ConnectedHealthInitiative

August 31, 2026

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1848-P
P.O. Box 8016
Baltimore, Maryland 21244-8016

RE: ***Comments of the Connected Health Initiative on the Centers for Medicare & Medicaid Services' Medicare and Medicaid Programs; 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*** **[CMS-1848-P; RIN 0938-AV82; 91 FR 43842]**

Dear Administrator Oz:

The Connected Health Initiative (CHI), an initiative of the Association for Competitive Technology (ACT), appreciates the opportunity to provide input to the Centers for Medicare & Medicaid Services (CMS) on its proposed changes to the Medicare Physician Fee Schedule (PFS) and the Quality Payment Program (QPP) for Calendar Year (CY) 2027.[1] The CY 2027 proposed rule is among the most consequential digital health rulemakings CMS has issued in a decade, because it would rewrite the conditions of payment for remote physiologic and remote therapeutic monitoring, revalue nearly every component of those services, introduce a new payment classification for clinical software, and ask the digital health community a set of foundational questions about how Medicare should pay for artificial intelligence (AI) and technology-enabled care. CHI offers the views and recommendations below, organized in the order in which the corresponding provisions appear in the proposed rule, and grounded in the cross-sectoral consensus positions of our members.

CHI's comments are organized as follows:

[1] Medicare and Medicaid Programs; 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, 91 FR 43842 (July 16, 2026) (CMS-1848-P; RIN 0938-AV82), https://www.federalregister.gov/documents/2026/07/16/2026-14327/medicare-and-medicaid-programs-cy-2027-payment-policies-under-the-physician-fee-schedule-and-other.

I. Executive Summary

I. Executive Summary

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 and payment, privacy and security, effectiveness and quality assurance, U.S. Food and Drug Administration (FDA) regulation of digital health, health data interoperability, and the rising role of AI in care delivery. Based on our

commitment to the responsible use of digital health innovations, CHI offers the following views on the PFS and QPP proposals that affect the digital health community in CY 2027:

- **Practice Expense Methodology and the Treatment of Clinical Software (Section II.B).** CHI supports CMS's effort to modernize practice expense (PE) methodology, including the removal of the indirect practice cost index and the extension of the combined work-RVU and clinical-labor-RVU allocation across the fee schedule, both of which reduce Medicare's reliance on 2007-2008 survey data that predates virtually every digital health technology in use today. We urge CMS to pair those steps with the reform CHI has sought for years, which is to recognize software that is a medical device (SaMD) as a **direct** practice expense rather than lumping it in with office productivity software as an indirect, non-allocable "computer software" cost. We also urge CMS to exempt codes undergoing correction of a known valuation error from the proposed five percent PE stabilization cap, and to approach the employed-physician request for information without assuming that a facility-based practitioner incurs no allocable technology cost.
- **Medicare Telehealth Services (Section II.C).** CHI supports the five G-codes CMS proposes to add to the Medicare Telehealth Services List, the conforming implementation of the Consolidated Appropriations Act, 2026 flexibilities, the revised critical care consultation descriptors, the teaching physician virtual presence proposal, and the updated originating site facility fee. We continue to urge CMS to use every tool available to make the geographic, originating site, audio-only, and practitioner-scope flexibilities permanent rather than allowing them to lapse on a rolling basis. On the new BB and BC modifiers, CHI asks CMS to confirm that they will be used for transparency only and will never become a basis for differential payment, coverage limits, or audit targeting, and we ask CMS to put the operative details out for comment as a proposal rather than settling them through guidance after the fact.
- **Remote Physiologic and Remote Therapeutic Monitoring (Section II.D.3.c.(48)).** This is the most consequential set of proposals in the rule for CHI members, and CHI opposes the core of it. CMS should reconsider the established-patient limitation for RPM rather than extend it to RTM, because remote monitoring should be available to new and established patients alike, particularly for the acute conditions CMS has confirmed it may be used to treat, and in any event CMS should not characterize the requirement as responsive to findings the Office of Inspector General made about a different service. CMS should not adopt a separately reportable initiating-visit condition of payment, which requires a second encounter that the CY 2018 policy did not, imposes a new cost-sharing obligation on beneficiaries, and leaves both "onset" and "separately reportable" undefined. CMS should not condition payment on clinical staff being direct employees of the billing practice, because that test measures payroll administration rather than clinical integration, is irreconcilable with 42 C.F.R. 410.26's express recognition of leased employees and independent contractors, and would break ordinary arrangements that today let hospitals, faculty practice plans, and academic health systems support monitoring for practices that could not staff it alone. On valuation, CHI asks CMS to do for CY 2027 what it did for CY 2026, which is to maintain the current work RVUs, direct practice expense inputs, and code structure for one more year. The practice expense review that will supply the device and workflow data CMS says it lacks meets in January 2027, after this rule is final and in effect, so any revaluation or bundling that review supports belongs in the CY 2028 proposed rule, where the public can see the data and comment on it.

