NARA
The National Association of Rehabilitation Providers and Agencies

September 11, 2025

Dr. Mehmet Oz, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1832-P
Mail Stop C4-26-05
PO Box 8016
Baltimore, MD 21244-8016

Submitted electronically at http://www.regulations.gov

RE: Medicare and Medicaid Programs; CY 2026 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments [CMS-1832-P]

Dear Administrator Oz:

The National Association of Rehabilitation Providers and Agencies (NARA) represents over 90,000 physical therapists (PT), occupational therapists (OT), and speech language pathologists (SLP) through our member organizations who provide therapy across the United States to Medicare beneficiaries. They provide therapy in all settings across the continuum such as outpatient clinics, skilled nursing facilities (SNFs), assisted living facilities (ALFs), retirement communities, hospital inpatient and outpatient, and in the beneficiary's home.

As a member-driven organization, NARA is dedicated to ensuring access to care for beneficiaries and advancing the growth and business success of rehabilitation providers through education, support, and advocacy. Our diverse membership gives us a unique and comprehensive perspective on payment and quality programs affecting services rendered as part of the physician fee schedule. Below are our comments on the proposed rule:

Proposed Updates to the Conversion Factor Payment Rates

NARA appreciates an increase of 0.75% for qualifying APM providers and 0.25% for non-qualifying providers. However, an increase of less than 1% to the Medicare Physician Fee Schedule (PFS) fails to meet the needs of providers, including physical, occupational, and speech therapists, and is unsustainable for ensuring continued access to quality care. Since 2011, rehabilitation therapy providers have absorbed cumulative reimbursement reductions of nearly 30% under the PFS, resulting in year-over-year erosion of financial stability despite rising practice costs. When viewed against this backdrop of consistent cuts, a sub-1% update not only fails to

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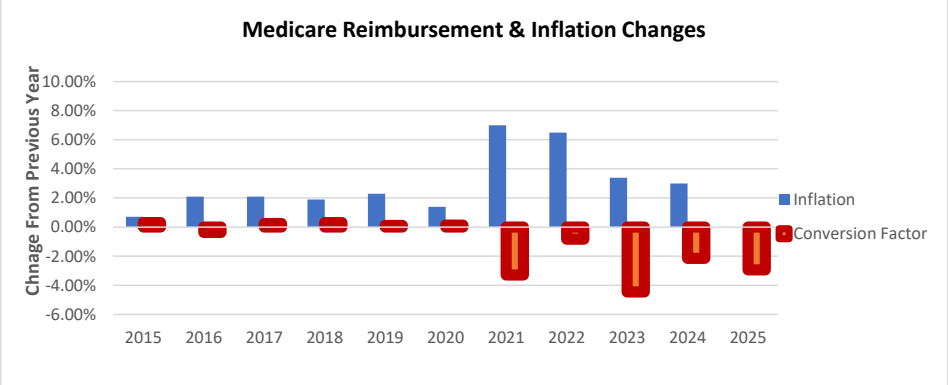
address inflationary pressures but actively exacerbates access risks for Medicare beneficiaries. See the graphic below that shows the conversion rate compared to the inflation rate since 2015 – note that the conversion rate has not been close to the annual inflation rate since 2015:



Therapy providers face the same escalating cost pressures as other areas of healthcare including rising wages, technology requirements, compliance obligations, and the administrative strain of prior authorizations and audits, all of which impact their ability to deliver care. However, unlike hospitals and other facility-based settings, outpatient therapy providers do not receive annual market basket updates or other structural adjustments that reflect real-world cost increases. Instead, they remain tethered to a PFS that continually lags behind inflation and imposes arbitrary reductions without regard to patient complexity or the broader value of rehabilitation services in preventing downstream hospitalizations and institutionalization.

The result is a widening gap between the true cost of care and Medicare reimbursement rates. For smaller and community-based therapy practices, small businesses which make up a significant portion of the therapy provider landscape, this gap creates untenable financial strain. Clinics are forced to limit staff, reduce service availability, or, in some cases, close altogether. This directly threatens beneficiary access, particularly in rural and underserved communities where rehabilitation services are already scarce. Without meaningful updates that account for inflation and cost growth, Medicare beneficiaries will face diminished access to essential therapy services, ultimately leading to poorer outcomes and higher system-wide costs.

