March 13, 2026

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

RE: Opportunities to Accelerate Tech-Enabled Care in Medicare Rulemakings

Dear Administrator Oz:

Congratulations on a transformative year in health care, particularly the policies that enable technology-enabled care. As the agency continues to make its bold vision of expanding technology-enabled tools a reality, **we urge you to build on this momentum and ensure continued access to the full spectrum of virtual care options for Medicare beneficiaries**. Telehealth and virtual care, expanded under the first Trump Administration, have reduced barriers to care by connecting patients, particularly rural Americans, to health care services and specialists.

The Alliance for Connected Care ("The Alliance") is dedicated to improving access to care through the reduction of policy, legal, and regulatory barriers to the adoption of connected care capabilities, including telemedicine, remote patient monitoring (RPM), and AI-enabled care. 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 opportunities enabled by virtual care.

As has long been true in health care, patients consistently seek easier navigation, timely and continuous support between visits, and simpler payment structures. Virtual care has made many strides in increasing access to services and empowering clinicians to create the best available care. We urge CMS to ensure patients and providers do not have to think about practice or payment barriers when considering the right modality for medical treatment. The delivery of health care should continue to be seamless across modalities.

The Alliance applauds the Administration for its forward-thinking policies on technology-enabled health care. Telehealth is now fully integrated into everyday care and often interchangeable with in-person care. We believe the choice between in-person and telehealth is a core capability of today's modern health care system. To this end, we remind CMS that the logistical processes related to offering and supporting telehealth services are generally the same as those for in-person services. This care is scheduled, managed, and supported by the same support staff working in the facility or medical practice.

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, it is a necessity. The Alliance believes that one key to scaling these services will be the continuing growth of technology that extends the capabilities of the clinician. Our current coding and reimbursement structures often stand in the way of this innovation.

More specifically, the Alliance respectfully urges CMS to ensure seamless health care delivery by considering policies that modernize practice and payment requirements to unlock the full potential of digital health beyond what is possible with in-person care. Additionally, we urge CMS to continue to work

with Congress and other federal agencies to ensure long-term certainty and access to the full spectrum of virtual care options for Medicare beneficiaries.

In these pre-rulemaking comments, the Alliance calls on CMS to:

- Ensure New Statutory Telehealth Modifiers Do Not Create Burdensome Requirements
- Create Provider Location Reporting Flexibility for Virtual-Only Providers
- Integrate AI-Enabled Care in Existing Medical Services, When Clinically Appropriate
- Build on Progress Supporting Remote Patient Monitoring
- Modernize Interprofessional Consultations
- Provide Opportunity for Virtual Supervision to Improve the Medical Workforce
- Continue Advancing Outcome-Oriented APCM Policies
- Establish National Pricing for Digital Mental Health Treatment to Sustain Progress
- Use ASM Waiver Authority to Remove Financial Barriers and Expand Technology Access for Virtual Specialty Care
- Integrate MDPP Into Primary Care Through Additional Billing Pathways and Care Team Alignment
- Expand Hospital Outpatient Department Billing for Telehealth E/M
- Build on ACCESS Model Ideas to Scale Technology-Enabled Care

We look forward to working with you during the upcoming rulemaking cycle on these ideas to modernize today's policies to reflect real-world applications.

Ensure Telehealth Modifiers Do Not Create Burdensome Requirements

As you know, Congress *temporarily* extended current telehealth flexibilities for two years, through December 31, 2027, and directed the agency to implement new payment modifiers, no later than January 1, 2027. As CMS implements this new policy, we encourage CMS to align with congressional intent and not create burdensome restrictions. Specifically, to ensure the effective implementation of the modifier for telehealth services furnished through a telehealth virtual platform, we respectfully request that CMS clearly define the term "virtual platform." A precise and transparent definition is essential to avoid confusion, promote consistent compliance, and ensure accurate claims reporting.

Our conversations with congressional committees about the intent of these payment modifiers indicated that Congress wishes to track the potential for increased utilization by direct-to-consumer telehealth platforms. Unfortunately, the language in statute could be misinterpreted to create far more burdensome requirements and capture nearly all clinicians offering care through telehealth, given the prevalence of technology-enabled platforms in care delivery.