- **Behavioral Health Integration and Collaborative Care (Section II.D.3.c.(51)).** CHI strongly supports the proposed increases to the work RVUs for the psychiatric collaborative care model and the related behavioral health integration add-on codes. Collaborative care is an inherently technology-enabled, team-based service whose undervaluation has been a documented barrier to adoption, and correcting it expands behavioral health capacity without waiting on a workforce that will not arrive in time. We ask CMS to reaffirm that the behavioral health care manager may be employed by or under contract to the billing practitioner, which is also a marker of the inconsistency in the remote monitoring employment proposal.
- **Payment for Office and Outpatient Visits Furnished With a Global Procedure (Section II.D.3.c.(58)). CHI strongly opposes** the proposal to pay half rate for a separately identifiable office or outpatient evaluation and management visit furnished on the same day as a procedure with a global period, because that visit is where monitoring is ordered, where transmitted data is reviewed, and where a digital therapeutic is prescribed. The proposal rests on an assumption of duplication that CMS does not substantiate, it reaches overlap that the existing code-specific valuation processes were built to remove, and it collides with CMS's own proposal in section II.D.3.c.(48) to require a separately payable visit before remote monitoring may begin.
- **Software as a Medical Service (Section II.D.3.c.(61)).** CHI has urged CMS for years to establish a coherent Medicare payment framework for clinical software and we welcome the agency's engagement, but the proposed "SaMS" definition, which reaches any technology that supports clinical decision making through algorithmic analysis, is too broad to serve as a payment classification with real consequences. CMS should publish objective inclusion and exclusion criteria, clarify how SaMS relates to FDA-regulated SaMD, conduct and publish a code-by-code analysis before removing any service from the Clinical Laboratory Fee Schedule, decline to assign all future SaMS laboratory codes to contractor pricing automatically, and publish a roadmap explaining how the same software service will be paid in the physician office, hospital outpatient, and ambulatory surgical center settings.
- **Redesigning Primary Care (Section II.E).** CHI strongly supports CMS's recognition that the resource inputs underlying the PFS were defined before generative and agentic AI existed. We urge CMS to reject a two-track care management code structure that segregates "technology-enabled" care from "traditional" care, because technology enablement is a property of how nearly all care is now delivered rather than a separate service line. We support simplifying and standardizing the care management family, and we caution that program integrity concerns are better addressed through claims transparency than through supervision and employment restrictions that suppress legitimate services. On the Annual Wellness Visit, CHI supports the use of AI to make the visit continuous rather than a point-in-time encounter, subject to clinician accountability and the human oversight principles in CHI's health AI policy framework.
- **Current Procedural Terminology Request for Information (Section II.H).** CHI takes no position on the institutional questions, which belong to the physician community, but we ask CMS to weigh one consideration that a payment rule can easily miss. The code set is national health data infrastructure as much as it is a payment tool, and every interoperability and AI commitment CMS has made assumes that a coded service means the same thing wherever it travels. There is no alternative available today, ICD-10-PCS cannot describe the services CMS has spent a decade building into the fee schedule, and bundling and capitation sit on top of granular coding rather than replacing it. The faster path

for digital health runs through the pathways that already exist, including Category III codes and Appendix S, aligned with the RAPID coverage pathway so that coding is not what delays access.

- **Rural Health Clinics, Federally Qualified Health Centers, and the Clinical Laboratory Fee Schedule (Sections III.B and III.C).** CHI supports the conforming telecommunication technology changes for RHCs and FQHCs, the recognition of diabetes self-management training and medical nutrition therapy as stand-alone billable visits, and the FQHC base rate increase, and does not object to the conforming CLFS changes implementing the Consolidated Appropriations Act, 2026. We ask CMS to give these providers the fullest available flexibility to use digital health tools beyond mental health, and not to require them to undertake a second remote monitoring billing conversion two years after CMS required the first.
- **Duplicate Testing, Result Sharing, and Interoperability (Section III.I).** CHI strongly agrees with CMS's diagnosis that duplicate testing is a symptom of an information failure rather than a billing failure, and we support strong action on the interoperability side. CHI supports a minimum national standard for sharing laboratory and imaging results, including structured FHIR R4 diagnostic reports through a USCDI+ framework, together with conformance testing, accountability for providers that fail to share, and a phased condition of participation. On the payment side we counsel caution, because frequency limits and automatic edits operate on claims that do not carry the clinical context distinguishing a wasteful repeat from a necessary one, and no clinician should face a penalty for reordering a test because the system that performed it first would not release the result.
- **Ambulatory Specialty Model and Medicare Shared Savings Program (Sections III.D and III.G).** CHI continues to support the Ambulatory Specialty Model as a vehicle for embedding remote monitoring, wearables, patient-generated health data (PGHD), and interoperable records in specialty care, while reiterating our concerns about mandatory participation and a payment-adjustment methodology that guarantees most participants a reduction. In the Shared Savings Program, CHI supports adding the new codes to the assignment definition, strongly supports the simplified certified electronic health record technology (CEHRT) requirement and asks CMS to keep every proposed pathway rather than narrowing to one, recommends carrying the MIPS small practice exclusion into that requirement and treating a new ACO as compliant in its first year, supports the proposed growth adjustment as a way to bring practices that have never had shared infrastructure into accountable care, supports the per-beneficiary advance investment payment, and urges CMS to use its waiver authority under 42 U.S.C. 1395jjj(f) to lift telehealth restrictions for all ACOs regardless of risk track or attribution method.
- **Quality Payment Program (Section IV).** CHI supports the transition to MIPS Value Pathways provided CMS preserves reporting options for clinicians whose specialties are not yet well served, and we ask CMS to pair the transition with a real reduction in how much has to be reported rather than reorganizing the same volume under a new name. CHI supports the move to FHIR-based digital quality measurement and asks CMS to be realistic about when the sector will be ready, to keep a workable route open for small practices that report through claims today, and to state that Promoting Interoperability will be wound down to its statutory floor as digital measurement takes over rather than run in parallel with it. CHI supports the new Improvement Activity recognizing clinician use of AI to improve patient care, asks CMS to give it high weighting, to align its expectations with established health AI governance frameworks rather than creating a bespoke standard, and to ensure it does not repeat the technology-specific framing CHI objected to in last year's proposed

patient safety AI activity. We continue to urge CMS to reduce its overreliance on CEHRT, to apply the 50-point Promoting Interoperability scoring standard used in other CMS programs while that category remains, and to grant credit for capturing PGHD through non-certified technology.

Each of these positions is developed in the sections that follow, in the order in which the corresponding provisions appear in the proposed rule.