Congress has had to assist providers like rehabilitation therapists from seriously drastic cuts on multiple occasions over the past 4 years when CMS overestimated funding it allocated to the G2211 add-on code when the projected utilization was significantly overstated. When CMS introduced G2211, it estimated that the code would be billed in 30–50% of all outpatient office E/M visits. CMS has emphasized that this code is mainly applicable to primary care, specialists

who manage patients longitudinally, such as oncologists, rheumatologists, cardiologists, psychiatrists, endocrinologists. This overstated assumption triggered budget neutrality adjustments and resulted in deeper across-the-board cuts to the PFS than necessary. The American Medical Association (AMA) has made clear in its letter to CMS on May 9, 2025[1] that this overestimate of G2211 utilization tripled the budget neutrality impact, leading to an unintended $1 billion annual reduction in physician payments. These reductions have disproportionately affected providers who cannot use G2211, including rehabilitation therapy providers.

CMS must correct this imbalance by reassessing the funding assumptions for G2211 and reallocating those resources toward other, high-value, low cost services, such as the therapy codes that are foundational to patient access and recovery. Directing funding more appropriately would not only mitigate the unsustainable reimbursement reductions imposed on therapy providers but also align with CMS's stated goals of preserving access to essential outpatient services for Medicare beneficiaries.

Failure to address this misallocation risks worsening financial strain on therapy practices, many of which are small, community-based providers already operating on narrow margins. CMS has the responsibility to ensure that funding supports patient access across all essential services, rather than being concentrated in a single code with inflated assumptions.

Payment Disparity Between Medicare Advantage and Traditional Medicare

A pressing concern for most healthcare providers including rehabilitation therapy providers is that the minimal update to the Medicare Physician Fee Schedule (PFS) for 2026 falls dramatically short of the 5.06% increase finalized for Medicare Advantage (MA) plans. This disparity is particularly alarming when viewed in context: MA rate increases have consistently outpaced updates for providers 3.3% in 2024, 3.7% in 2025, and now more than 5% for 2026 while therapy providers under the PFS continue to face negative updates (until the CY 2026 sub 1% increase) despite rising costs. MedPAC has estimated that MA payments in 2024 were 22 percent above traditional Medicare, a difference that amounts to $83 billion in annual spending[2]. MA plans receive a fixed payment for each member, regardless of services delivered, so it is to the advantage of the MA plan to restrict care through delays or denials. MA plans continue to have high grossing revenues per enrollee compared to individual, group employer or Medicaid managed care markets. According to a 2024 KFF[3] report, for calendar year 2023 was $934 per enrollee more than individual market enrollees, $1072 per group employer enrollee, and $1229 more than Medicaid enrollees. This significantly higher gross margins is consistent with prior

[1] https://www.ama-assn.org/practice-management/medicare-medicaid/overestimate-tripled-budget-neutrality-medicare-physician-pay?
[2] MedPAC, *Report to the Congress: Medicare Payment Policy,* March 2024, Chapter 12, "The Medicare Advantage Program," p. 372, https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch12_MedPAC_Report_To_Congress_SEC-1.pdf
[3] https://www.fiercehealthcare.com/payers/kff-insurance-market-had-highest-gross-margins-last-year

years according to the same report. While MA plans are enjoying these high gross margins, MA enrollees face inadequate provider networks and higher out of pockets costs due to low reimbursement rates, excessive administrative burden, and lengthy credentialing processes for providers.

