HEALTH INNOVATION ALLIANCE

September 14, 2026

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

Re: CY2027 Medicare Physician Fee Schedule Proposed Rule (CMS 1848-P)

Submitted electronically via regulations.gov

Dear Administrator Oz,

HIA appreciates the opportunity to comment on the *CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program* proposed rule. HIA is a diverse coalition of patient advocates, health care providers, consumer organizations, employers, technology companies, and payers who support the commonsense use of data and technology to improve health outcomes and lower costs.

HIA has long supported policies that give patients and providers greater access to technology-enabled care. Telehealth, remote physiologic monitoring (RPM), and artificial intelligence (AI) can expand access to care, provide clinicians with better information, reduce administrative burden, and help prevent more costly health interventions. We are pleased that CMS continues to consider how Medicare can better incorporate these technologies into care delivery.

HIA offers the following comments on artificial intelligence, telehealth, and RPM:

- **Artificial Intelligence:** HIA supports policies that accelerate responsible adoption of clinical AI, including AI-enabled Annual Wellness Visits, while applying oversight based on clinical risk. CMS should also pursue longer-term incentives and regulatory flexibility to support AI adoption and evidence generation.
- **Telehealth:** HIA supports expanding the Medicare Telehealth Services List and using new claims modifiers to better understand how telehealth is delivered. CMS should preserve patient and clinician choice and use the additional data to inform future policy rather than assuming that particular telehealth models provide lower-value care. CMS should also do more to support access to the MDPP via virtual means.
- **Remote Physiologic Monitoring:** HIA urges CMS to withdraw its broad proposed RPM restrictions, which could reduce access to clinically appropriate remote monitoring, particularly for smaller practices and underserved patients. Instead, CMS should address program integrity

concerns through targeted, data-driven oversight and enforcement focused on anomalous billing and bad actors.

More details on each issue area are below.

Artificial Intelligence in Clinical Care

HIA appreciates CMS's request for information on technology and clinical AI in primary care. We believe primary care is a very promising setting for thoughtful deployment of AI because annual well-checks and the type of problems primary care physicians often treat are generally lower acuity and lower risk. Used appropriately, AI can give clinicians more time to do what only clinicians can do: interact directly with patients, make care decisions, and collaborate on a care plan in consultation with a patient.

Privacy and Patient Data

CMS asks how patient data and privacy are adequately protected when AI tools are used.

AI does not exist outside the health care regulatory environment. HIPAA, HITECH, applicable state law, contractual requirements, and other existing privacy and security obligations continue to apply when regulated health information is used through an AI-enabled tool. CMS should therefore avoid creating a duplicative AI-specific privacy regime for entities and data already governed by existing health care privacy requirements. Duplicative or conflicting rules could make compliance, and therefore AI deployment, more difficult without meaningfully improving patient privacy. Regardless of technology, the objective should remain the same: strong, consistent protection of health information while allowing data to be used appropriately to improve care.

Technology and AI-Augmentation in the Medicare Annual Wellness Visit

HIA is particularly interested in CMS's discussion of using technology and AI to augment the Medicare Annual Wellness Visit (AWV). The traditional health care encounter provides clinicians with a point-in-time view of a patient. Technology makes it increasingly possible to develop a more complete longitudinal picture with minimal burden on the patient and minimal cost to the system. AI could support the AWV before the patient ever speaks with a clinician by executing a number of actions that CMS notes in the rule: collecting information directly from the patient, tailoring intake questions based on previous responses, incorporating relevant information from the patient's electronic health record and other authorized sources, and synthesizing that information into a useful summary for the clinician.

Done well, this would augment, rather than replace, the clinician. It would eliminate much of the work that prevents the clinician from focusing on the patient. It would also streamline and improve the patient experience – no one looks forward to filling out the same one hundred-question survey at their wellness check. With appropriate incorporation of AI tools, the clinician could begin the AWV interaction with a concise understanding of relevant history, risks, changes, gaps in preventive care, and issues requiring discussion instead of spending substantial portions of the visit gathering information that technology could have assembled in advance.

There is also an important connection between this vision and CMS's RPM and RTM proposals. Remote monitoring can supply precisely the type of longitudinal information that would make an AI-supported AWV more productive. Blood pressure trends, adherence information, physiologic measurements, and other remotely collected information can help provide a more complete picture of the patient's health,

thereby enabling the clinician to make the best clinical judgement. CMS should avoid advancing a policy in one section of the rule that envisions more data-driven and longitudinal primary care while simultaneously making it substantially more difficult to collect valuable longitudinal information through remote monitoring.