While we strongly support increased data collection on the utilization and benefits of telehealth in the Medicare program, we encourage CMS to establish a clear exemption list within its definition of clinicians offering care through a "virtual platform." Given statutory intent, CMS should exempt the following from this definition:

- Any telehealth services furnished by a clinician or provider organization capable of offering care in-person (as these services would 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)

- 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 that would otherwise receive the same care).
- Any telehealth service furnished as the result of a referral from an existing provider (as these services represent care decisions within an existing care relationship and not new utilization)
- Any telehealth service offering a "second opinion" in response to a patient's existing in-person care team (as this is a patient-initiated visit that is crucial for patients with limited access or in areas with provider shortages).

Telehealth providers operate within coordinated care frameworks that already include clinical oversight, patient protection, and accountability mechanisms consistent with congressional intent. Providing clarity in these areas will help ensure that any modifier is appropriately tailored, safeguard patient access to high-quality care, and prevent unintended administrative burden on established care delivery models.

Similarly, while we support the collection of data on the usage of incident to services in the Medicare program, we believe the creation of this modifier creates a double standard by treating clinicians providing telehealth services differently from clinicians providing in-person services. As noted through years of comments, the Alliance believes remote care to simply be a modality change in the delivery of the same care services. The primary concern of the Alliance is that a modifier for telehealth incident-to services will lead to data on these services being provided without a corresponding in-person care control group. *It would be inappropriate for CMS to make telehealth policy decisions based on this modifier data without having the capability to evaluate telehealth against in-person care.*

In conclusion – while we support data collection for telehealth, we believe the creation of an additional regulatory burden is unacceptable in any situation in which it may influence the patient or provider decision on the modality of care being offered. Patients and their clinicians should always be free to choose the modality that works best for their needs.

Create Provider Location Reporting Flexibility for Virtual-Only Providers

We applaud CMS for allowing practitioners with a physical location to render telehealth services from a location (such as their home) without creating and reporting as an additional billing location. The Alliance's provider members are encouraged by CMS' vision of empowering clinicians to provide the care their patients need how, when, and where they need it. As such, we believe that there is room to build on this movement by creating a path for providers without a physical practice location.

<u>We request CMS leadership in ensuring that telehealth practitioners working solely from a home-based location do not need to report their private residence to the federal government for purposes of enrollment or billing.</u> Rather, we believe that CMS should 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, and a geographic indicator such as a zip code be reported for payment adjustment by geographic cost and wage index. <u>We respectfully request that CMS, as part of its policymaking in this area, convene a roundtable or a similar effort to ensure the experiences of virtual-only practitioners are considered.</u>

Integrate AI-Enabled Care in Existing Medical Services, When Clinically Appropriate

Our experience with telehealth, through which policymakers created statutory and regulatory permissibility designed for one moment, without anticipation of the evolution of that care should be a

lesson for policymaking in the age of AI. Federal policymakers should avoid repeating this cycle by regulating AI to the point of stagnation or focusing primarily on guardrails when incentive-aligned policy frameworks more effectively promote safe, scalable innovation. These guardrails (such as location requirements for telehealth) ultimately become barriers to care long after the concern they were designed to address has passed.

Millions of Americans have already turned to non-medical AI chatbots to help them diagnose conditions, determine treatment plans, evaluate medication conflicts and other functions. ***The fact that patients are seeking this support outside of the expert medical community underscores a policy imperative. We must accelerate the enablement of HIPAA protected, AI-enabled capabilities to empower health care professionals to better meet the needs of their patients.***

As shared in our comments to the AI RFI*, it is our overarching position that federal policy should approach agentic AI capabilities not as a standalone treatment tool, but as an extension and modernization of modern digital health services*. The majority of these patient-facing capabilities fall within the definitions of treatment already covered as medical services and should be viewed as the evolution of that care. To the extent that separate policy is required, AI-enabled care should be evaluated, regulated, and reimbursed based on the quality of care delivered and the health outcomes achieved. By aligning oversight and payment frameworks with this evolution, HHS can foster innovation while preserving trust, accountability, and access to high-quality care.

A practical near-term policy option, **i**ncluded in a recent NEJM Catalyst article, proposed that HHS consider a dual billing pathway similar to synchronous Evaluation and Management services—permitting reimbursement based on medical decision-making (MDM) complexity rather than time alone. This modification would allow clinicians to retain accountability for care delivered under their supervision while capturing the clinical value, liability, and oversight associated with AI-enabled workflows.