The March 2025 MedPAC[4] report identified two factors driving higher MA payments: favorable selection and coding intensity. First, MA plans are able to strategically market to healthier Medicare beneficiaries and structure coverage policies that restrict access for higher-acuity beneficiaries. A 2024 investigation by the U.S. Senate Permanent Subcommittee on Investigations (PSI)[5] confirmed that MA organizations use prior authorization not to improve quality, but to restrict access to necessary post-acute care services, including therapy, as a means of boosting profits. Second, MA plans leverage coding intensity to inflate reimbursements. An October 2024 OIG report[6] found $3.5 billion in MA overpayments stemming from in-home health risk assessments, which artificially increased patient diagnoses to drive higher CMS payments.

In stark contrast, therapy providers have endured nearly 30% in cuts since 2011 under the PFS, despite providing essential, high-value services that prevent hospitalization, improve function, and reduce overall healthcare costs[7]. Rewarding MA organizations with a 5.06% increase while rehabilitation therapy providers receive less than 1% creates a severe payment imbalance. This imbalance threatens the ability of rehabilitation practices, many of which are small businesses, to meet the needs of Medicare beneficiaries, particularly those in rural and underserved areas.

Equally concerning, MA payment increases from CMS are not being passed down to providers. Instead, MA plans often pay outpatient therapy clinics 25–33% less than traditional Medicare rates, all while failing to account for rising labor costs, inflation, and administrative burdens such as prior authorization. This misalignment between CMS-approved plan increases and actual provider reimbursement compromises the sustainability of outpatient therapy and places patient access to medically necessary rehabilitation services at risk.

Healthcare providers are facing a mounting crisis in caring for MA enrollees due to excessive administrative hurdles that delay or deny medically necessary care.

1. **Prior Authorizations Cause Harmful and Costly Delays in Care**

Commented [KS2]: Should we add something here about the profits the MAs are reporting publicly, too?

Commented [CC3R2]: Any recommendations? I had found some graphics and information showing their profit by commercial, government, etc and government (MA) was significantly higher over a 4 year period but I think the data was 2020 - 2023 so I wasn't sure about using that.

Commented [LF4R2]: **KFF (2023):** MA gross margins per enrollee were approximately **$1,982**, notably higher than in individual ($1,048), group employer ($910), or Medicaid managed care ($753) markets https://www.fiercehealthcare.com/payers/kff-insurance-market-had-highest-gross-margins-last-year?utm_source=chatgpt.com

Commented [KS5]: I am concerned about us putting in writing how much less we are being paid by the MA plans while we ask Medicare for an increase. I am concerned this could lead them into thinking they still pay us too much. Please consider removing this paragraph.

Commented [CC6R5]: The House recently introduced HR 4559 which requires MA plans to plan in networks at traditional Medicare rates so I think everyone knows MA plans do not pay what Traditional Medicare pays.

[4] https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch11_MedPAC_Report_To_Congress_SEC.pdf
[5] https://www.hsgac.senate.gov/wp-content/uploads/2024.10.17-PSI-Majority-Staff-Report-on-Medicare-Advantage.pdf
[6] Department of Health and Human Services. Office of Inspector General. Office of Evaluation and Inspections. Medicare Advantage: Questionable Use of Health Risk Assessments Continues to Drive UP Payments to Plans by Billions. October 2024. OEI-03-23-00380. Available at: https://oig.hhs.gov/documents/evaluation/10028/OEI-03-23-00380.pdf
[7] https://www.valueofpt.com/globalassets/value-of-pt/economic_value_pt_u.s._report_from_apta-report.pdf

