extremely rural areas where a teaching physician is not available. It could also support experiential learning through the provision of care in a community-based setting.

Teaching physicians should be allowed to determine when their virtual presence would be clinically appropriate, based on their assessment of the patient's needs and the competency level of the resident.

Telemedicine Evaluation and Management (E/M) Services

The Alliance applauds CMS for not proposing to adopt new and duplicative telemedicine E/M codes for payment under Medicare. The Alliance appreciates the work and intent of the AMA in putting forth new coding for telehealth services, we believed that these codes would ultimately undermine the broader efforts of the Administration to ensure equitable access to the full spectrum of Medicare services. The Alliance and its members opposed the creation of these new telehealth codes, as mentioned in a letter to CMS. We received a response from CMS, appreciating our input on this important issue.

Telehealth is a modality of care and not a different service. Adoption of these codes would create complexity and potential payment variation as well as negatively impact billing operations and patient access.

Advanced Primary Care Management

Under its proposed Advanced Primary Care Management model, CMS is proposing that an initiating visit could be provided in-person or as a Medicare telehealth service. The Alliance supports allowing an initiating visit to be provided as a Medicare telehealth service. Health care services provided by practitioners via telehealth are same as in-person, just simply through a different modality. In general, the Alliance is supportive of the inclusion of more flexible coding options for important care management services that are often offered virtually. The Alliance encourages continued work to enable greater access for beneficiaries – including efforts to ensure we also incent greater access for patients without the benefit of access to a practitioner in a sophisticated alternative payment model.

CMS also requested comments on whether other CTBS services, such as remote physiologic monitoring and/or remote therapeutic monitoring should be incorporated into the advanced primary care hybrid payments. The Alliance does not believe it would make sense to include remote physiologic monitoring (RPM) and/or remote therapeutic monitoring (RTM) to be incorporated into this model. RPM and RTM are currently discrete, time-based codes and bundling these codes into the model would not make sense. We look forward to working closely with you separately on options that would better incentivize remote monitoring for those patients that would most benefit – and yield important savings for the Medicare program through avoided hospitalizations and other valuable clinical outcomes.

CMS seeking in regarding how evolving changes in practice may warrant reconsideration of payment and coding policies for behavioral health integration (CPT codes 99492, 99493, 99494, and 99484 and HCPCS code G0323). We believe that, while the current codes provide a framework for collaborative care, their implementation in a fee-for-service environment presents specific challenges. As the agency reviews the codes, it should consider whether they fully capture the services provided in a collaborative care model. Expanding codes to include additional services or adjusting the payment models to better reflect evolving practice patterns could further enhance the viability of these models in a fee-for-service environment.

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

One-Year Delay of In-Person Visit Requirements for Remote Mental Health Services

The Alliance applauds CMS for proposing an additional extension to continue to delay the in-person visit requirement for mental health services furnished via communication technology by RHCs and FQHCs to beneficiaries in their homes until January 1, 2026. The Alliance supports ongoing work between CMS to and Congress to permanently remove the in-person visit requirements for remote mental health services for not just RHCs and FQHCs, but also all Medicare telehealth services.

More broadly, we continue to oppose any in-person visit requirements on telehealth services, and we urge CMS to continue to work with Congress to ensure that the decision for an in-person visit should be left between the patient and provider.

After four years of pandemic flexibilities, there is no evidence that an in-person requirement is medically necessary for the delivery of comprehensive mental health services. A 2024 study published in *JAMA Health Forum* found that a new in-person visit requirement would substantially change current mental health practice. A 2022 study conducted by Epic Research found that mental health and psychiatry had among the lowest rates of needed in-person follow-up, indicating that patient needs are fully met through telehealth. In fact, follow-up care is significantly more common among individuals whose care was initiated via telemedicine than among those receiving in-person care.

