



January 26, 2026

Submitted via regulations.gov

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Request for Information on Future Directions in Medicare Advantage (CMS-4212-P)

Dear Administrator Oz,

The [Alliance for Connected Care](#) (“the Alliance”) welcomes the opportunity to provide comments on the request for information on the Medicare Advantage (MA) program. 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 (RPM). Our members are leading health care and technology organizations from across the spectrum, representing health systems, health payers, 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 virtual care.

Virtual care is an integral part of the modern health care system, having changed and improved the way care is delivered over the last decade. In our comments, we outline the role that telehealth has played in providing access to care in the MA program and key policy considerations for CMS to ensure this and related technology is harnessed to provide high quality care for all MA beneficiaries.

Our top recommendations for CMS include:

- As previously [proposed by the Alliance](#), CMS should update network adequacy policies to fully reflect telehealth’s role in access to care by transitioning away from rigid time and distance metrics in favor of more meaningful, access and patient experience-focused measures that are technology agnostic.
- CMS should build on this change by encouraging additional pathways for cross-state practice through licensure portability and ensuring that out of state telehealth providers also fully count toward MA network adequacy requirements.
- CMS should build on its work through the proposed ACCESS Model and Health Tech Ecosystem initiatives to provide incentives for multipayer alignment and support for tech-enabled care across Traditional Medicare and the MA program. This alignment should include priorities such as remote patient monitoring that can yield downstream savings for the larger Medicare program.

Statutory Limitations



In 2018, Congress passed the Bipartisan Budget Act of 2018 (P.L. 115-123), which greatly expanded coverage for telehealth services within the MA program. Specifically, Section 50323 of the law created new flexibilities that allowed MA plans to provide “additional telehealth benefits” to enrollees beginning in plan year 2020. CMS further solidified this change in the CY2020 MA and Part D Flexibility Final Rule ([CMS-4185-F](#)), which established regulatory requirements allowing MA plans to cover Part B benefits furnished through electronic exchange but not payable under section 1834(m) of the Social Security Act as MA additional telehealth benefits within the basic benefit structure.

This was a critical step to expanding access to telehealth services and care options for MA beneficiaries. While these flexibilities have been paramount in ensuring MA enrollees could benefit from receiving telehealth services where and when they need it, more can be done to ensure that the MA program can use digital health services to enhance its future direction. To best utilize the capacity of telehealth for MA enrollees, additional action from Congress will be needed to permanently allow more virtual care services and practitioners in Part B and bring more virtual care options into the base MA benefit.

Expand Access: Coverage and Care

In April 2019, CMS [finalized](#) the CY2020 MA and Part D Flexibility Final Rule ([CMS-4185-F](#)), implementing authorities from the Bipartisan Budget Act of 2018 that allow MA plans to offer additional telehealth benefits beyond those covered in Medicare fee-for-service. Beginning in plan year 2020, MA plans were permitted to include telehealth services in their basic benefit packages, including services furnished to beneficiaries in their homes, as well as to offer supplemental telehealth benefits for services not otherwise covered under traditional Medicare. By 2022, approximately [95 percent](#) of MA plans offered telehealth benefits, providing access to nearly 99 percent of MA beneficiaries.

In early 2020, CMS further [exercised](#) enforcement discretion to allow MA plans to expand telehealth coverage beyond their approved benefit packages, including permitting video-enabled telehealth visits for diagnosis documentation, waiving or reducing cost-sharing, and allowing access to Medicare Part B services via telehealth regardless of geographic location. These flexibilities made telehealth a critical tool for maintaining access to care during the pandemic, with more than [28 million](#) Medicare beneficiaries using telehealth in the first year alone, including nearly half of MA enrollees. During this period, MA beneficiaries accounted for a greater share of telehealth utilization than beneficiaries in traditional Medicare fee-for-service.

While telehealth utilization returned to a more normal rate in post-pandemic years, a large portion of patients still rely on telehealth to receive their care. The Centers for Disease Control and Prevention (CDC) National Center for Health Statistics [reported](#) that in 2021 and 2022, 30.8 percent of MA beneficiaries used telemedicine in the past 12 months. A 2024 [study](#) from Harvard University researchers showed that telehealth has improved access to care for Medicare fee-for-service beneficiaries at a relatively low cost, even after the pandemic.

To ensure the greatest opportunity to utilize these services for MA beneficiaries, we provide several recommendations below for how to improve access to telehealth in MA and eliminate regulatory barriers that impede care delivery through this modality.

Modernizing Network Adequacy Standards

As part of ongoing modernization efforts, CMS [finalized](#) policies in the [Contract Year 2021 MA and Part D final rule](#) that address maximum time and distance standards to strengthen network adequacy rules by encouraging the use of telehealth by providers in contracted networks. CMS provided MA plans a 10 percent credit towards the percentage of beneficiaries that must reside within required time and distance standards when the plan contracts with telehealth providers for certain specialties. The Alliance for Connected Care strongly supported these changes, as they begin to recognize the capabilities of telehealth to address unmet needs and provider shortages. The Alliance also strongly supported the expansion of provider types eligible for these services and is encouraged by CMS' movement in this direction as demonstrated by the [Contract Year 2025 MA and Part D final rule inclusion](#) of Outpatient Behavioral Health facility specialty to the list of the specialty types that will receive a 10 percent credit toward meeting required time and distance standards.