II. Introduction and Statement of Interest

CHI is the leading multistakeholder policy and legal advocacy effort dedicated to improving health outcomes while reducing costs through digital health innovation. CHI aims to realize an environment in which Americans see improvements in their health through policies that allow connected health technologies to advance outcomes and reduce costs. Our members develop and deploy connected health technologies across a wide range of use cases, including telehealth platforms, remote physiologic and remote therapeutic monitoring, software as a medical device, prescription digital therapeutics, clinical decision support, and AI-enabled diagnostic and workflow tools. We advocate before Congress, numerous federal agencies, and state legislatures and agencies on coverage and payment, privacy and security, health data interoperability, FDA regulation of digital health, and the role of AI in care delivery. For more information, see https://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 including the Federal Communications Commission and the U.S. Congress. CHI is also an appointed member of the American Medical Association's (AMA) 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 solutions involving coding, payment, and coverage. To ground coverage and payment decisions in evidence rather than assertion, CHI maintains a Digital Health Evidence Resource, a curated database of U.S. clinical studies on remote monitoring and other digital health outcomes that CMS is welcome to draw on directly.[2]

A PFS and QPP, and a broader Medicare program, that serves beneficiaries effectively must use the full range of digital health tools available today, and we offer these comments in that spirit and welcome the opportunity to discuss any of them with CMS in greater detail.

III. Connected and Digital Health's Integral Role in the Future of Medicare

Data and clinical evidence from a wide range of use cases continue to demonstrate that digital health technologies available today improve patient care, prevent hospitalizations, reduce complications, and improve patient engagement. These benefits are particularly pronounced for the chronically ill, who account for the overwhelming majority of Medicare spending. Connected health tools, including wireless health products, mobile medical devices, software as a medical device, mobile medical applications, and cloud-based portals and dashboards, can improve and transform American healthcare. Despite those proven benefits, statutory restrictions and

[2] Connected Health Initiative, Digital Health Evidence Resource, https://connectedhi.com/resources/digital-health-evidence-resource/.

regulatory-level policy decisions continue to inhibit their use, and utilization remains below what the evidence would support.

CMS's coverage of remote monitoring began in CY 2018, when the agency unbundled CPT code 99091.[3] In the CY 2019 and CY 2020 rules, CMS activated and paid for the RPM code family, and in CY 2022 it established the RTM family, an important step in supporting use cases where remote asynchronous technologies improve outcomes and reduce costs. CMS has also supported the use of AI in specific clinical applications, integrated digital health into value-based care through MIPS quality measures, and, most recently, restructured the remote monitoring code set to recognize shorter time and data-transmission increments. Each of those steps reflected a considered judgment, developed through notice-and-comment rulemaking and supported by the record, that Medicare beneficiaries benefit when care extends beyond the four walls of the clinic.

That progress is why several of the CY 2027 proposals concern CHI so deeply. A framework built deliberately over nine years, in which the billing practitioner retains overall direction and control while clinical staff furnish defined components under general supervision, would be replaced by an employment-status test. Valuations that CMS maintained one year ago pending a scheduled revaluation would be cut by between roughly a quarter and nearly eighty percent depending on the code, using reference codes that carry no equipment or supply cost at all. A code family that CMS and the CPT Editorial Panel refined so that each component of the service could be separately identified would be re-bundled into four codes. CHI does not question CMS's program integrity objectives, but we do question whether these particular instruments serve them, and we explain below why we believe they do not.

Several proposals in this rule are genuinely forward-looking, beginning with CMS's willingness to reconsider a practice expense methodology anchored in 2007-2008 survey data, its request for information on how AI is changing primary care, its proposal to let ACOs demonstrate interoperability through FHIR capabilities, its interest in a national minimum standard for sharing diagnostic results, and its proposed Improvement Activity recognizing responsible clinical AI use, all of which are steps CHI has urged for years. CHI commits to continued collaboration with CMS as it works through them.

IV. CHI Recommendations on the Proposed CY 2027 Physician Fee Schedule (Section II of the Proposed Rule)

a. Determination of Practice Expense RVUs (Section II.B)

Practice expense methodology is a key mechanism that determines whether a clinically validated software product or a connected medical device placed in a beneficiary's home is treated as a resource the practice actually consumes in furnishing a service, or as an unallocable overhead cost that Medicare declines to recognize. CHI therefore takes a close interest in section II.B, and we offer both support and caution.

[3] CY 2018 PFS final rule, 82 FR 52976, 53013-14 (Nov. 15, 2017).

1. The CY 2027 Conversion Factor

The proposed rule projects CY 2027 conversion factor reductions for both the qualifying and non-qualifying alternative payment model conversion factors, which reflect the expiration of the temporary statutory increase applicable in CY 2026.[4] CHI notes the compounding effect, because a conversion factor cut lands on top of every code-level cut discussed elsewhere in these comments, so that a practice deciding whether to keep a remote monitoring program running in 2027 will feel both at once. CHI urges CMS to account for that combined effect when it weighs the access consequences of the proposals in section II.D.3.c.(48).

2. Allocating Indirect PE Using Both Work RVUs and Clinical Labor RVUs

CMS proposes to allocate indirect PE using both the work RVU and the clinical labor RVU for all services other than those with 010-day and 090-day global periods, extending across the fee schedule an approach that currently applies only to services billable with professional and technical components.[5] CHI supports this extension, because a methodology that allocates indirect cost by reference to both practitioner work and clinical labor produces a more faithful picture of the resources a practice devotes to a service than one keyed to a single input, and it removes an arbitrary distinction between services that happen to carry professional and technical component modifiers and services that do not. That distinction has never had a defensible basis in the digital health context, where a single service routinely combines practitioner interpretation, clinical staff activity, and a technology input.

3. Removal of the Indirect Practice Cost Index

Under the proposal, the steps of the current methodology that rely on the indirect practice cost index (IPCI) would be removed, phasing the change in over two years by applying half the measured IPCI variation in the first year and none in the second.[6] CMS explains that the IPCI overweights 2007 survey data and suppresses the influence of more current, code-level inputs.