Additionally, nationally-recognized experts agree that in-person requirements, particularly for tele-behavioral health services do not represent current practice for mental health services. The Medicare Payment Advisory Commission (MedPAC) Commissioners discussed their support for the removal of in-person requirements in Medicare with respect to behavioral health. Many Commissioners agreed that an in-person requirement for behavioral health services is a baseless provision for fraud concerns. Additionally, a telehealth researcher emphasized that in-person visit requirements limit the ability of telehealth to expand access to mental health services for patients who live far from any mental health clinician and, therefore, cannot have in-person care.

Proposed Payment Policy for General Care Management Services

The Alliance appreciates the intent of CMS' proposal to allow RHCs and FQHCs to be closely aligned with the broader fee schedule requirements for other provider and bill the individual codes that make up the general care management HCPCS code G0511, but has several implementation concerns. As you know, a number of these services are frequently offered through telehealth and play a significant role in strengthening care at RHCs and FQHCs. While we ultimately do believe that the alignment of these services though telehealth across payment sites to be the right approach, we believe that the rapid year-over-year changes will be harmful and impact the ability and willingness of these providers to adopt digital care management services.

With respect to remote physiologic monitoring and remote therapeutic monitoring, the shift will result in a dramatic decrease in reimbursement for these services from the CY2024 rate. This change will follow the first year of eligibility for these providers to bill for RPM/RTM, creating significant turbulence which may cause many providers currently in the process of expanding access to halt their plans. We speak about the challenges related to broader reimbursement in the section below, but due to the policy changes, they will apply equally to providers in RHCs and FQHCs.

Given these concerns, we call on CMS to implement a transition period of at least one year during which providers may bill for RPM/RTM services under either the G0511 code or under the individual service codes as proposed for CY2025. This path will allow the greatest access to care management services for patients and will simplify compliance for providers that are still new to billing these services. It will also help to ensure that a patient beginning treatment in 2024 does not lose access to that treatment in 2025 as reimbursement models change.

Global Payment Accuracy

CMS is seeking comment on how remote monitoring and other types of new technologies represent new resource costs and/or produce efficiencies and effectiveness of post-operative care. The Alliance does not believe the primary goal of remote monitoring and other new technologies is to produce efficiencies in the initial delivery of care. These services do not replace an alternate form of care, rather they enhance care with additional capabilities that improve patient outcomes. The ultimate goal of including these services is to extend access to care management and support for patients that ultimately lead to better patient outcomes and lower downstream costs. It is important to consider that these costs savings may not materialize within the global payment window, but would ultimately benefit Medicare.

Remote Patient Monitoring

While CMS has specifically requested feedback on remote patient monitoring reimbursement as part of its consideration of global payment packages, the Alliance would like to respond more broadly. The Alliance and its members are concerned about the sustainability and prioritization of the broader RPM payment in Medicare. The national average nonfacility Medicare reimbursement for monthly recurring RPM services have dropped significantly since 2019. Such significant decreases in a short period of time limit patient access to these demonstrably high-value services. RPM helps improve the health of patients by allowing providers to monitor their patients' chronic conditions – and is a crucial capability due to these

conditions being the leading causes of death and disability in America. We know that moving more care into the home is a CMS priority, but cuts to RPM, particularly the device supply code, are aggressively undermining those goals.

In 2022, CMS made a payment adjustment to chronic care management (CCM) codes, recognizing that "the updated values was consistent with [CMS'] goals of ensuring continued and consistent access to these crucial care management services and acknowledges [CMS's] longstanding concern about undervaluation of care management under the PFS." We urge CMS to use its authority to make a similar change for RPM services. RPM should be an integral part of CMS' ongoing push to support and enhance care management services for Medicare beneficiaries. RPM can be key to delivering effective primary care – at home – to Medicare beneficiaries. We kindly request CMS to seriously consider the impact of decreased reimbursement to RPM to the Medicare population.

