ConnectedHealthInitiative

January 26, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-8013

RE: ***Connected Health Initiative Comments to the Centers for Medicare & Medicaid Services'*** **Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan** ***[CMS-4212-P; 90 FR 54894]***

Dear Administrator Oz:

The Connected Health Initiative (CHI) appreciates the opportunity to provide input and suggestions to the Centers for Medicare & Medicaid Services (CMS) on its proposed revisions to the Medicare Advantage (Part C), Medicare Prescription Drug Benefit (Part D), and Medicare cost plan regulations to implement changes related to Star Ratings, marketing and communications, drug coverage, enrollment processes, special needs plans, and other programmatic areas.[1]

CHI is the leading multistakeholder policy and legal advocacy effort dedicated to connected health technologies that improve health outcomes and reduce costs. We seek to advance responsible pro-digital health policies and laws in areas including reimbursement/payment, privacy/security, effectiveness/quality assurance, U.S. Food and Drug Administration (FDA) regulation of digital health, health data interoperability, and the rising role of artificial/augmented intelligence (AI) in care delivery. For more information, see www.connectedhi.com.

CHI is a longtime advocate for the increased use of telehealth and remote monitoring across the Department of Health and Human Services (HHS) as well as before other agencies such as the Federal Communications Commission and the U.S. Congress. CHI is also a current appointed member of the American Medical Association's Digital Medicine Payment Advisory Group, an initiative bringing together a cross-section of nationally recognized experts that identifies barriers to digital medicine adoption and proposes comprehensive solutions revolving around coding, payment, coverage, and more.[2] A Medicare system that serves beneficiaries effectively must leverage the benefits of the range of digital health tools available today (and in development), consistent with other major Medicare programs.

[1] 90 FR 54894.
[2] https://www.ama-assn.org/delivering-care/digital-medicine-payment-advisory-group

Data and clinical evidence from a variety of use cases continue to demonstrate how the connected health technologies available today—whether called "telehealth," "mHealth," "store and forward," "remote patient monitoring," "remote physiologic monitoring," "communication technology-based services," or other similar terms—improve patient care, prevent hospitalizations, reduce complications, and improve patient engagement. These benefits are particularly impactful for the chronically ill. Connected health tools, including wireless health products, mobile medical devices, software as a medical device, mobile medical apps, and cloud-based portals and dashboards, can fundamentally improve and transform American healthcare.[3] Despite the proven benefits of connected health technology to the American healthcare system, statutory restrictions and CMS regulatory-level policy decisions, among other constraints, inhibit the use of these solutions. As a result, there was low utilization of digital health innovations prior to the COVID-19 public health emergency (PHE), despite the ability to drastically improve beneficiary outcomes and generate immense cost savings.

Further, as discussed below in further detail, CMS should support the use of health data and patient-generated health data (PGHD) through AI. There are various applications of AI systems in healthcare such as research, health administration and operations, population health, practice delivery improvement, and direct clinical care. Payment and incentive policies must be in place to invest in building infrastructure, preparing personnel and training, as well as developing, validating, and maintaining AI systems with an eye toward ensuring value. Payment policies must incent a pathway for the voluntary adoption and integration of AI systems into clinical practice as well as other applications under existing payment models.

As CMS recognizes, the need for rapid modernization of Medicare incentives is more imperative considering public health crises in the United States. As a community, we continue to support CMS' efforts to utilize advanced technology to augment care for every patient. With the congressionally mandated shift from fee-for-service to value-based care in Medicare approaching, it is essential CMS continues efforts to advance the range of connected health innovations that will help American healthcare improve outcomes and cost savings.

Thanks to CMS' incremental expanded support, reliance on digital health technologies has increased over time. Use of these tools continues to allow many underserved populations' access to prevention, diagnosis, and treatment for both acute and chronic conditions, particularly in rural areas of the country. CMS should leverage every opportunity for permanent policy changes that will incent responsible deployment and use of innovative digital health technologies that will be vital in ensuring that no American beneficiary is left behind.

We further commend CMS for its broader efforts across administrations to advance the uptake of connected health innovations across other programs, including but not limited to:

- In its PFS, CMS has now activated and provided unbundled payment for the technical and professional elements of remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM), more recently aligning coverage with key updates in CPT coding;

[3] This CHI resource is publicly accessible at https://bit.ly/2MblRou.