CHI supports this removal, and CMS's stated rationale deserves a closer look. The Physician Practice Information Survey on which the IPCI rests was fielded in 2007 and 2008. At that time, remote physiologic monitoring was not a Medicare benefit, remote therapeutic monitoring did not exist as a concept, no software product had been authorized by FDA as a prescription digital therapeutic, and clinical AI was a research topic rather than a line item in a practice's budget. A methodology weighted toward that survey cannot describe what it costs to run a practice in 2027, and CHI has said as much in successive PFS comment cycles.[7] CMS should also keep working to

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[4] Proposed rule, 91 FR at 43844. See also section VII (Regulatory Impact Analysis). CHI understands the proposed CY 2027 non-facility, non-qualifying APM conversion factor to be $32.8409 and the qualifying APM conversion factor to be $33.1693, and CMS should confirm these figures in the final rule.

[5] Proposed rule, 91 FR at 43846, 43849-50 (section II.B.2.c).

[6] Proposed rule, 91 FR at 43850 ("we are proposing to remove the steps of the current methodology that rely on the indirect practice cost index (IPCI) from the calculation of the PE RVUs").

[7] Comments of the Connected Health Initiative on the CY 2026 Physician Fee Schedule and Quality Payment Program proposed rule (CMS-1832-P), Docket No. CMS-2025-0304 (Aug. 2025) (urging CMS to incorporate updated practice expense survey data and to modernize PE methodology for software-based inputs).

bring updated practice expense survey data into the fee schedule, so that removing the IPCI is a step toward better data rather than a step toward no data.

4. The Proposed Five Percent Practice Expense Stabilization Adjustment

CMS proposes a new step capping any single-year increase or decrease in a code's PE RVU at five percent, applied before the statutory phase-in of significant reductions. The cap would not apply to new or revised codes, or to codes newly moved from contractor pricing to national pricing, and CMS seeks comment on whether to extend it to those categories.[8]

CHI supports payment stability as a general matter, because practices, and especially the small and independent practices that our members serve, cannot absorb abrupt swings in the payment for services they have built workflows around. But CHI urges CMS to recognize that a symmetric cap has an asymmetric effect on emerging technologies. Where a code has been **undervalued** because the methodology failed to capture a technology input, a five percent annual ceiling means that correcting the error takes many years, and the practices that would adopt the technology in the meantime simply do not. CHI recommends that CMS exclude from the cap any code whose PE RVU is being adjusted to correct an identified methodological error or to incorporate a newly recognized direct input, in the same way CMS proposes to exclude new and revised codes. CHI further recommends that CMS decline to extend the cap to codes moving from contractor pricing to national pricing, because the entire purpose of that transition is to replace a fragmented local rate with an accurate national one, and a five percent annual glide path would frustrate it.

CHI also asks CMS to confirm in the final rule that the stabilization adjustment would not be used to phase in the remote monitoring reductions discussed in section IV.c below, because those reductions should not be finalized at all and a cap that spreads an unsupported reduction across several years does not make it supported.

5. Site-of-Service Payment Differential and the Employed-Physician Request for Information

For CY 2027 CMS would continue the CY 2026 policy of allocating only half of the work-RVU-based portion of indirect PE to facility settings, would equalize nursing facility visit rates regardless of whether the stay is covered under Part A or Part B, and has issued a request for information on facility practice expense for hospital-employed and health-system-employed physicians, including whether the indirect PE allocation for such practitioners should be reduced below fifty percent or to zero, and whether a new HCPCS modifier should identify employed physicians.[9]

CHI supports equalizing nursing facility visit rates regardless of whether the stay is covered under Part A or Part B. Skilled nursing facility residents are among the beneficiaries who benefit most from remote monitoring, telehealth consultation, and virtual specialty access, and a payment differential turning on which part of Medicare covers the stay bears no relationship to the resources a practitioner expends.

CHI does not take a position on the appropriate facility indirect PE percentage, which turns on cost accounting questions outside our expertise. We do ask CMS to avoid one assumption built into the

[8] Proposed rule, 91 FR at 43850-51 (section II.B.2.c).

[9] Proposed rule, 91 FR at 43859-61 (section II.B.4.d).

framing of the request for information, which is that a physician who practices within a facility therefore incurs no practice expense attributable to the PFS service. Technology costs frequently do not follow the facility line, and a practitioner employed by a health system may still bear, directly or through the practice, the cost of a clinical software subscription, an interface or application programming interface (API) license, a device management platform, or a monitoring service that is used to furnish the professional service and is not reflected in any facility payment. If CMS reduces facility indirect PE toward zero on the premise that the hospital bears all overhead, it should make sure that services with identifiable direct technology inputs are not swept along with it. This concern reinforces, rather than substitutes for, CHI's recommendation in subsection 7 below that such inputs be classified as direct practice expense in the first place, where they belong and where the site-of-service differential does not reach them.

On the proposed employed-physician modifier, CHI supports the identification function and asks CMS to keep identification separate from adjudication. A claims-level identifier that improves CMS's visibility into who furnished a service and in what setting is a reasonable instrument, but the same identifier used as an automatic trigger for a reduction in practice expense, without regard to whether the practitioner in fact incurred allocable technology costs, is not. CHI's general preference for claims transparency over categorical payment restrictions applies here and, as discussed at length in section IV.c, applies with even greater force to remote monitoring.

6. Payment Transparency, Component RVUs, and Global Surgical Packages

In section II.B.6, CMS posts public use files displaying professional and technical component RVUs for services not currently billable with those modifiers, and imputed RVUs for post-operative visits within global surgical packages. CMS proposes to pause the statutorily mandated global surgery data collection based on CPT code 99024 reporting and seeks comment on whether to instead require all providers to report that code.[10]

CHI supports the publication of component-level RVU data, which allows the digital health community to engage seriously with valuation, and it bears directly on the SaMS discussion in section IV.f, because a service whose computational component can be identified and priced on its own is a service CMS can reason about consistently across payment systems. On global surgery data collection, if CMS believes the current 99024 reporting requirement produces data of poor quality, the answer is better data capture rather than less data. Capturing post-operative encounters automatically through certified health IT and, where appropriate, remote monitoring, would produce a fuller and less burdensome record than reporting by the limited subset of practitioners CMS requires to report today.