Within these comments the Alliance called on HHS to use its authority and work with Congress and states to strengthen virtual care foundations for AI-enabled care and allowing the integration of AI-enabled care into existing medical services by –

- Recognizing AI-enabled care as a natural evolution of connected care, not a new kind of care in need of unique policy or regulatory solutions.
- Clearing the decks on longstanding barriers to telehealth and remote patient monitoring that will be equally burdensome to the expansion of AI-enabled care.
- Avoiding policymaking mistakes made in other digital health areas, where narrow allowances later hampered patient access.
- Pursuing regulatory and reimbursement changes that allow for modality-agnostic care delivery to facilitate the expansion of AI-enabled care.
- Circumventing barriers like time-based reimbursement to the expansion of AI-enabled care.
- Further growing AI-enabled care delivery in models based on outcomes, where these changes can be made most easily.
- Enabling innovative “regulatory sandboxes” that create AI regulatory relief pathways that allow for temporary exemptions from regulation, subject to rigorous due diligence, safety constraints, and narrowly scoped use cases at the state and federal level.

We urge CMS to consider these comments as the virtual care ecosystem evolves, while ensuring all uses are clinically appropriate.

Build on Progress Supporting Remote Patient Monitoring

The Alliance for Connected Care and its members appreciate CMS' 2026 policy changes, which took steps to address the sustainability and prioritization of broader RPM payment in Medicare. Remote monitoring services empower clinicians and patients in the management of chronic conditions such as hypertension, diabetes, musculoskeletal disorders, and mental health. For example, a study of more than 10,000 patients found that a remotely delivered hypertension program produced an average systolic blood pressure reduction of 9.7 mmHg, with similar results across racial, ethnic, and primary language groups, which demonstrates the clinical effectiveness of remote monitoring at scale.

As we previously shared, the Alliance supported the use of OPPS geometric mean cost data to set payment for device codes. We understand the challenges of accurate digital tool pricing -- CMS has previously noted, "as the PE data age, these issues involving the use of software and other forms of digital tools become more complex". Ultimately, we continue to request that CMS makes clear that its goal remains to update and modernize the practice expense calculation to improve practice expense for codes like 99454, and that the use of OPPS data is an interim measure until such time as CMS is able to work with stakeholders to meaningfully modernize the calculation of practice expense for device codes. During this rulemaking cycle, we request CMS begin to work with stakeholders, through a listening session and a request for information, to create a better valuation model for technology-enabled tools, like RPM. This work will complement other CMS' efforts to enable technology-driven capabilities such as those leveraging software as a service and artificial intelligence.

The Alliance also supported the CMS proposal for a code to reimburse for data collected and reported for 2-15 days. CMS' actions in the 2026 PFS will enable additional clinical use cases for RPM, such as in a post-acute situation when a longer period of monitoring is not required. We look forward to working with CMS to further outline and expand upon the clinical use cases for short-term monitoring.

The Alliance appreciates HHS' commitment to more efficient, connected care models that leverage emerging technology where it is needed most. As we wrote in our AI in Clinical Care RFI comments, the Alliance is supportive of CMS updating reimbursement policies to recognize and incentivize the use of artificial intelligence and advanced technology in the delivery of RPM services. To encourage AI uptake and tech-enabled care proliferation, CMS could consider payment mechanisms that account for the significant costs of developing, integrating, and maintaining AI platforms used in remote monitoring, ensuring that reimbursement policy rewards clinical efficiency and technological investment.

The Alliance encourages CMS to continue to consider additional real-world practice elements as it captures expenses to accurately reimburse for RPM. Top Alliance recommendations include:

- Consider the implementation of a G-code or add-on code for providers that captures the cost of technology used to automate many care management services and increase efficiency in the delivery of patient care while lowering overall costs to the Medicare program. A new code should not duplicate existing services but should create a pathway to increase automation and limit treatment management services while maintaining accountability for patient engagement and the vitals captured.

- 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. This should include the creation of specific flexibility for situations in which the care is provided adjacent to an existing treating practitioner – *such as in a SNF, where the resident has a treating practitioner and has undergone a comprehensive admission assessment and treatment plan – even if there is not a formal E/M service (this recommendation*

should also apply to other care management services such as RTM, CCM, and behavioral health integration).

- Allow for the concurrent billing of RPM and Remote Therapeutic Monitoring (RTM), given the significantly different clinical use cases for the services. RPM and RTM monitor different aspects of a patient's health; RPM focuses on physiological and metabolic data, while RTM tracks adherence to therapeutic regimens, functional abilities, and medication response. Because these services use different devices to gather different data for different clinical purposes, prohibiting concurrent billing prevents providers from obtaining a complete picture of a patient's health status.