- CMS has allowed home health agencies to include evidence-based remote physiologic monitoring expenses used to augment the care planning process as allowable administrative costs that are factored into the costs per visit under the Home Health Prospective Payment System;
- CMS has put key incentives in place for the future value-based Medicare system, as well as taken steps to promote flexible use of PGHD in care coordination in the QPP Merit-based Incentive Payment System (MIPS). As a community, we continue to support CMS' efforts to utilize advanced technology to augment care for every American patient; and
- CMS also ensured utilization of RPM/RTM in existing alternative payment models such as Medicare Advantage, where RPM has been eligible for inclusion as a basic benefit.

While the policy changes noted above represent important digital health updates, the pace of uptake for digital health innovations in the Medicare system continues to lag when compared to the well-established benefits and efficiencies this cutting-edge technology offers. As a community, we continue to support CMS' efforts to utilize advanced technology to augment disease prevention, diagnosis, and treatment. It is essential that Medicare Advantage providers leverage the wide range of connected health tools and services available today, as well as those in development to advance care and lower costs.

Building on the above, we provide the following recommendations to CMS:

Leveraging Digital Health Innovations

- In improving MA, CMS should directly address and support the need for using advanced technology (telehealth, RPM/RTM, and other communications-based technology services) in improving care. These technologies, when deployed responsibly, are vital to accomplishing CMS' objectives. CMS should also enable disease prevention through the utilization of the range of technologies available today as well as in development, supporting that functionality, content, user interface, and service access features are designed to maximize efficiency and quality. Digital health technologies should be leveraged to empower individuals (and individuals making care decisions for those) receiving care, address patients' full range of health needs, promote healthy behaviors, and facilitate the improvement of health for individuals, families, and communities.
- Because the goals of the Medicare Access and CHIP Reauthorization Act of 2015[4] relating to shifting the Medicare system from quantity-focused to quality-focused remain unrealized until there is a prioritization of the responsible use of digital health technologies in advancing value-based care, we encourage CMS to align with a CHI-developed and healthcare ecosystem-consensus report identifying key challenges to the responsible use of digital health technologies in advancing value-based care and developed corresponding recommendations to policymakers on how to overcome them.[5]

[4] Public Law No. 114-10, 129 Stat. 87 (2015).
[5] https://www.connectedhi.com/blog/2021/7/14/the-value-based-care-revolution-will-stall-without-health-tech.

- CMS should provide MA plan sponsors with maximum discretion that enables making the determination that different digital health services are clinically appropriate, and to offer those services to beneficiaries as needed. CMS should make clear that asynchronous services that do not meet the definition of Medicare telehealth services (in other words, all services that are not live voice/video calls) do not face the onerous restrictions of Section 1834(m) of the Social Security Act. Currently, regulations provide that MA plans to cover Part B benefits provided via electronic exchange as "additional telehealth benefits" (including remote monitoring) and as a basic benefit as defined in § 422.101. We strongly encourage CMS to ensure that its implementation of Section 50323 of the Bipartisan Budget Act of 2018 provides for MA plans' alignment with CMS' established approaches to Medicare fee-for-service telehealth services, as well as to remote monitoring (both RPM and RTM]) and other "remote communications technology" that CMS has expressly stated do not fall under 1834(m) and its restrictions.
- CHI renews its request that CMS ensure its implementation of Section 50323 of the BBA aligns with CMS' established approaches in its PFS to Medicare Telehealth Services subject to the restrictions of 1834(m) of the Social Security Act, and that remote physiologic or therapeutic monitoring and other "remote communications technology" that CMS has expressly stated do not fall under 1834(m) and its restrictions. Further, we urge CMS to confirm that remote physiologic and therapeutic monitoring technologies may be included as part of basic MA benefits and are not subject to 1834(m).
- CHI urges CMS to encourage MA plans to cover all visits and other services that are on the Medicare Telehealth Services list when provided through telehealth by patients' physicians.
- CHI encourages CMS to permit MA plans to use virtual Medicare Diabetes Prevention Program (MDPP) encounters in addition to in-person MDPP encounters, and to permit virtual MDPP to register as Medicare Suppliers to enable uptake by MA plans. Without this allowance, in-person MDPP providers will be unable to service MA plans which will leave numerous beneficiaries without access. CMS can alleviate this issue by affirming that MA plans may use virtual MDPP to meet network adequacy requirements and satisfy the requirement to provide MDPP services; and by allowing virtual MDPP providers to register as Medicare Suppliers for this purpose. We also note that, whether in the Medicare fee-for-service or MA context, a successful MDPP will require the inclusion of a virtual program the MDPP supplier enrollment, preliminary recognition, and supplier standard provisions of the final rule.
- CHI urges CMS to allow all Medicare-eligible individuals with end-stage renal disease (ESRD) to enroll in MA plans, which will help improve the lives of, and empower, beneficiaries with ESRD (consistent with the President's Executive Order on Advancing American Kidney Health) by giving them choices in the type of Medicare coverage they receive, including MA plans enabling greater use of digital health technologies supporting hemodialysis and peritoneal home dialysis and remote physiologic monitoring. CMS also should ensure that ESRD patients are properly informed about their potential out-of-pocket costs and the adequacy of plan networks so that they can make good decisions as they consider switching to MA for their health care coverage.