7. The Unfinished Work of Recognizing Software as a Medical Device as a Direct Practice Expense

CHI cannot comment on practice expense methodology without returning to the issue we have raised in every recent PFS cycle. Practice expense consists of direct costs, meaning clinical labor, medical supplies, and medical equipment, and indirect costs, meaning administrative labor, office expense, and other expenses including computer software. Direct costs are estimated per service, while indirect costs are largely non-allocable and rest on the outdated survey data discussed

[10] Proposed rule, 91 FR at 43861-62 (section II.B.6).

above. Under that structure, software that FDA regulates as a medical device is treated as though it were no different from a word processor.

That treatment is not defensible, because a SaMD product is a device under the Federal Food, Drug, and Cosmetic Act regardless of whether it runs on a dedicated ancillary medical device or on a general purpose computing platform. Its developer carries quality system, postmarket surveillance, cybersecurity, and adverse event reporting obligations that are every bit as demanding as those borne by a manufacturer of physical equipment. It is acquired, deployed, validated, updated, and patched for the purpose of furnishing a specific clinical service to a specific patient. Software updates and security patches to SaMD are the functional analogue of disposable medical supplies, which Medicare recognizes as direct PE. CMS has itself acknowledged, in the CY 2021 and CY 2026 rules among others, that its PE methodology struggles to account for software algorithms and AI. The agency has the authority to fix that, and what has been missing is the decision to do so.

CHI reiterates the recommendation we have made consistently, which is that CMS should classify SaMD used in medical practice as a direct practice expense, aligned with medical equipment, whether the underlying resource is physical or software-based. Where CMS pays for software as a direct supply input, it should derive the per-service cost from the most accurate evidence available, principally invoices, rather than by crosswalking to a service that contains no software input at all. CHI supports crosswalking as a general mechanism, as we explain in section IV.i, and our objection here is narrower, since a crosswalk cannot supply the value of a resource the reference code does not contain. CMS's equipment amortization formula should apply only where a program is locally installed with an identifiable useful life and an upfront payment, and not to subscription or per-use arrangements. And the fact that a service is furnished for a fee does not mean the practice incurs no other cost in furnishing it, because a fee-based input and indirect practice costs are not mutually exclusive.

Cross-walking SaMD-inclusive codes to the whole rates of unrelated services, which CMS has used as an interim measure since 2022, is not a lasting substitute for fixing the methodology. CHI appreciates those interim steps and recognizes the constraints CMS has worked within, but the CY 2027 rule, which proposes both a wholesale reconsideration of indirect PE allocation and a new payment category for clinical software, is the right vehicle for finishing the job. CHI also reiterates that CMS should use the flexibility it has in deciding whether a digital medical device or diagnostic falls within an existing Medicare benefit category, and should say whether SaMD fits within an existing category and if so which one. The Medicare statute does not address digital health technology apart from telehealth services, and it does not limit CMS's ability to cover digital health technologies within the benefit categories that already exist.

b. Payment for Medicare Telehealth Services (Section II.C)

More patients than ever rely on digital health platforms and services to consult with their caregivers, and sustained utilization of Medicare telehealth services remains an important factor in realizing greater value for the program. CHI is broadly supportive of section II.C and offers the following specific input.

1. Codes Proposed for Addition to the Medicare Telehealth Services List

CMS reports that it received no requests to add or remove services for CY 2027 and, on its own initiative, proposes to add five HCPCS G-codes to the Medicare Telehealth Services List, namely advance care planning codes GACP1 and GACP2, a shared medical appointment code GSMAS, a pediatric speech-language pathology code GSLPP, and a vaccine adverse effects code GADV1, each of which CHI supports.[11]

The shared medical appointment code deserves particular attention. Group-based care is one of the clearest cases in which a virtual modality is materially better than in-person delivery, because it removes travel and scheduling barriers that fall hardest on the beneficiaries most likely to benefit from peer-supported chronic disease management. CHI encourages CMS to monitor uptake and to consider whether other group-delivered services, including diabetes self-management training and medical nutrition therapy, should follow. The pediatric speech-language pathology code likewise reflects a use case in which remote delivery expands access to a scarce specialty workforce.

CMS's simplified process for adding and removing services from the List, finalized for CY 2026 after CHI supported it, also appears to be working as intended. The absence of external addition requests this cycle reflects a List that has become substantially more complete rather than any stakeholder disinterest. CHI encourages CMS to maintain that streamlined approach and to continue evaluating services on their clinical merits rather than on categorical assumptions about what can be delivered through interactive telecommunications technology.

2. Statutory Flexibilities, Audio-Only Access, and the Case for Permanence

CMS proposes conforming changes reflecting the Consolidated Appropriations Act, 2026, which extended the geographic and originating site flexibilities and the expanded practitioner list through December 31, 2027, and extended audio-only telehealth and delayed the in-person requirement for tele-mental health through January 1, 2028.[12] CHI supported the enactment of those extensions and appreciates CMS's prompt implementation.

CHI's position on the underlying policy has not changed, and rolling extensions are a poor substitute for permanence. Every expiration date on the calendar is a reason for a health system not to make a capital investment, for a practice not to hire a virtual care coordinator, and for a beneficiary not to build a care relationship that may not exist in eighteen months, so that the instability is itself a barrier to access, independent of the substantive policy. CHI recognizes that the geographic and originating site restrictions are statutory and that permanence requires Congress to act, and we continue to advocate for that outcome directly.[13] In the meantime, CMS should use its administrative authority to the fullest, should state clearly in the final rule that it supports permanence, and should avoid adopting any policy that would be difficult to unwind if Congress acts.

