ALLIANCE for CONNECTED CARE

April 3, 2025

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

RE: Regulatory Options to Unleash Virtual Care

Dear Administrator Oz,

Congratulations on your confirmation as the Administrator of the Centers for Medicare and Medicaid Services. We look forward to working with you to continue the transformation of health care in the United States, through technology-enabled care that meets patients where they are and creates cost-saving efficiencies for the federal government. As you know, there are many antiquated restrictions on care that stand in the way of our technology-enabled future. Below, please find Alliance for Connected Care's list of "shovel-ready" regulatory issues that CMS either has the authority to act on without Congressional action or that would benefit from CMS subject matter expertise.

As you may know, the Alliance for Connected Care worked closely with the first Trump Administration to expand access to virtual care and telehealth. Highlights included -

- ✓ The Alliance worked with CMS to unbundle Chronic Care Management and Remote Patient Monitoring codes, making RPM coverage a reality in Medicare.
- ✓ The Alliance worked closely with CMS to support rapid steps implementing telehealth expansion in 2020.
- ✓ The Alliance has continued to emphasize policies that support the modernization of the health care workforce through telehealth and digital health. This includes efforts to expand access to practitioners and enhance market competition through greater care across state lines.

Here are our top recommendations for shovel-ready digital health projects in 2025.

Reduce burden and risk associated with provider location reporting.

CMS allowance for practitioners to render telehealth services from a location (such as their home) without creating and reporting as an additional billing location will end on December 31, 2025. In an informal survey of Alliance members, the impact of this policy ending would be profound.

Differentiating and reporting home addresses on billing and enrollment forms would result in a 40-times increase in the number of billing addresses tracked and reported to CMS by a health system.

Multiple health systems estimated the resulting operational costs of this change at approximately $1 million in labor.[1] CMS itself would have significant operational costs related to the processing the large increase in additional documentation that would be submitted to the agency.

Given this reality, we call on CMS to make two changes -

- Make permanent the ability for a provider with a physical practice location to report that billing location, even when offering the occasional telehealth visit from another location.
- Create a separate pathway for fully virtual providers without a brick-and-mortar location, as a home address is their primary practice location. For these practitioners, allow the reporting of a business address, zip code, MSA or other geographic identifier rather than a home address when providing care.

The time to implement these changes is now. Our understanding from past meetings is that some of the barriers to CMS making these changes were legacy issues related to enrollment and billing processes. CMS now has a chance to leverage its active reform of the Provider Enrollment, Chain and Ownership System (PECOS) to make system-wide changes that facilitate a modernized system that reflects the real-world usage of telehealth services. We stand ready to work with you to ensure the new system works well for virtual providers.

Drive more efficient and coordinated care for those with chronic disease by ensuring adequate reimbursement for remote patient monitoring (RPM) technology.

Remote patient monitoring has a huge potential to reduce Medicare expenditures through better health and avoided hospital admissions. A priority for the Alliance in its comments to CMS in 2024 (and continuing into 2025) are 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 recognize to be high value for patients with chronic conditions. CMS actions to unbundle these codes from G0511 for RHCs and FQHCs last year were promising steps towards more rural access, but are unfortunately directly undermined by decrease in payment rates.

The national average non-facility Medicare reimbursement for monthly recurring RPM services have dropped significantly since 2019. 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 the context of other technology enabled services, CMS has acknowledged its challenges in appropriately valuing software cost. Adjustments to RPM to more accurately capture these costs are crucial to continuing and scaling technology-enabled care of all kinds.

Modernize health plan network adequacy requirements to fully leverage virtual care.

It is time for telehealth access to be treated more equally with in-person care when considering network adequacy requirements in Medicare Advantage and Medicaid. As health care delivery models leveraging both telehealth and in-home care expand, CMS must reconsider the merits of using time and distance as

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I. A system reported that it would take their operations staff around 6 hours of work per provider, per year, to add and maintain an average of three billing addresses per telehealth provider. For a health system with more than 3,300 telehealth clinicians, that results in more than 20,000 hours of additional staff work per year. Another system found similar estimates, with more than 4,500 telehealth clinicians resulting in approximately 27,000 staff hours of additional staff work per year.

metrics entirely and instead move to a more accurate measure of patient access including more outcome focused tools, such as beneficiary access, satisfaction, and wait times for providers – either in person or delivered via telehealth. The National Association of Insurance Commissioners (NAIC) model law allows for "other health care service delivery system options, such as telemedicine or telehealth."

Medicaid has considered modernizations to take telehealth into account for purposes of network adequacy through its 2018 proposed rule (CMS-2408-P) which would have overhauled the Medicaid managed care network adequacy criteria. In that rule, CMS proposed to do away with federal time and distance standards for measuring network adequacy by replacing them with more qualitative standards that more accurately reflect access and utility, noting that "a state that has a heavy reliance on telehealth in certain areas of the state may find that a provider to enrollee ratio is more useful than meaningful access, as the enrollee could be well beyond a normal time and distance standard but can still easily access many different providers on a virtual basis." The agency went on to cite a 2017 report by the USC-Brookings Schaeffer Initiative for Health Policy which notes that "in some clinical areas, telemedicine could make proximity measures obsolete, or counterproductive."[2]

Make permanent the availability of direct supervision through telehealth for both the treatment of patients and the training of residents.