- In Medicare Advantage, nearly all enrollees require prior authorization for rehabilitation therapy services. In 2021 alone, providers submitted over 35 million such requests, with more than 2 million fully or partially denied. These denials often delay treatment and only 11% of them are appealed, yet 82% of appeals reverse the original denial revealing that many denials were inappropriate in the first place[8]. Given the small number of requests that are ultimately denied, we question whether prior authorization is achieving its intended purposes of weeding out fraud, waste, and abuse or if it is instead discouraging or delaying access to care.
- The American Medical Association (AMA) reports that prior authorization consumes substantial time and resources: physicians average 43 requests per week, dedicating about 12 hours weekly to handling them. Moreover, 78% of physicians indicate patients abandon treatments due to authorization issues, and 95% say prior authorization significantly contributes to burnout.[9]
- Beneficiaries should be receiving the right care, at the right time, and in the right setting. In the July 22, 2025, House Committee on Ways & Means[10] joint hearing on Medicare Advantage, Dr. David Basel testified that prior authorizations, particularly in rural areas, create delays to lower cost care in the most appropriate setting. Insurers rely on prior authorization as a tool to confirm that services are medically necessary and appropriate, and it is commonly used across the health care system to manage costs and limit unnecessary care. Yet, when applied excessively or without transparency, prior authorization can create barriers to timely access, compromise the quality-of-care patients receive, and increase healthcare costs for all stakeholders.
- Streamlining the prior authorization process is essential to meaningful MA reform. While burdensome for all providers, payers make it disproportionately difficult for out-of-network providers to obtain authorizations, creating intentional barriers that restrict patient access and discourage out-of-network care altogether. MA plans vary widely in their acceptance rates for prior authorization requests as well as in the methods required for submitting supporting documentation. Even when electronic submission is available, it is typically limited to proprietary plan portals with access only to network providers that demand significant staff time to log in, extract data, and comply with plan-specific, idiosyncratic requirements. More commonly, providers are still forced to rely on outdated systems such as fax machines and call centers. Further compounding the problem, providers and their staff must navigate plan-specific rules and processes that not only vary

[8] https://www.marketwatch.com/story/medicare-advantage-prior-authorizations-can-delay-healthcare-for-seniors-a-bipartisan-group-of-lawmakers-is-trying-to-streamline-care-900bdc80
[9] https://www.ama-assn.org/press-center/ama-press-releases/ama-survey-indicates-prior-authorization-wreaks-havoc-patient-care
[10] https://waysandmeans.house.gov/2025/07/24/six-key-moments-hearing-on-medicare-advantage-past-lessons-present-insights-future-opportunities/

substantially across plans and services but are also unilaterally changed in the middle of a contract year adding further uncertainty, administrative burden, and delays in patient care.

2. **Algorithms Used to Deny Care**
    - A Senate investigation revealed that major MA insurers UnitedHealth, Humana, and CVS Health have utilized unregulated algorithms tools to deny post-acute rehabilitation care. By 2022, these insurers were denying approximately 25% of all such care requests for MA enrollees[11]. Congress has even urged CMS to not allow denials of care, especially for those with complex health conditions in favor of a person-centered approach which is the basis of the Medicare program[12]. MA plans continue to utilize internal assessments to delay and deny care without specific medical reasoning.
    - Additional reporting exposes how these algorithmic tools override clinical judgment leading to improper denials, even when patients clearly need continued rehabilitation[13].
3. **Improper Denials Requiring Appeals**
    - In 2022, the federal Office of Inspector General (OIG) found that 13% of MA prior authorization denials met Medicare coverage criteria and would have been approved under traditional Medicare but the MA plans use clinical criteria that is not a part of Medicare coverage rules. This requires the provider to appeal further delaying care for beneficiaries.
    - Aetna MA plans restrict the amount of care a beneficiary can receive to 4 units of service; however, when a beneficiary with a complex acuity requires 2 therapies and the claim indicates that with appropriate modifiers, one is denied, and the claim must be appealed. This would not happen under Traditional Medicare.
    - Some health plans, such as BCBS-VA, require that prior authorization requests be submitted within two business days of the patient's evaluation. According to APTA's *Defensible Documentation* guidelines, best practice is for clinicians to complete documentation within 24–48 hours. However, in most outpatient settings it is support staff not the evaluating therapist who submits and processes prior authorization requests. This workflow makes a two-business-day submission requirement unrealistic and often unattainable, creating administrative barriers that can delay patient access to care.

As Medicare Advantage enrollment continues to grow, it is critical to preserve traditional Medicare as a strong and sustainable public option. Traditional Medicare's lower administrative costs, broad and inclusive provider networks, and strong beneficiary protections ensure that it remains a reliable and accessible choice for millions of seniors. Maintaining a robust traditional

Commented [SW7]: I don't disagree with any of this but given the current administration's love of AI I wonder if we should include this?