- 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 clinically distinct 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, proper care could require a blood glucose monitor for their diabetes and a blood pressure monitor for their hypertension.

Additionally, the Alliance emphasizes that as the Administration works to meet patients where they are by enabling clinical care centered around the home, we urge CMS to continue to exempt virtual care, such as telehealth, remote physiologic monitoring, and remote therapeutic monitoring, from the list of codes impacted by efficiency adjustment.

Modernize Interprofessional Consultations

Interprofessional consultations allow 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 condition without seeing the patient. However, the current time requirement of a minimum of 16 minutes does not reflect the average eConsult time, which is less than 10 minutes.

CMS should consider policies to modernize interprofessional consultations to reflect the increasingly efficient modalities through which clinicians engage with each other. This means removing time constraints and patient consent requirements for these simple consultations. We should encourage more clinician cooperation in the delivery of care, particularly as newer and asynchronous forms of communication allow it to improve. To reflect the increasingly efficient modalities through which clinicians engage with each other, CMS should recognize secure messaging, EHR-based consults, and virtual care reviews and ensure codes reflect clinical complexity, not just time thresholds.

Additionally, specialty shortages make team-based consultations essential. CMS should consider broadening the clinicians eligible to bill this code, including non-physician practitioners where clinically appropriate. The Association of American Medical Colleges (AAMC) projects a shortage of up to 86,000 physicians by 2036, making it imperative that CMS enable the full range of qualified practitioners to participate in interprofessional consultations rather than limiting this collaborative care tool to physicians alone.

The Alliance also believes there is a need to collect public input on how AI capabilities will reshape what interprofessional consultations should look like. We believe experts and stakeholders should provide input on the ideal future workflow (such as agentic capabilities that escalate to a specialist) as CMS considers policies for the next evolution of virtual care.

Provide Opportunity for Virtual Supervision to Improve the Medical Workforce

The Alliance applauds CMS for allowing teaching physicians to have a virtual presence when billing for services involving residents in all teaching settings, but only when the service itself is furnished virtually (e.g., a 3-way telehealth visit with the patient, resident, and teaching physician in separate locations). 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 preparing them for diverse job opportunities.

For any service delivered via real-time audio-visual technology in which the attending performs the key and critical elements, CMS should allow flexibility on where the attending and trainee are located. This will reflect the wide range of clinical situations in which trainees participate in telehealth.

Training in outpatient telemedicine is essential across many specialties, so residents and fellows gain the skills they need for practice after training. Requiring trainees and attendings to be physically together for telemedicine visits when patients are at home creates logistical and operational barriers, reducing available trainee telemedicine slots and limiting patient access. There will be situations where co-location is appropriate (for example, when both are already working together in clinic), and others where the attending, trainee, and patient are each in different locations. It may also be appropriate for the trainee to be on site with the patient while the attending is remote, provided the service is a virtual one and the attending can personally perform the key and critical elements (for example, a psychiatry resident is in-person with a patient while the psychiatry attending conducts the visit via video).

In short, CMS should allow attendings to bill based on how they interact with the patient and the key and critical elements they personally perform and should provide location flexibility for clinical teams.

An informal survey of Alliance members identified anticipated challenges if the summer 2025 proposed rule requiring attending and trainee co-location is adopted:

- *Anticipated operational challenges in psychiatry* where it is common for over half of the care provided is delivered via telemedicine. Institutions would need to operationalize in-person clinical or office space to co-locate trainees with attendings for virtual visits.
- *A growing number of virtual-only clinics like virtual diabetes clinics where both attending providers and staff off-site provide telemedicine care to patients at home*. Ideally, trainees would be able to participate in these opportunities as they would any other teaching setting outpatient opportunity, and attendings would be able to bill if they are present with the patient over audio-visual technology for the key portions of the visit.
- *During weather emergencies (and other operational challenges like power outages), medical teaching hospitals convert many outpatient visits to telemedicine visits.* Requiring in-person colocation of attending and trainee during an emergency event would be immensely burdensome and limit patient access to telemedicine visits at these times.

Medical teaching hospitals have also 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. While not appropriate in all circumstances, virtual 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.

The Alliance urges CMS to add to its guidance clinical scenarios where it may be appropriate to permit the virtual presence of the teaching physician and request input from stakeholders of academic medical schools, attendings, and residents on the impact of this important policy on the opportunity for residents to assist them with meeting the rapidly-growing demand for telehealth and prepare them for diverse job opportunities.