Role of Direct Clinician Involvement

CMS also asks which AWV activities continue to require direct clinician involvement. HIA recommends a risk-based approach rather than a bright-line rule.

AI can appropriately conduct many intake and information-management functions: collecting patient information, asking follow-up questions, organizing medical history, incorporating existing records, identifying possible gaps, and preparing information for review. Allowing technology to perform those functions can make the time between clinician and patient substantially more productive.

CMS should also explore whether, for low-risk portions of the AWV, synchronous clinician involvement is necessary in every circumstance. If an AI-enabled process appropriately collects required information, identifies no concerning findings, and the beneficiary has no additional issues to raise, there may be circumstances where requiring another interaction with a clinician adds little clinical value. Any such model should preserve the beneficiary's ability to request clinician interaction and should include clear escalation pathways.

Where the information suggests that diagnosis, treatment, referral, or another clinically significant intervention may be necessary, appropriate human review should occur before consequential clinical action is taken. This would serve both patient safety and program integrity purposes. Consistent with HIA's longstanding principles, the appropriate level of human oversight should vary according to the risk and context of the use case rather than be imposed uniformly on every AI-supported activity.

Clinician Use of Artificial Intelligence to Improve Patient Care Improvement Activity

Finally, HIA supports CMS's proposal to create a MIPS Improvement Activity recognizing clinician participation in responsible AI initiatives. This proposal appropriately recognizes that Medicare should encourage clinicians and health care organizations to become thoughtful adopters of technology.

While this is a good step for the time being, CMS is simultaneously proposing to sunset MIPS entirely after the 2028 performance year. CMS needs to consider longer-term incentives that create predictable expectations for clinicians. More than that, adoption should be incentivized more strongly than a single improvement activity – there needs to be robust support for usage of these tools, if the administration is serious about being AI-forward. While a portion of that will inevitably come from the long-term payment structures CMS discusses setting up at a later time, there are other levers the agency can use to clear the way for broader adoption of AI.

One potential lever at the disposal of the administration broadly is setting up a structure whereby innovators, states, and federal regulators can test AI tools in specific use cases while temporarily waiving existing barriers. A growing number of state laws and legislative proposals risk creating a patchwork of inconsistent requirements for technologies that operate — and must be trusted — across state lines. Many of these laws, while well-intentioned, apply consumer-protection frameworks that were not designed for clinically deployed technologies. Others impose restrictions that limit how AI can function within clinical workflows — even for tools that support, rather than replace, clinician judgment. Some restrict AI use in

behavioral health and therapeutic settings, limiting access to tools with demonstrated clinical value, including AI-assisted cognitive behavioral therapy and related applications where peer-reviewed evidence supports meaningful patient benefit. A potential solution would be to create a testing environment where relevant state and federal regulations are waived for specific use cases in return for robust transparency and reporting requirements on AI deployers for the purpose of safeguarding patients and providing real-world evidence to regulators.

Telehealth

HIA has long recognized the tremendous benefits of telehealth, including increasing access to health care services and clinicians, particularly for patients who have transportation challenges or who live far from the care they need. Patients and clinicians should be able to use telehealth when it is clinically appropriate and makes sense for them.

Expansion of the Medicare Telehealth Services List

HIA encourages CMS to finalize the proposed addition of services to the Telehealth Services List. In the future, CMS should continue evaluating services for telehealth eligibility based on whether they can be safely and effectively delivered remotely rather than presuming in-person delivery should be the default.

Specifically, we support CMS's proposal to add the G-codes for advance care planning and individual treatment of speech, language, voice, communication, and auditory processing disorders for pediatric patients. These services are well suited for delivery through telehealth. Advance care planning is primarily based on communication among patients, families, and health professionals rather than a physical procedure that inherently requires the patient and clinician to occupy the same room. Similarly, many speech and language therapy services can be appropriately provided remotely when clinically suitable. Providing these services through telehealth can make care more convenient for patients and families and expand access to specialized clinicians who may not be available nearby.

The same principles support CMS's broader proposed additions to the telehealth list, including shared medical appointments and other services that can be appropriately furnished through interactive telecommunications technology. Medicare policy should continue to recognize that the appropriate site and modality of care depend on the service, the individual patient, and clinical judgment.