Commented [CC8R7]: I have removed the AI part of the comment

[11] https://www.statnews.com/2024/10/17/medicare-advantage-insurers-ai-technology-prior-authorization-claims-denials-senate-investigation/
[12] https://www.statnews.com/2024/06/25/medicare-advantage-ai-tools-denial-unitedhealth-lawmawkers-cms/
[13] https://journalistsresource.org/home/how-they-did-it-stat-reporters-expose-medicare-advantage-algorithm/

Medicare program not only safeguards patient access and choice but also provides an essential counterbalance to for-profit MA plans, fostering competition that helps protect the integrity and affordability of the Medicare system. We strongly urge policymakers to work with CMS to reform the MA payment and oversight framework by:

- Requiring accountability and transparency in how MA plans allocate CMS funding, including disclosure of provider reimbursement rates;
- Mandating that a minimum percentage of annual MA payment increases be passed directly to providers, or incorporating prospective adjustments for inflation and labor shortages into MA methodologies;
- The House recently introduced HR 4559 – Prompt and Fair Pay Act[14] which would require effective Jan 1, 2027, MA plans to reimburse in-network providers at least at the same rates as traditional Medicare fee-for-service, and impose enforceable prompt payment standard with interest penalties for tardiness; and
- Establishing mechanisms that ensure provider reimbursement rises proportionally whenever CMS increases MA plan payments.

This widening payment gap between Medicare Advantage and traditional Medicare is unsustainable and inequitable. While MA plans continue to secure substantial annual increases, providers under the Physician Fee Schedule who deliver essential, hands-on care are left struggling with inadequate updates that fail to keep pace with inflation and rising operating costs. The result is a system where federal dollars disproportionately benefit private insurers rather than beneficiaries, fueling barriers to access, care restrictions, and increased out-of-pocket costs. To preserve stability across the healthcare system and ensure access to rehabilitation therapy and other vital services, it is critical that Congress and CMS take immediate steps to rebalance payment policy and align provider reimbursement with the true cost of delivering care. We request that CMS ensure rebalancing of payment policy by reducing the MA increases and using that funding to increase the physician fee schedule to offset the decreases.

Efficiency Adjustment Unjustified For Rehabilitation Providers

We strongly disagree with CMS's proposal to apply an "efficiency adjustment" to the work RVUs for non-timed codes commonly used by rehabilitation providers for physical therapy, occupational therapy and speech-language pathology. This adjustment is misguided, duplicative, and fails to reflect the realities of clinical practice for several key reasons:

1. **Existing Payment Reductions Already Apply**
   Non-timed therapy codes are already subject to the Multiple Procedure Payment Reduction (MPPR). Layering an additional "efficiency" cut on top of the MPPR unfairly compounds the payment reductions for therapy services, penalizing providers twice for

[14] https://www.congress.gov/bill/119th-congress/house-bill/4559

Commented [SW9]: Do we mention Congress is interested in this issue as demonstrated by the introduction of HR4559?

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Commented [CC12R11]: I like that Sarah! Added the last sentence. Using HR 4559 demonstrates that Congress is taking some action - or attempting.

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Commented [CC14]: Wondering if we should put this higher in letter as a higher priority?

the same rationale. *CMS should not apply the efficiency adjustment to codes: 97010 – 97036.*

2. **Failure to Consider the AMA RUC Process**
   Work RVUs for these codes have already been reviewed and established through the American Medical Association's Relative Value Scale Update Committee (RUC) process, which assesses therapist work using validated survey and consensus methods. CMS's unilateral efficiency adjustment disregards this established process, undermining the integrity of evidence-based valuation.

Applying an additional "efficiency" adjustment to therapy work RVUs is inappropriate, duplicative, and unsupported by evidence. Rehabilitation therapists already operate under significant payment constraints, including MPPR and repeated negative PFS updates, while facing escalating practice costs and workforce challenges. This proposal will only exacerbate financial pressures and further threaten patient access to critical physical, occupational, and speech therapy services. We encourage CMS to reconsider the proposed efficiency adjustment and partner with stakeholders to develop fair, evidence-based reimbursement policies that fully capture the complexity and value of rehabilitation services.