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[11] Proposed rule, section II.C.1.b, 91 FR at 43863. The advance care planning codes are established in section II.G.1.

[12] Proposed rule, section II.C.2, 91 FR 43842.

[13] Connected Health Initiative, Congress Took Steps to Support Medicare Telehealth. We Hope They Keep Up (Feb. 12, 2026), https://connectedhi.com/congress-took-steps-to-support-medicare-telehealth-we-hope-they-keep-up/.

On audio-only services specifically, CHI reiterates that audio-only telemental health should be available to any beneficiary who requires mental health services, for both new and established patients, and that CMS should extend comparable support to treatment across other conditions. Audio-only access is not a lesser modality for the beneficiary who lacks reliable broadband, lacks a video-capable device, or cannot navigate a video interface, because for that beneficiary it is the only modality, and CHI has consistently urged CMS not to adopt policies that discriminate against virtual modalities without evidence of harm.

CHI further urges CMS to continue permitting distant site practitioners to bill under their enrolled practice location rather than their home address when furnishing telehealth services from home. That flexibility addresses genuine practitioner safety and privacy concerns as well as administrative burden, and CHI is aware of no evidence that it has created program integrity problems.

3. The New BB and BC Claims Modifiers

As required by section 6209(g) of the Consolidated Appropriations Act, 2026, CMS proposes to create modifiers BB and BC, effective January 1, 2027, for telehealth claims furnished through a contracted virtual platform or incident to a practitioner's professional service. CMS states that the modifiers do not affect payment and are intended to make platform-affiliated telehealth identifiable in Medicare claims data, with operational guidance to follow.[14]

CMS says it is establishing these modifiers and that operational guidance will follow, rather than setting out a proposal that describes how they would work and inviting comment on that description. The Consolidated Appropriations Act, 2026 directs CMS to create the modifiers, but it does not tell CMS how to define the arrangements they identify, which claims must carry them, what documentation supports them, or what happens when one is left off. Those questions determine what the requirement costs a practice to comply with, and the public has had no opportunity to be heard on any of them. CHI asks CMS to set out the operative details in a proposal and to take comment on them before the requirement takes effect. A claims requirement that governs how a service must be reported is a substantive standard, and for the reasons discussed in section IV.c.3, Medicare's own rulemaking obligations point toward notice and comment rather than sub-regulatory guidance.

CHI does not object to a transparency modifier and, as noted throughout these comments, we generally prefer claims-level visibility to categorical restrictions. We ask CMS to make three commitments in the final rule. First, CMS should state expressly that BB and BC will be used for data analysis and will not serve as the basis for differential payment, coverage limitations, or automated audit targeting. Second, CMS should publish operational guidance well before January 1, 2027, and should specify the modifiers' application where a practitioner uses a platform under a subscription or licensing arrangement rather than an employment or contracting arrangement, where a practice uses more than one platform, and where the platform is a component of a certified electronic health record rather than a standalone service. The statutory language reaches practitioners who contract with the platform owner and those with a payment arrangement for platform use, and the boundary between those categories and ordinary health IT procurement is

[14] Proposed rule, section II.C.2, 91 FR 43842 (implementing section 6209(g) of the Consolidated Appropriations Act, 2026).

not self-evident. Third, CMS should confirm that a modifier omitted in good faith during an initial transition period will not result in claim denial.

The same instinct that produced a transparency modifier here produced, in the remote monitoring context, a categorical employment prohibition. Congress addressed a visibility concern about platform-mediated care by requiring that the arrangement be identified on the claim rather than by prohibiting the arrangement. CHI urges CMS to apply the same logic in section II.D.3.c.(48).

4. Telehealth Critical Care Consultations

CMS proposes revised descriptors for HCPCS codes G0508 and G0509 to align them with the underlying critical care time thresholds.[15] CHI supports the alignment, because descriptor consistency between telehealth G-codes and their in-person analogues reduces coding error, simplifies compliance for practices that furnish care in both modalities, and removes an unnecessary source of confusion for the critical care consultation services that tele-critical care programs depend on. CHI encourages CMS to apply the same principle systematically wherever a telehealth G-code has drifted from the code it was modeled on.

5. Teaching Physicians and Virtual Presence

Teaching physicians would be allowed to bill for telehealth services involving residents when either the teaching physician or the resident is in the same physical location as the beneficiary.[16] CHI supports this proposal, which reflects the reality of how academic medical centers deliver virtual care and removes a requirement that served no identifiable patient protection purpose.

CHI encourages CMS to go further and to permit teaching physician billing where the teaching physician participates through real-time audio-video technology and neither party is co-located with the beneficiary, provided the teaching physician is present for the key portion of the service and the supervision requirements at 42 C.F.R. 415.172 are otherwise met. Virtual presence for teaching purposes raises the same considerations as virtual presence for supervision generally, addressed in subsection 7 below, and CHI sees no principled basis for treating them differently.

6. Originating Site Facility Fee

CMS proposes a CY 2027 originating site facility fee under HCPCS code Q3014 of $32.65, reflecting a 2.5 percent increase consistent with the Medicare Economic Index.[17] CHI welcomes the update as a technical matter, though the originating site fee is a vestige of a statutory architecture built for clinic-to-clinic telemedicine, and its shrinking relevance in a period when most telehealth originates in the beneficiary's home is a further argument for the statutory modernization CHI supports.

7. Supervision via Remote Digital Modalities

Although the CY 2027 rule does not propose further changes to the definition of direct supervision, CHI takes this opportunity to reiterate its longstanding position, which bears directly on the remote

[15] Proposed rule, section II.C.3, 91 FR at 43864.

[16] Proposed rule, section II.C.4, 91 FR at 43864-65.