Continue Advancing Outcome-Oriented APCM Policies

The Alliance appreciates CMS' continued leadership in advancing Advanced Primary Care Management (APCM) as well as the agency's recognition of the high prevalence of behavioral health conditions and their frequent co-presentation with chronic physical health conditions. Integrating behavioral health into primary care is essential to improving outcomes for Medicare beneficiaries. As CMS considers priorities for the CY 2027 Physician Fee Schedule, we strongly support APCM, which allows CMS to pay for patient outcomes and longitudinal accountability rather than strictly the amount of time a clinician spends. Outcome-oriented care management codes better reflect the realities of team-based, technology-enabled care and are critical to managing patients with multiple chronic conditions efficiently and effectively.

Recognizing that patient care management programs like APCM and RPM can be used concurrently, we recommend that CMS simplify consent management across these programs (CCM, APCM, RPM) – providers need to be able to enroll a patient into an overarching care management program and bill according to the services as provided.

Given the preventative nature of much of the care that is offered under APCM, the Alliance continues to believe that it would be appropriate to at least partially waive patient cost-sharing for APCM services. These services manage patients cost effectively while creating flexibility for technology-supported care that meets key benchmarks – this is a win-win for the Medicare program.

We also believe that CMS should remove the prohibition of offering Transitional Care Management (TCM) and APCM services to the same patient. These services are distinct and simultaneous billing would allow patients discharged from a hospital or SNF to transition into a primary care APCM relationship more seamlessly.

Establish National Pricing for Digital Mental Health Treatment to Sustain Progress

The Alliance appreciates CMS's thoughtful engagement on Digital Mental Health Treatment (DMHT) services and its efforts to incorporate digital therapeutics into Medicare. As CMS looks ahead to CY 2027 PFS, we strongly urge the agency to move forward with establishing a national pricing methodology for DMHT services. While we understand concerns about variation and the relative newness of these services, the absence of consistent national payment has created significant uncertainty and uneven access across Medicare Administrative Contractors. Without a predictable reimbursement framework, progress in scaling evidence-based digital mental health tools risks stalling. Even if refinement is needed over time, establishing a national payment structure is essential to ensure that momentum in expanding access to DMHT does not recede.

Use ASM Waiver Authority to Remove Financial Barriers and Expand Technology Access for Virtual Specialty Care

The Alliance appreciates CMS's use of its waiver authority within the Ambulatory Specialty Model (ASM) to expand telehealth flexibility and modernize specialty care delivery. As CMS continues development of this model, we encourage the agency to use that authority not only to permit telehealth, but to actively

incentivize beneficiary engagement in high-value virtual services central to model success. Specifically, CMS should:

- Remove copayments and other financial barriers for telehealth and RPM and RTM services that are deeply relevant to success in specialty-focused models, including heart failure and lower back pain. Reducing cost-sharing would meaningfully support beneficiary participation in these high-value services.

- Strengthen and clarify safe harbor provisions to make clear that providers may furnish patients with necessary connectivity tools, including internet access and smart, without fear of inducement penalties. Access to technology is foundational to participation in virtual care models.

Aligning financial incentives and program integrity policies with the realities of technology-enabled specialty care will ensure virtual services are fully leveraged to drive better outcomes.

Integrate MDPP Into Primary Care Through Additional Billing Pathways and Care Team Alignment

The Alliance appreciates CMS's prior steps to expand access to the Medicare Diabetes Prevention Program (MDPP), including permitting CDC-recognized virtual suppliers to participate. As CMS considers future refinements for CY 2027, we encourage the agency to prioritize stronger integration of MDPP services within beneficiaries' existing care teams.

Current restrictions such as limiting MDPP billing to standalone suppliers under their own NPI may undermine efforts by primary care providers and other clinicians to incorporate prevention services into a patient's broader care plan. Prevention is most effective when embedded within longitudinal, team-based care.

CMS should create an additional billing pathway, such as incident-to billing, allowing primary care providers to oversee delivery of MDPP services furnished by CDC-recognized suppliers. This would embed diabetes prevention directly into existing chronic care frameworks, strengthen coordination, and ensure MDPP participation is part of a comprehensive treatment strategy for Medicare beneficiaries.