Artificial Intelligence

- CHI notes its support for CMMI's exploration of AI's utility via its new Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model, and strongly supports CMS' exploration of a next-generation risk adjustment model as outlined in the Request for Information, particularly the potential incorporation of AI to enhance predictive accuracy, reduce administrative burdens, promote competition, and better capture beneficiary health needs.

  While CMMI's explorations are vital, CHI urges CMS to make policy-level changes now to move MA toward an AI-enhanced risk adjustment methodology that leverages richer, real-time data sources, such as wearables and remote physiologic monitoring devices (for continuous tracking of activity, heart rate, sleep, and other vital trends), electronic medical records, prescription drug events, laboratory results, and utilization patterns, to more dynamically infer conditions, severity, and expected costs compared to the current linear framework. This approach could improve capitated payment precision, incentivize MA plans to invest in preventive care, chronic disease management, personalized decision support tools, and beneficiary empowerment technologies, while curbing overpayments from coding intensity and fraud. To ensure responsible implementation, this systemic change should include robust safeguards, including sufficient transparency in model development and outputs, regular audits, explainability, and appropriate human oversight.

  Further, CHI has worked with the broader community to develop, and strongly encourage the HHS strategy to align with, healthcare ecosystem-wide consensus recommendations on the use of AI in healthcare (each is appended to this comment):

  - **CHI's *Health AI Policy Principles***, a comprehensive set of recommendations on the areas that should be addressed by policymakers examining AI's use in healthcare, and how they should be addressed (https://connectedhi.com/wp-content/uploads/2022/02/Policy-Principles-for-AI.pdf);
  - **CHI's *Advancing Transparency for Artificial Intelligence in the Healthcare Ecosystem***, a proposal on ways to increase the transparency of and trust in health AI tools, particularly for care teams and patients (https://connectedhi.com/wp-content/uploads/2022/02/AdvancingTransparencyforArtificialIntelligenceintheHealthcareEcosystem.pdf); and
  - **CHI's *Health AI Roles & Interdependency Framework***, which proposes clear definitions of stakeholders across the healthcare AI value chain, from development to distribution, deployment, and end use; and suggests roles for supporting safety, ethical use, and fairness for each of these important stakeholder groups that are intended to illuminate the interdependencies between these actors, thus advancing the shared responsibility concept (https://connectedhi.com/wp-content/uploads/2024/02/CHI-Health-AI-Roles.pdf).

Network Adequacy

- CHI generally supports CMS' approach to its network adequacy methodology and standards, and to permit MA plans to receive a 10 percent credit towards the percentage of beneficiaries residing within published time and distance standards when they contract with certain telehealth specialty providers (dermatology, psychiatry, cardiology, otolaryngology, and neurology). However, given the demonstrated benefits of digital health technologies in both the prevention and treatment of disease, CHI urges CMS to expand this credit to further specialty provider types including nephrology for home dialysis. We urge CMS to regularly consider further expansions to this list of specialties moving forward.

Special Needs Plans

- CHI believes that MA plans should expand supplemental benefits covering devices/services or integrate them into Special Needs Plan care coordination for dually eligible beneficiaries. While Chronic Condition Special Needs Plans (C-SNPs) and Institutional Special Needs Plans (I-SNPs) provide specialized services, Dual Eligible Special Needs Plans (D-SNPs) can offer superior integration of Medicare and Medicaid benefits for some of America's most vulnerable individuals. To enhance D-SNP value, CMS should clarify that D-SNPs can offer RPM/RTM as supplemental benefits under § 422.102, support Model of Care innovations incorporating telehealth, and expedite MOC approval for evidence-based digital health enhancements.
- CHI supports all Special Needs Plans permitting MA organizations' annual face-to-face visits to be conducted via a "visual, real-time, interactive telehealth encounter" within the first 12 months of enrollment within the plan.

Programs of All-Inclusive Care for the Elderly (PACE)

- CHI supports CMS' providing Programs of All-Inclusive Care for the Elderly (PACE) organizations with the ability to utilize the efficiencies of digital health technologies. Additionally, we recommend allowing PACE interdisciplinary teams (IDTs) to conduct a reassessment prior to approving a service delivery request either in-person or through the use of remote technology (if deemed necessary by the IDT and agreed to by the plan participant).