[17] Proposed rule, section II.C.5, 91 FR at 43865.

monitoring proposals discussed next. CHI strongly supported CMS's decision to make permanent, effective January 1, 2026, the allowance for direct supervision through real-time audio-video technology for services under 42 C.F.R. 410.26 other than those with a global surgery indicator of 010 or 090, and its extension to applicable services under 42 C.F.R. 410.32, including cardiac, pulmonary, and intensive cardiac rehabilitation.

CHI does not share the concern, expressed by CMS in earlier rulemakings, that virtual supervision inherently creates patient safety risk. Clinical staff and auxiliary personnel perform a wide range of tasks that are efficiently and safely supervised virtually, and such staff do not perform the complex, high-risk, surgical, interventional, endoscopic, or anesthesia procedures CMS has cited when explaining its reservations. CMS should continue moving away from policies that disfavor virtual modalities absent evidence of harm, and should permit supervision through real-time audio-video technology across as many services as possible. Greater use of effective virtual presence technology supports medically necessary care while helping to address workforce shortages that Medicare beneficiaries feel most acutely in rural and underserved areas.

c. Remote Physiologic and Remote Therapeutic Monitoring (Section II.D.3.c.(48))

Section II.D.3.c.(48) of the proposed rule addresses the remote monitoring code family and proposes five changes, which are an established-patient condition of payment extended to RTM, a separately reportable initiating-visit condition of payment, a requirement that clinical staff furnishing these services be directly employed by the billing practice, a revaluation of nearly every code in the family through crosswalks and the removal of practice expense inputs, and a comment solicitation on replacing seventeen codes with four HCPCS G-codes.[18] CMS grounds the package in two reports of the HHS Office of Inspector General (OIG).[19] [20]

The OIG's central finding was that Medicare claims data does not tell CMS enough, because it does not identify the ordering practitioner for a large share of monitored beneficiaries, does not identify who actually furnished an incident-to service or how many people contributed to the reported time, and does not identify the condition or the data being monitored. Every one of those is an information gap, and none of the proposals in section II.D.3.c.(48) closes any of them. A practice could satisfy the established-patient requirement, furnish an initiating visit, place every staff member on its own payroll, and bill under whichever code structure CMS adopts, and CMS would still be unable to determine who ordered the monitoring, who performed the service, what was

[18] Proposed rule, section II.D.3.c.(48), captioned "Remote Monitoring (CPT Codes 98975-98981, 98984-98986, 99091, 99453-99454, 99457-99458, 99473-99474, 99445, 99470)." The discussion appears at approximately 91 FR 43894-43896. CMS describes its bundling solicitation as replacing seventeen codes. The caption above lists nineteen because it also names CPT codes 99473 and 99474, which CMS uses as crosswalk reference codes rather than as remote monitoring services, and the practice expense review discussed in section IV.c.4 is described as covering all nineteen codes in the caption. CMS states that the proposals respond to two reports of the HHS Office of Inspector General and, if finalized, would take effect January 1, 2027.

[19] HHS Office of Inspector General, Additional Oversight of Remote Patient Monitoring in Medicare Is Needed, OEI-02-23-00260 (Sept. 2024), https://oig.hhs.gov/reports/all/2024/additional-oversight-of-remote-patient-monitoring-in-medicare-is-needed/.

[20] HHS Office of Inspector General, Billing for Remote Patient Monitoring in Medicare, OEI-02-23-00261 (2025), https://oig.hhs.gov/reports/all/2025/billing-for-remote-patient-monitoring/.

being monitored, or whether the results were ever acted on, and CHI urges CMS to solve the problem it actually has.

1. The Established-Patient Condition of Payment

CMS proposes to require, as a condition of payment, that RPM and RTM be furnished only to established patients, extending to RTM a requirement that already applies to RPM. CMS reasons that a practitioner with an established relationship will have had the opportunity to collect relevant history and, as appropriate, conduct a physical examination before ordering monitoring.

For several rulemaking cycles CHI has taken the position that remote monitoring should be available to both new and established patients. CMS's rationale for the established-patient limitation rests on an assumption that holds for some chronic disease management scenarios and does not hold for others, and CMS has itself clarified that RPM may be furnished for acute as well as chronic conditions. In an acute presentation, there is by definition an opportunity to furnish a new patient evaluation and management service, and the clinical case for beginning monitoring immediately is often strongest where no prior relationship exists. Practitioners should be able to use remote monitoring when it is medically necessary, and CHI therefore urges CMS to reconsider the established-patient limitation for RPM rather than extend it to RTM.

If CMS declines that recommendation and finalizes an established-patient requirement for RTM, two further points should be reflected in the final rule. First, CMS should acknowledge that the requirement continues what the agency has long expected rather than adding a new safeguard. CMS signaled as early as the CY 2022 rulemaking that the RTM codes were modeled on the RPM codes, and stated in the CY 2024 final rule that although it had not settled the question in rulemaking, it believed RTM services would follow the establishment of a treatment plan after some initial interaction with the patient. The CPT general guidelines define an established patient as one who has received professional services from the same practitioner, or another practitioner of the same specialty and subspecialty in the same group, within the preceding three years. Written down in those terms, the requirement would change little in practice, which is why it cannot carry the program integrity weight CMS places on it.

Second, CMS should not characterize the requirement as responsive to the OIG's findings. The 2024 OIG report expressly stated that its review covered remote monitoring of physiologic data and did not cover remote therapeutic monitoring, and the 2025 report analyzed only RPM codes. The OIG conducted its analysis on the express premise that an established relationship was **already required** for RPM, citing the CY 2021 final rule as the source of that requirement, so that what the OIG identified was noncompliance with an existing rule by a small number of outlier practices rather than a gap in the rule. Of the more than four thousand practices that routinely billed RPM in 2024, the OIG's claims-based method failed to locate a prior relationship for more than eighty percent of patients at a few dozen, while most practices had prior relationships with nearly all of their monitored patients. The OIG did not review medical records and expressly cautioned that its measures did not establish fraud, overpayment, or noncompliance. Extending an existing RPM requirement to a different service the OIG did not examine does not address what the OIG found.