HOPD Payment for Telemedicine Evaluation and Management Services

Under the hospital outpatient clinic visit policy, the CPT codes describing office/outpatient E/M visits are not recognized under OPPS and instead hospitals report HCPCS code G0463 (Hospital outpatient clinic visit for assessment and management of a patient) when billing for the facility costs associated with an outpatient E/M visit. CMS has not yet recognized the telemedicine E/M code set under OPPS. More specifically, this situation hinders genetic counselors who cannot bill G0463. Our members are seeing that, in the absence of the ability for cancer genetic counselors to bill their services to Medicare under the G0463 code, the counselors must run Medicare visits as a shared visit with a physician or APP and bill an E/M code. This wastes critical clinical resources as the physician and the APP are not necessary for the visit. Additionally, the use of E/M coding loses the specificity of the clinical services. Finally, the complexity of billing further limits access to an already constrained specialty service, as genetic counseling is in short supply nationally.

Studies on virtual genetic counseling, particularly for cancer care, have reported high patient satisfaction, as well as comparable rates of trust and rapport, confidence in privacy, health behavior changes, and psychosocial outcomes, few represented diverse populations. Studies consistently reported a decrease in the patients' costs and time required for travel when patients are seen via telehealth compared to in-person with a similar reduction in costs to the health system.

Build on ACCESS Model Ideas to Scale Technology-Enabled Care

The Alliance has been supportive of the ideas represented in the Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model, as we believe they are important step towards removing barriers to technology-enabled care pathways. As CMS continues to develop and refine this model, we urge the agency to ensure it fully delivers on its promise as a vehicle for scaling virtual and remote care services for Medicare beneficiaries with chronic conditions.

One key to scaling these services will be enabling technology to extend the capabilities of the clinician to allow providers to manage larger and more complex patient populations without sacrificing quality or continuity of care. The ACCESS Model creates a meaningful opportunity to advance this vision by moving away from volume-based payment structures that constrain innovation. By compensating quality and outcomes rather than volume, ACCESS ensures that patients and providers are not forced to weigh outdated regulatory or payment barriers when determining the best modality for care. We urge CMS to build on this foundation and ensure the model's design fully unlocks the potential of telehealth and RPM as core components of chronic care delivery.

The model as proposed is not viable for most providers interested in offering more technology-driven solutions for their patients – both because of restrictions on other care that can be offered to these patients and because of the low reimbursement levels.

Given these factors, the Alliance for Connected Care calls on CMS to create a similar model that incorporates many of the components of the ACCESS framework, but which is designed for health care providers to leverage in lieu of other services. This, more provider-accessible version of ACCESS should accommodate clinicians with existing patient relationships, including a narrower fee-for-service exclusion. Much like the opportunity created with APCM, we believe there is an opportunity for a technology-driven, outcome payment version of ACCESS that replaces many fee-for-service codes currently being billed by health providers.

Continue to Work with States to Drive Interstate Care

The Alliance recognizes and appreciates efforts that CMS has taken to incent interstate care through the CMMI rural health transformation program. We believe this work should be just the beginning. President Trump led on efforts to reform occupational licensure during his first term and that continued leadership is needed to advance efforts that will make health care more efficient and competitive. President Trump also signed into law legislation authorizing the Department of Defense to invest in the creation of occupational licensure compacts to ease licensure mobility barriers. We encourage CMS to consider policies that will increase pressure on states to reform outdated licensure restrictions which reduce competition and access in health care.

As a national payer, the Medicare program should take a leading role in pushing for seamless nationwide access to care across state lines. The antiquated system of state-by-state licenses stifles the ability of providers to consult with and treat Americans wherever they may be, exacerbating our workforce maldistribution issues and forcing Americans to drive to appointments that could be done virtually. States are modernizing, however, through the joining of occupational licensure compacts which enable patients to access care across state lines more easily and enable providers to provide that care without unnecessary barriers.

The ability to practice across state lines is crucial for the delivery of care in both remote rural areas and those with practitioner shortages. This access is also needed for decentralized clinical trials, rare diseases, college students or others who travel, and many other specific use cases. 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.

Continue Work with Congress on 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 support continuation of the clinical care currently being provided. We also call on CMS to continue capturing and publishing as much data on telehealth services and their outcomes as possible, to educate long-term policymaking.

Thank you for your consideration of these requests. We look forward to meeting with you on opportunities to advance all of the policies above. Please feel free to reach out to rikki.cheung@connectwithcare.org for additional information and context.

Sincerely,

Christopher Adamec

Executive Director