Telehealth Claims Modifiers

HIA supports the CMS proposal to implement modifiers BB and BC to identify certain telehealth services furnished through virtual telehealth platform arrangements and telehealth services furnished incident to a physician's or practitioner's professional service.

This proposal would enable better information collection about how telehealth services are being furnished. Claims-level information can help CMS better understand telehealth utilization, distinguish among care models, and identify patterns that may warrant additional examination. Better data can also support more informed policymaking rather than broad restrictions based on incomplete information.

However, HIA cautions against using the existence of a particular platform arrangement or other telehealth delivery model as a proxy for the value or quality of the service. CMS states that these modifiers will not affect payment. We encourage the agency to maintain that principle unless and until evidence demonstrates that a particular payment distinction is clinically or economically justified. The

fact that a service is furnished through telehealth, or through a particular technology arrangement, should not by itself make that service less valuable than clinically comparable care delivered in person.

Medicare Diabetes Prevention Program
HIA appreciates CMS' continued support of offering a variety of modalities for services through the Medicare Diabetes Prevention Program (MDPP), but believes more can be done to cement appropriate virtual care as a part of the program. Specifically, encourages CMS to address the payment differential between in-person and Online learning sessions and extend the Online modality and virtual-only supplier policies beyond 2029 while the Agency develops the evidence necessary to consider permanent adoption.

We support CMS's continued efforts to expand access to the MDPP via fully asynchronous Online delivery and allowing virtual-only suppliers to participate through December 31, 2029. However, HIA is concerned that the current payment structure may undermine participation in the Online modality by reimbursing Online core and maintenance sessions at $18, compared with $27 for in-person and distance-learning sessions. Online suppliers incur meaningful upfront costs to furnish MDPP services, including investments in technology and connected devices that enable beneficiaries to monitor their weight accurately and conveniently from home and allow suppliers to provide ongoing, individualized support. Moreover, CMS data indicate that beneficiaries attending MDPP sessions virtually have achieved average weight loss of 5.3 percent, compared with 4.6 percent among those attending primarily in person. HIA therefore urges CMS to establish payment parity for Online MDPP sessions during the testing period or, alternatively, adopt a payment methodology that better accounts for the Online model's cost structure. Such approaches could include greater emphasis on outcomes-based payments or an upfront or milestone payment that recognizes costs associated with enrollment, technology, and connected devices while retaining incentives tied to beneficiary weight-loss outcomes.

HIA also urges CMS to provide a pathway for the Online MDPP modality and virtual-only supplier participation to continue beyond December 31, 2029. Appropriate reimbursement and greater long-term certainty are important not only to sustaining supplier participation and investment, but also to ensuring that CMS can meaningfully evaluate the Online model. If reimbursement discourages suppliers from participating during the testing period, beneficiary enrollment and utilization may be artificially constrained, limiting CMS's ability to assess the modality's potential.

Remote Physiologic Monitoring

We are concerned that the remote physiologic monitoring (RPM) policies in the proposed rule would make it substantially more difficult for legitimate providers to offer remote monitoring, particularly smaller practices and providers serving rural, homebound, chronically ill, and medically underserved Medicare beneficiaries.

HIA has long supported the appropriate use of remote patient and remote physiologic monitoring as a way to improve care, manage chronic disease, reduce strain on health care providers, and avoid more costly interventions. Remote monitoring allows clinicians to better understand what is happening with a patient outside of an occasional office visit, providing valuable information that can help identify concerning changes before they become medical emergencies. If the Administration is truly committed to addressing chronic disease, then CMS should be particularly cautious about adopting policies that could substantially reduce access to RPM and RTM services that work in support of that goal.

We recognize CMS's concerns regarding potentially inappropriate billing and utilization of RPM services. Bad actors should be identified and held accountable, and CMS should have the tools necessary

to protect beneficiaries and taxpayer dollars. Rather than impose new structural requirements across the entire RPM and RTM ecosystem, CMS should focus its oversight and enforcement efforts on the providers and organizations exhibiting genuinely concerning billing or utilization patterns.

Program Integrity Concerns Should Be Addressed Through Targeted Oversight

HIA agrees that CMS should investigate unusual billing patterns and take enforcement action where fraud, abuse, or inappropriate billing is identified. However, we believe the broad changes CMS proposes goes beyond rooting out bad actors. Rather, it represents a massive shift in an established and important set of services. The OIG analyses cited in support of the proposed changes should not be interpreted as demonstrating that inappropriate conduct is widespread throughout remote monitoring. OIG itself cautioned that the billing characteristics it identified do not establish that a particular practice engaged in inappropriate behavior – rather they stated that additional investigation would be necessary to reach that conclusion.