More broadly, the Alliance encourages CMS to consider additional elements as it capturing expenses and reimburses for RPM in order to make reimbursement more viable. Top Alliance recommendations include:

- Update the valuation of 99454 to account for RPM software as a direct practice expense input in addition to the medical device. CMS has previously considered this step, noting, "as the PE data age, these issues involving the use of software and other forms of digital tools become more complex", and may consider adding software as a direct PE input in the future.
- Allow 99453 and 99454 to be reported more than once per patient during a 30-day period if multiple medical devices are provided to a patient for their conditions**.** CMS does not permit reporting of multiple instances of 99453 and 99454 when multiple devices are provided to a patient, even when medically necessary. For example, in the case of a patient with type 2 diabetes and hypertension, requires a blood glucose for their diabetes and a blood pressure monitor for their hypertension.
- Allow reimbursement for payment for care management of less than 20 minutes in conjunction with RPM. Currently, the 20-minute threshold for reimbursement under 99457 and 99458 results in approximately 30% of care being uncompensated. Shorter intervals of care would better allow for preventative care maintenance when a patient is following their care plan and doing well. A shorter code could be useful as patient transition off of a remote monitoring.

Other RPM recommendations include:

- Create additional clarity around the established patient requirement to ensure that RPM services can be initiated by a different practitioner within institution following in-person medical care, without an additional unnecessary visit.
- Allow for the concurrent billing of Remote Physiological Monitoring and Remote Therapeutic monitoring, given the significantly different clinical use cases for the services.
- CMS should solicit clinical use cases under which it should allow flexibility in the 16-days of data collection requirement in order to facilitate innovative uses of RPM.

Digital Mental Health Treatment (DMHT)

CMS has proposed Medicare payment to billing practitioners for digital mental health treatment (DMHT) devices used in conjunction with ongoing behavioral health care treatment under a behavioral health treatment plan of care. The Alliance supports the expansion of access to digital therapeutics in the Medicare program, as we believe these devices have potential to further expand the capacity of an existing, stretched, behavioral health workforce.

Ensuring the Future of Technology-Enabled Care

In addition to these more specific responses, the Alliance encourages CMS to reexamine its current stance that artificial intelligence services represent an "indirect practice expense," akin to overhead. While not a substitute for care provided by a skilled practitioner, we believe that AI-augmented services have the potential to increase access and improve the patient experience. We encourage CMS to work to develop a comprehensive strategy and payment methodology for this care that crosses CMS programs and services. Given the increasing number of products receiving FDA authorization and clearance, clearer payment pathways to enable patient access to these services is an important step toward permanent incorporation. A public input process such as an RFI would be a helpful step towards the development of this consistent methodology.

A Path Towards Permanent Telehealth Access

The Alliance and its members strongly support prompt action to ensure continued Medicare payment for telehealth – including audio-only, to avert catastrophic in-person requirements on mental health, and to ensure that a wider range of practitioners can leverage telehealth. As CMS works with Congress to develop a more permanent path for Medicare beneficiaries to access high-quality, medically necessary health care services via telehealth, we urge CMS to emphasize guardrails that do not impede the clinical care currently being provided.

Recent legislation that would *temporarily* extend current telehealth flexibilities include several guardrails that attempt to ensure patient safety. While we strongly support increased data collection on the utilization and benefits of telehealth in the Medicare program, we do not believe that a proposal to require the use of a modifier for a practitioner that contracts with or works with a virtual platform to be workable. The policy outcome that this modifier would achieve also remains unclear and unjustified. Similarly, while we support the collection of data on the usage of incident to services in the Medicare program, we do not support the creation of a modifier that creates a double standard by treating clinicians providing telehealth services differently from clinicians providing in-person services.

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The Alliance greatly appreciates CMS's leadership in working to ensure that seniors are able to continue to access telehealth and remote patient monitoring. Patients and clinicians need telehealth to expand access to care and support strong and flexible relationships. Current telehealth flexibilities have played a critical role in promoting access to vital health care services. This is particularly true for patients in rural and underserved areas, patients with mobility issues, and patients with transportation or other limitations that prevent them from accessing in-person care in a timely manner.

We appreciate the opportunity to provide feedback on the Medicare Physician Fee Schedule (PFS) proposed rule for the calendar year (CY) 2025, and look forward to an interim final rule pending congressional action. If you have any questions, please do not hesitate to contact Rikki Cheung and rikki.cheung@connectwithcare.org.

Sincerely,

Chris Adamec
Executive Director
Alliance for Connected Care