CMS has permanently allowed virtual direct supervision for lower acuity health care services provided incident to a physician, but has not yet acted to fully enable the ability of virtual supervision to increase efficiency and access in Medicare. In 2025, CMS adopted a definition of direct supervision that allows "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only), but only for the following subset of incident-to services described under § 410.26 and for incident-to services

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.

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.

Allow the virtual provision of Intensive Cardiac Rehabilitation (ICR) from a hospital-based location.

The Alliance for Connected Care and the American College of Cardiology have asked CMS to allow for hospital-based virtual cardiac rehabilitation. Cardiac rehabilitation is a cornerstone of secondary prevention for individuals with cardiovascular disease, offering structured exercise programs, education, and counseling to reduce the risk of recurrent events and improve overall cardiovascular health. However, traditional in-person CR programs face numerous barriers, including in-person session, transportation challenges, scheduling conflicts, and reduced mobility. While these services were proven effective during the pandemic with "hospital without walls" authorities, we believe the Center for Medicare and Medicaid Services (CMS) has legal authority to permit virtual CR in the outpatient settings because, when creating

[2] "Notice of Proposed Rulemaking (NPRM); Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care (CMS-2408-P)," CMS, 8 Nov 2018. https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24626.pdf

CR/ICR programs, Congress expressly authorized the Secretary of HHS to identify other appropriate "settings" for these programs, which could include patients' homes.

Reducing burdensome restrictions on interprofessional consultations.

We appreciated your comments during the March 14 Senate hearing on the opportunity for telehealth to strengthen health care capability in rural areas. One mechanism for this is through interprofessional consultations, which allows treating providers to request the opinion and/or treatment advice of another provider with specific specialty expertise to assist in diagnosis or management of the patient's problem without seeing the patient. It is widely known that e-consults provide clinical value and can reduce referrals to specialists – reducing costs to the Medicare program. We believe CMS should take additional steps to reduce administrative burdens of these services, in particular for primary care and other practitioners.

Specifically, the current time requirement of a minimum of 16 minutes is difficult for providers to meet when billing CPT code 99452 (*Interprofessional Telephone/Internet/Electronic Health Record Consultations*). Several studies have shown that the average needed for e-consult was less than 10 min on average.[3][4] We request CMS to lower the time frame to a reasonable amount based on the average time used for e-Consults or to consider including another code that captures additional follow-up time. Another regulatory burden around these codes is the collection of consent. We would appreciate CMS clarification that consent for eConsults can be part of general consent collected by support staff.

Engage with the Drug Enforcement Administration (DEA) on its regulatory overreach related to telehealth.

Medicare beneficiaries may have restricted access to telehealth services due to overbroad restrictions being considered by the DEA. In January, the DEA released a proposed regulation that would significantly curtail telehealth and the practice of medicine when a controlled substance is required for treatment. Controlled substances are clinically appropriate for many forms of care offered through telehealth, with mental health treatments being disproportionately impacted. This regulatory overreach follows two bipartisan Congressional directives to allow the prescribing of controlled substances through telehealth with appropriate protections against diversion. Current allowances for this telehealth to continue end on December 31, 2025.

We believe DEA needs the health care operations expertise of CMS to publish a rule that focuses on its core role of preventing the diversion of controlled substances, without creating unworkable restrictions on the practice of medicine. As an example, the January proposal included a requirement for a telehealth provider to offer a large portion of their care in-person – which is not a workable solution for most telehealth providers. Not only would this limit telehealth, but it would dramatically increase regulatory documentation burdens on all practitioners.

CMS thought leadership is needed to catalyze progress on duplicative state licensing regulations that limit health care competition and stifle care delivery innovation.

Many seniors live in areas with limited access to in-person care. Greater access to telehealth can be transformative for these communities, but it is hindered by barriers in access to care across state lines. The ability to practice across state lines is crucial for the delivery of care in both remote rural areas and

[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6747903/
[4] https://medinform.jmir.org/2016/1/e6

those with practitioner shortages. According to an Alliance survey, 84% of health care practitioners and over 8 in 10 telehealth patients support the option to receive telehealth services from health care practitioners across state lines, suggesting that those who have received care via telehealth in the past view their experiences favorably. This access is also needed for de-centralized clinical trials, rare diseases, college students or others who travel, and many other specific use cases. As you know, President Trump led on efforts to reform occupational licensure efforts during his first term and that continued leadership is needed to advance efforts which will make health care more efficient and competitive.

Thank you for your consideration of these high-level opportunities. Our members would welcome the chance to discuss any of these issues in greater detail – please contact me at cadamec@connectwithcare.org to set up a meeting or follow up with any questions.

Thank you,

Chris Adamec
Executive Director
Alliance for Connected Care