We are not saying CMS should ignore suspicious conduct. We are saying that CMS should distinguish suspicious conduct from compliant care before establishing policies that apply to every provider participating in RPM and RTM. CMS should use AI-enabled claims analytics – as the agency has done elsewhere – to identify genuine outliers, including implausible device utilization, unusual patterns in which every component of a service is billed for nearly every patient every month, duplicative billing involving the same beneficiary, and other patterns that merit additional scrutiny. Those findings can then support targeted audits and enforcement under existing conditions of payment.

Third-Party Clinical Staff

HIA is particularly concerned with CMS's proposal to require clinical staff furnishing certain RPM services to be direct employees of the billing practitioner or practice. The employment relationship between a physician practice and the staff supporting remote monitoring does not, by itself, determine whether the service is clinically appropriate or whether the physician is meaningfully engaged in the patient's care. Small and rural practices frequently do not have the scale or resources to hire, train, and manage dedicated remote monitoring personnel internally and choose to rely on outside organizations to provide clinical staff and technology under the direction and general supervision of the billing practitioner. These arrangements can allow smaller practices to offer services that would otherwise be available only through larger integrated health systems.

For patients undergoing cancer treatment, for example, appropriately designed remote monitoring can play an important role in identifying changes or treatment-related complications between in-person visits and prompting timely clinical follow-up. While we understand CMS is seeking to address program integrity and clinical accountability concerns, the proposed changes in this area are quite broad and could inadvertently limit access to clinically integrated monitoring programs, particularly for practices that may not have the staffing or infrastructure to bring these functions entirely in-house.

Eliminating this model would not necessarily improve program integrity. In many cases, it would simply mean that the practice could no longer offer remote monitoring, ultimately resulting in greatly diminished patient access. We recommend CMS revise the proposal to establish clear accountability for the billing practitioner and the organization supporting the service.

Potential Consolidation of RPM and RTM Codes

CMS also seeks comment on potentially replacing the existing RPM and RTM code families with a smaller number of bundled G-codes. HIA supports reducing unnecessary administrative complexity, but simplification should not reduce the flexibility necessary to care for individual patients.

Remote monitoring does not occur in precisely the same way for every beneficiary every month. A patient may transmit clinically valuable information even if every component required under a bundled payment is not furnished during that particular period. Similarly, a care team may make repeated efforts to engage a beneficiary without ultimately meeting a particular time or interaction threshold required for billing.

CMS itself has previously recognized that legitimate remote monitoring services may fall below existing billing thresholds. Creating a new bundled structure that requires multiple components to occur together could recreate that problem and leave appropriate care uncompensated. Before replacing the current code structure, CMS should demonstrate that a consolidated approach reflects actual clinical workflows, preserves appropriate flexibility, and does not create incentives for providers to stop monitoring patients whose needs do not fit neatly within a bundled code.

A More Targeted Approach

HIA encourages CMS to reconsider the proposed RPM restrictions and instead build on the program integrity tools already available to the agency.

A more targeted approach could include:

- Better identification of the practitioners and outside organizations participating in RPM services;
- Clear accountability and supervision standards for billing practitioners and supporting organizations;
- Claims analytics designed to identify genuinely anomalous utilization;
- Focused audits of high-risk providers or organizations; and
- Meaningful enforcement, including termination or other sanctions where existing Medicare requirements are violated.

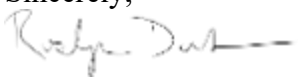
This framework would allow CMS to address the underlying program integrity concerns without making legitimate remote monitoring substantially more difficult to provide. Remote monitoring accounts for a relatively small portion of overall Medicare spending while serving populations with significant chronic disease and access challenges. Medicare policy should encourage responsible use of these technologies while aggressively targeting those who abuse the program.

HIA urges CMS to withdraw the broad restrictions included in the proposed rule and instead pursue a targeted, data-driven approach that protects program integrity while preserving access to clinically appropriate RPM and RTM services.

Conclusion

Thank you for your consideration of these comments. HIA stands ready to collaborate with CMS to expand the efficient use of AI in healthcare, chart a better path forward for RPM, and continue providing the telehealth services Medicare beneficiaries have come to expect.

Sincerely,



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