Part D and Prescription Drug Benefits

- CHI strongly agrees with CMS that Part D must move to accommodate enrollees by enhancing the use of digital technologies used in Part D e-prescribing. We support CMS' efforts to give Part D plans a flexible way for enrollees to securely access formulary and beneficial information through smartphones and other mobile devices. We also support the development and scaling of real time benefit tools.
- CHI recommends CMS ensure real-time digital reporting of manufacturer discounts to beneficiaries through plan mobile applications and online portals, enabling beneficiaries to make informed decisions about prescription drug choices and understand how discounts count toward their out-of-pocket maximum.

- CHI supports the inclusion of processing time, approval/denial rates, and denials overturned on appeal in prior authorization metrics in MA plan Star Ratings.
- As CMS implements the IRA's Part D redesign with the $2,100 out-of-pocket threshold (§ 423.104(d)(5)), CHI recommends encouraging Medicare Advantage Prescription Drug plans to use mobile applications and digital tools for beneficiary education on the new benefit structure, Medicare Prescription Payment Plan enrollment, and real-time formulary information. For chronic conditions requiring regular medication, integrate RPM adherence data with Part D benefit information to support medication management.

Quality Measurement, Risk Adjustment, and Star Ratings

- CMS should make systemic changes now to ensure that next-generation risk adjustment approaches that incorporate real-time data from wearables (e.g., activity, sleep, vital trends) and RPM/RTM devices as "alternative data sources" to better capture persistent/chronic conditions, inferred risks, and severity without relying solely on traditional diagnosis codes or encounters. This would improve model accuracy, reduce administrative burden, incentivize preventive monitoring, and align with goals of transparency, competition, and fraud reduction. CHI also urges CMS to leverage AI to calibrate models, analyze diverse inputs (e.g., from EMRs, labs, wearables, or RPM), and support inferred risk or utilization-based adjustments.
- CHI supports CMS's efforts to streamline the Star Ratings program. We recommend CMS consider adding Part C measures that assess beneficiary access to telehealth services and remote patient monitoring utilization for chronic disease management. These measures would incentivize MA plans to deploy evidence-based digital health innovations that improve outcomes while ensuring technology access across.
- CHI requests that CMS ensure that the MA/Part D and Accountable Care Organization risk adjustment policy to incorporate diagnoses from digital health-enabled remote encounters. Providing this clarity would resolve uncertainty as to whether connected health modalities are risk adjustable since they are not face-to-face visits.
- CHI shares CMS' goal of improving patients' access to useful information regarding drug benefits and costs; however, when considering implementation of real-time benefit technology, we urge CMS to consider the ability of such tools to support patient-physician discussions regarding treatment selection and the utility of the data for the majority of Medicare patients.
- CMS should modify its MA Part D and Accountable Care Organization (ACO) risk adjustment policy to incorporate diagnoses from digital health-enabled remote encounters, including audio-only telehealth services where clinically appropriate.
- CMS should ease restrictions on risk adjustment data releases (§ 422.310(f)) to enable pre-reconciliation sharing for care coordination, beneficiary tools (e.g., via APIs like Blue Button 2.0), and integration of wearable data into compliance monitoring, predictive analytics, or decision support.
- CHI urges CMS to align Star Ratings with measures rewarding effective use of wearables for chronic disease prevention and management (e.g., improved adherence, reduced

hospitalizations). Further, CHI supports the inclusion of processing time, approval/denial rates, and denials overturned on appeal in prior authorization metrics in MA plan Star Ratings.

Data Exchange and Interoperability

- To realize an improved care continuum, it is essential that data exchange occurs seamlessly between regular Medicare and MA plans as patients move between the systems (and increasingly migrate to MA). Already, the Office of the National Coordinator for Health IT has laid the groundwork for improved information exchange based on HL7® FHIR® Application Programming Interfaces (APIs), and has provided several APIs to encourage data exchange (such as Blue Button, MyHealthEData, the Beneficiary Claims Data API for accountable care organizations [ACOs], the Data at Point of Care API pilot, and the AB2D API that allows stand-alone prescription drug plans to receive original Medicare data).

  As part of its efforts to improve MA, CMS should lead in providing an AB2C API that will enable regular Medicare to engage in data exchanges with MA plans. Access to the AB2C API could be facilitated by CMS having MA plans utilize the ONC Trusted Exchange Framework and Common Agreement (TEFCA) when accessing Medicare fee-for-service data.

CHI appreciates the opportunity to comment on CMS's Contract Year 2027 proposed rule. CHI stands ready to provide technical assistance to CMS in developing implementation guidance for connected health technologies. Please contact us if we can provide additional information or expertise on the above recommendations.

Sincerely,

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