Additionally, we are deeply concerned that the file[15] of therapy codes identified for the proposed "efficiency adjustment" includes several timed codes, such as 97113 (aquatic therapy), 97124 (massage therapy), 97140 (manual therapy techniques), and 97533 (sensory integrative techniques). This inclusion directly contradicts CMS's stated intent that the adjustment would apply only to non–timed codes.

1. **Inconsistent with CMS Policy Statement**
   Time-based codes are structured in 15-minute increments, and the value already reflects therapist time and intensity of services delivered. By definition, these codes are not subject to the same concerns CMS identified regarding non-timed codes, where payment does not vary by service duration. Their inclusion in the efficiency adjustment file therefore appears to be an error or misalignment with the agency's stated methodology.
2. **Risk of Double Discounting**
   Applying an efficiency reduction to timed therapy codes effectively penalizes providers twice. Therapists must already document and bill in 15-minute units based on CMS guidelines, ensuring resource use is directly tied to payment. Reducing work RVUs for these codes introduces an additional, unnecessary cut that is not supported by data and that compounds existing payment reductions such as the Multiple Procedure Payment Reduction (MPPR).
3. **Undermines the Valuation Process**
   Many of these timed codes, including those named above, have been recently reviewed through the AMA RUC process, which considers survey data, clinical intensity, and

Commented [SW15]: FWIW, I like how this is stated.

Commented [CC16R15]: Thank you!

[15] https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1832-p

practice expense inputs. Imposing a unilateral efficiency adjustment on top of the RUC-validated values disregards this established process and undermines confidence in the stability and credibility of the RVU system.

4. **Threatens Access to Medically Necessary Services**
   Therapy services such as aquatic therapy, manual therapy, and sensory integrative techniques are critical components of individualized rehabilitation plans. Applying unjustified payment cuts to these services reduces provider capacity, places financial strain on practices already operating under thin margins and threatens patient access particularly in rural and underserved communities.

We strongly urge CMS to reconsider this proposal and minimally remove all **timed** therapy codes from the file of services subject to the proposed efficiency adjustment. Their inclusion is inconsistent with CMS's stated policy, unsupported by evidence, and harmful to both providers and beneficiaries. CMS should instead work collaboratively with stakeholders to ensure accurate, consistent, and transparent valuation that reflects the true cost of delivering rehabilitation therapy services.

Removal of "Provisional" for CPT Codes Used for Telehealth Services

We would like to thank CMS for its decision to remove the provisional telehealth distinction applied to certain CPT codes and to recognize these services as permanent components of the Medicare telehealth benefit. This action represents a meaningful step forward in ensuring equitable access to care. By making these codes permanent, CMS is strengthening the ability of beneficiaries, particularly those living in rural and underserved communities to receive timely and necessary care without the burden of travel, workforce shortages, or geographic limitations. Rehabilitation therapy and other essential health services are more accessible when telehealth is supported with stable, predictable policy.

We applaud CMS for this important policy advancement and strongly encourage continued efforts to expand telehealth flexibilities and remove barriers that limit beneficiary access.

Valuation of Remote Therapeutic Monitoring (RTM) Services

CMS should continue to value Remote Therapeutic Monitoring (RTM) codes separately from Remote Physiologic Monitoring (RPM) codes to ensure accurate recognition of the distinct resources and workflows each requires. RPM services are primarily physician-driven, rely on FDA-cleared physiologic devices, and involve higher technology and infrastructure costs. In contrast, RTM was intentionally designed for therapists and other non-physician providers, focusing on musculoskeletal, respiratory, and adherence data that are frequently patient-reported and supported by software-based tools. Equating the valuation of these codes risks misalignment with actual practice costs and could undermine adoption of RTM in rehabilitation and other non-physician settings, ultimately reducing access to patient-centered monitoring solutions.