Over the past five years, telehealth has demonstrated its capacity to meet a substantial portion of health care needs nationwide. CMS should now build on this experience by modernizing network adequacy standards to more fully account for telehealth's role, using available data on utilization, quality, and outcomes to responsibly expand flexibility.

First, [CMS should modernize network adequacy rules by expanding the list of provider types eligible for the 10 percent credit to include all practitioners eligible to furnish Medicare telehealth services.](#) There is no policy rationale for maintaining a narrower list for MA than for Part B telehealth services.

Second, while in-person care remains essential in certain clinical circumstances, [telehealth should move beyond 10 percent credit for time and distance standards and be treated more equally with in-person care.](#) Telehealth can fill critical access gaps in areas experiencing workforce shortages, enabling MA plans to better serve beneficiaries and expand plan availability in medically underserved and rural areas where MA penetration remains significantly lower than in non-rural markets.¹

Finally, [CMS should consider a more fundamental modernization of network adequacy standards by moving beyond time and distance metrics altogether.](#) Geographic proximity does not necessarily equate to meaningful access, particularly as hybrid models that combine telehealth and in-home care continue to expand. More modern, outcome-oriented measures would better reflect how beneficiaries actually access care.

We encourage CMS to modernize its assessment of network adequacy to emphasize more outcome-focused tools, such as beneficiary access, satisfaction, and wait times for services provided either in person or via telehealth. These tools would better capture the value of telehealth services to patients in MA plans. We also encourage the use of qualitative tools to measure provider networks against the needs of enrolled populations and the clinical appropriateness of delivering that care remotely.

Modernizing Access Across State Lines

State licensure requirements remain a significant barrier to modern, virtual care delivery in MA. State borders often create artificial access constraints, particularly in metropolitan regions that span multiple states and in rural areas that rely on out-of-state specialists. Evidence shows that approximately [two-](#)

¹ County-level Medicare / MA Enrollment Data Source: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-MA-Enrollment-by-State-County-Contract>

[thirds](#) of rural Medicare telehealth visits with out-of-state clinicians involved providers located in neighboring states.

Previous licensure flexibilities demonstrated the value of modernizing licensure policies to allow clinicians to deliver care across state lines, improving continuity of care, expanding patient choice, and addressing workforce shortages.

We recommend that CMS promote additional paths to access practitioners across state lines by supporting licensure portability and ensuring that these providers count toward appropriate network adequacy requirements. We recommend that CMS convene stakeholders to develop a voluntary national framework for interstate licensure based on mutual recognition, allowing qualified clinicians licensed in one state to provide telehealth services across state lines without the burden of multiple licenses. Such an approach would modernize access standards, strengthen the MA workforce, and better align program rules with contemporary care delivery models.

ACCESS Model and Tech-Enabled Care

As outlined by CMS [Administrator Oz](#), the current system needs to shift the paradigm for health care from a system that focuses on sick care to one that fosters prevention, wellness, and chronic disease management as the Medicare population continues to age, and clinician shortages worsen. The use of technology to manage patients with multiple chronic conditions or in high-risk post-acute circumstances is not just an imperative, but a necessity to drive [better quality care](#) to patients.

The Alliance for Connected Care is enthusiastic about the promise of the Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model in innovating the way providers use technology to deliver cost-effective care. We recommend CMS continue moving towards an outcome-focused model by harnessing digital health technology to improve patient care. The ACCESS model is a step in the right direction and CMS should build on its plans for multi-payer adoption by creating incentives for Medicare Advantage providers to participate. In doing so, CMS can progress toward multi-payer alignment for the digital health tools that are the present and future of high-value care.

Of particular relevance is the access and use of remote patient monitoring technologies to help manage Medicare patients. RPM is vital for patients with either complex conditions in the post-acute space, or a senior at home managing multiple chronic conditions concurrently. By combining consistent, real-time tracking of patients' blood pressure and other vital signs outside of the clinical setting and support from a responsive provider, RPM creates a transparent way for patients to see how their chronic and/or post-acute condition(s) are progressing. The capabilities enabled by RPM allow patients and providers to work together to manage a multitude of conditions through a combination of clinical and lifestyle interventions.

Published literature continues to demonstrate how technology-enabled care, like RPM can enhance patient adherence, provide early detection of hypertensive or diabetic crises, and facilitate timely intervention by health care providers. For example, RPM enables clinical staff to proactively reach out when they see a sudden blood sugar spike or weight gain in the patient which may indicate potentially life-threatening (and high-cost medical condition) that can be addressed promptly and proactively. Notably, RPM helps identify inconsistent [medication adherence](#), driving timely, data-informed decisions that improve outcomes and reduce hospital readmissions.



Additionally, patients receiving this care may otherwise [face challenges](#) in obtaining and/or maintaining access to coordinated care, longitudinal interpersonal relationships, all which [ensure care continuity](#). As you know, upward of [\\$25 billion in annual health care spending](#) in the United States is attributable to preventable hospitalizations, defined as admissions that potentially could be avoided with better treatment of acute conditions or management of chronic conditions.

Thank you for the opportunity to comment on this important topic – we hope you will consider these recommendations as you look to improve modernize the MA program. We look forward to working with you and welcome further discussion on this topic. Please reach out to Chris Adamec at cadamec@connectwithcare.org with any questions.

Sincerely,

A handwritten signature in blue ink that reads "Christopher Adamec".

Chris Adamec
Executive Director, Alliance for Connected Care