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CMS proposes to maintain the current work RVUs for CPT codes 98980 and 98981, rather than adopt the updated values recommended by the RUC as part of the recent revisions to Remote Therapeutic Monitoring (RTM) services. NARA opposes this proposal and urges CMS to accept the RUC-recommended work RVUs for these codes.

CMS justifies its position by noting that RTM services will be placed on the New Technology list and re-evaluated after three years of data collection under the 2026 CPT code structure. However, CPT codes 98980 and 98981 are not new—they have been in use for over three years and were recently reviewed and revalued through the established AMA CPT and RUC processes. When these codes were initially valued, they represented a new service with limited utilization data, requiring some degree of estimation. Since then, provider experience with RTM services has grown substantially, and the RUC's updated recommendations are based on more robust survey data from clinicians with direct experience delivering these services. Maintaining outdated RVUs based on early assumptions, rather than adopting the RUC's evidence-based recommendations, undermines the accuracy and integrity of the valuation process. The RUC process is designed to ensure transparency, stakeholder engagement, and methodological rigor. Rejecting the RUC's recommendations without clear justification appears arbitrary and risks misaligned valuations that could negatively impact patient access to care. We strongly recommend that CMS adopt the RUC-recommended work RVUs for CPT codes 98980 and 98981 to ensure accurate, data-driven reimbursement that reflects current clinical practice.

Updated Descriptions for RTM CPT Codes
The RTM device supply codes remain tied to a 30-day window, while the corresponding management codes are aligned with calendar months. This misalignment creates unnecessary administrative complexity, forcing providers to track two separate timeframes for the service, leading to billing inefficiencies and increased risk of errors. CMS should align RTM device supply codes with calendar months, consistent with the management codes, to streamline billing, reduce administrative burden, and ensure greater consistency and accuracy in claims processing.

Proposing to Add 4 new RTM CPT codes
We appreciate CMS's adoption of the four new RTM CPT codes, as they represent a meaningful improvement for patient access and provider flexibility. The addition of 2–15 day device codes and a 10-minute management code allow billing in cases where patients require shorter-term or lower-touch monitoring, ensuring that reimbursement more accurately reflects the intensity of care delivered. These updates better align with real-world clinical workflows, particularly for patients whose conditions stabilize quickly or who need only brief interventions, ultimately expanding access to RTM services while reducing unnecessary barriers.

Establishment of a National Price Floor for CPT Codes 98975, 98977, and 98XX5
CMS should establish a national price floor for CPT codes 98975, 98977, and 98XX5 to reflect the reality that technology costs are fixed and do not vary geographically like labor or practice expense inputs. Locality adjustments under the current system create inequities, with providers

in certain regions reimbursed less for delivering identical remote monitoring services. Setting a national floor at the Medicare average would ensure geographic equity, align with CMS's stated recognition of fixed technology costs, and support broader adoption of RTM services, particularly in rural and underserved areas where access to digital health solutions is most critical.

Removal of the Concurrent Billing Limitation for RPM and RTM
CMS's prohibition on concurrent billing of RPM and RTM is both clinically and logically inconsistent. RPM is intended to monitor physiologic measures such as continuous glucose data, while RTM captures functional and therapeutic information like musculoskeletal outcomes. Blocking their concurrent use penalizes patients who require comprehensive monitoring across different domains of care.

For example, a Medicare beneficiary with type 2 diabetes may be appropriately enrolled in RPM for continuous glucose monitoring while also undergoing physical therapy for a musculoskeletal condition that qualifies for RTM. Under current policy, the provider cannot bill for both, even though improving mobility through therapy could reduce insulin resistance, lessen reliance on glucose monitoring, and ultimately lower long-term Medicare costs.

We urge CMS to remove the concurrent billing restriction, or at minimum, provide clear pathways for concurrent reporting when services address distinct conditions and are not duplicative.

Digital Health Services Research and Data CMS Intends to Review Prior to April 2030
The Consolidated Appropriations Act requires CMS to conduct a review of digital health services by April 2030. To support this process, stakeholders need clear visibility into the categories of evidence CMS considers most valuable so that ongoing research efforts can be aligned accordingly. We recommend CMS identify priority domains—such as functional outcomes, adherence, cost savings, disparity reduction, and comparative effectiveness—so providers and technology developers can generate data that directly informs the mandated review and enables a rigorous, evidence-based assessment.

Concern Regarding OASIS Requirement for Medicare Part B Outpatient Therapy Patients Treated by HHAs
It is our understanding that CMS will be retracting the guidance in the CMS Quarterly OASIS Q&As issued on July 2, 2025[16], stating that OASIS assessments are required for patients receiving outpatient Medicare Part B therapy services in the home when those services are furnished by a home health agency. We applaud CMS for concluding that the OASIS is not required for PT, OT or SLP outpatient services provided by a Home Health Agency and billed under the Part B benefit when a home health plan of care is not in effect. We encourage CMS to act swiftly in issuing a retraction to prevent the administrative burden by this incorrect guidance.

[16] https://qtso.cms.gov/system/files/qtso/CMS_OAI_Qtr_2_2025_QAs_July_2025_final%20508.pdf

Credentialing Barriers with Medicare Advantage Organizations

NARA continues to hear significant concerns from our members regarding restricted provider networks and excessively lengthy credentialing and contracting processes with commercial payers offering MA plans. These processes can take between 90 to 180 days, during which time beneficiaries may face substantial barriers to accessing timely care particularly those in HMO plans, with limited transportation options, or residing in assisted and independent living communities where the provider on-site is not yet credentialed.

A key issue compounding this delay is the lack of retroactive contract effective dates. Unlike traditional Medicare, where private practice providers can often receive a retroactive enrollment date within established CMS parameters, MA plans frequently delay contract activation without retroactivity—effectively preventing beneficiaries from receiving needed care for months after referral by their physician. This is not just an administrative inconvenience; it is a care access issue that disproportionately affects medically complex and mobility-limited beneficiaries, in direct conflict with CMS's goals of reducing avoidable care delays and easing provider burden. Moreover, these delays are paired with lower reimbursement rates and higher administrative demands, making it increasingly unsustainable for providers to participate in MA networks.

NARA urges CMS to:

- Standardize and streamline credentialing and contracting processes across MAs, mirroring the timeliness and retroactivity standards already established for traditional Medicare;
- Mandate retroactive effective dates for credentialed Medicare providers upon completion of the application, where appropriate;
- Increase oversight and transparency of MA network management practices, ensuring they align with CMS's goals of timely access to care; and
- Monitor and mitigate administrative burdens that detract from clinical care delivery, especially in underserved or aging communities.

As MA enrollment continues to grow rapidly due to added benefits and cost flexibility, CMS must ensure that provider networks and administrative processes keep pace protecting both beneficiary access and provider participation in the program.

Conclusion

Our members continue to face significant challenges in maintaining operations and delivering high-quality care amidst ongoing reimbursement reductions and increased regulatory penalties. Providers strive to prioritize the well-being of patients and staff, yet mounting administrative requirements increasingly limit the time and resources available for direct care delivery. Many tasks mandated by current regulations do not align with staff skillsets, contributing to inefficiencies, burnout, and ultimately jeopardizing patient access to essential services.

NARA thanks CMS for the opportunity to provide feedback on this proposed rule and for your continued engagement with stakeholders. We also appreciated the opportunity to submit comments on Executive Order 14192, *Unleashing Prosperity Through Deregulation of the Medicare Program*. As the healthcare workforce shortage intensifies, CMS's efforts to reduce provider burden and streamline regulatory processes are more important than ever. We urge CMS to continue prioritizing policies that support provider sustainability and ensure timely, equitable access to care for all Medicare beneficiaries.

Should you have any questions concerning these comments, please contact Christie Covington, NARA Executive Director at christie.covington@naranet.org.

Commented [CC19]: In paragraph above as well.

Respectfully submitted,

Chris Carlin, OTR/L, MBA
President of the Board, National Association of Rehabilitation Providers & Agencies