2. CMS Should Not Adopt the Proposed Initiating-Visit Condition of Payment

CMS proposes that a practitioner reporting RPM or RTM furnish a separately reportable initiating visit at the onset of monitoring. The visit must be face-to-face, in person or via telehealth,

separately payable under Medicare, and furnished by the billing practitioner. A visit that is not face-to-face, or not separately payable, cannot serve as the initiating visit, and monitoring must be discussed with the patient at that visit or the visit does not count.

CHI opposes this proposal and urges CMS not to finalize it. The clinical step CMS wants to see already happens, because a practitioner does not order monitoring without first evaluating the patient. What is new is the demand that the step be delivered as a discrete, separately billable encounter, which reaches well beyond the narrower requirement CMS has applied since CY 2018, imposes a new and unnecessary cost on beneficiaries, and is not calibrated to any finding in the record.

The historical requirement was narrower and better targeted, because in the CY 2018 final rule CMS required an initiating visit only for a new patient or a patient the billing practitioner had not seen within the preceding year. The CY 2027 proposal drops that limitation and would require a discrete, separately billable encounter even for a patient who is already established, was recently evaluated, and is being managed under a current plan of care. CMS has not explained what clinical purpose the additional encounter serves in that scenario. Consider the ordinary case in which a practitioner examines a patient, confirms a chronic diagnosis, develops a plan of care, discusses the possibility of monitoring, and three weeks later determines that monitoring should begin. Under the proposal, that patient must return for another visit that generates a claim and a coinsurance obligation, produces no additional clinical information, and delays the start of monitoring for a patient whose practitioner has already determined that monitoring is warranted.

The proposal also leaves its central term undefined, because CMS does not explain what constitutes the "onset" of monitoring, and the answer determines how often the requirement recurs. CHI asks CMS to state, if it finalizes anything in this area, how the requirement would apply in the situations practices encounter routinely, such as when responsibility for the patient passes to a different practitioner within the same group, when the monitoring device is swapped or upgraded, when transmission stops while the beneficiary is hospitalized or traveling and after what interval that matters, and when a second monitored condition or a new therapeutic goal is added to an existing program. CMS should also say whether each discrete episode of monitoring requires its own visit or whether one visit covers a course of care. Without answers, practices cannot build compliant workflows, and the predictable response is to avoid the service.

The requirement is particularly ill-suited to RTM, because physical therapists, occupational therapists, speech-language pathologists, and other qualified practitioners furnish RTM but do not report office or outpatient evaluation and management services. If CMS requires a separately payable face-to-face visit as the trigger, it must state whether a therapy evaluation, re-evaluation, or other separately payable plan-of-care service satisfies the requirement. If it does not, the proposal effectively removes RTM from the practitioners for whom Congress and the CPT Editorial Panel designed a substantial part of it.

CHI also asks CMS to clarify what it means by a "separately reportable" visit. We understand the intent to be distinguishing the encounter at which monitoring is discussed from the monitoring service itself, but the phrase does not say what has to be separate from what. The need for monitoring is often identified during an encounter that is real, documented, and clinically sufficient, yet not separately reported, such as a hospital or discharge visit that falls inside a global surgical period. Read literally, the proposal would disqualify that encounter and require the practitioner to bring the patient back for a visit that adds nothing, which is the opposite of what

CMS says it intends. CHI asks CMS to state in the final rule that an encounter which is documented and clinically adequate satisfies any initiating requirement whether or not it is separately payable.

If CMS believes some initiating encounter requirement is warranted, CHI recommends that it return to the targeted historical approach of requiring a qualifying encounter where the patient is new, has not been seen within a defined period, or has not otherwise received a recent service sufficient to assess the condition and establish a monitoring plan. A recent evaluation and management service, therapy evaluation or re-evaluation, annual wellness visit, transitional care management service, or comparable qualifying encounter should satisfy the requirement where the medical record shows that monitoring was considered and subsequently incorporated into the plan of care. That approach preserves the clinical substance CMS is concerned about without manufacturing a claim.

3. CMS Should Not Condition Payment on Direct Employment of Clinical Staff

Payment for RPM and RTM would be available only where the services are furnished by clinical staff who are direct employees of the practitioner or practice. Beginning January 1, 2027, the codes could not be billed where the service is performed by anyone else, and contracting with third-party companies would not be permitted. CMS states that outsourcing can fragment care, produce insufficient practitioner involvement, and allow entities with only a loose association with the treating practitioner to participate in the beneficiary's care, citing OIG findings about companies cold-calling beneficiaries.

CHI opposes this proposal in the strongest terms and urges CMS not to finalize it. It would discard, without adequate explanation, a supervision framework CMS built deliberately over nearly a decade, it is inconsistent with the regulation that governs incident-to services, it substitutes a payroll test for a clinical one, and it would fall hardest on the practices and beneficiaries Medicare should be working hardest to reach.

The framework CMS built. CMS's decisions to permit general supervision for remote monitoring were deliberate and repeatedly reaffirmed:

- In CY 2018, CMS treated remote monitoring as part of longitudinal care management.[21]
- In CY 2019, after initially stating that CPT code 99457 described professional time that could not be furnished incident to, CMS issued a technical correction confirming that these services may be furnished by auxiliary personnel incident to a practitioner's professional service.[22]
- In CY 2020, CMS designated the RPM treatment-management services as care management services eligible for general supervision.[23]
- In the CY 2021 rule, published in December 2020, CMS expressly recognized that auxiliary personnel furnishing these services include employees, leased employees, and contracted employees.[24]

[21] CY 2018 PFS final rule, 82 FR 52976, 53013-14 (Nov. 15, 2017).

[22] CY 2019 PFS technical correction, CMS-1693-CN2, 84 FR 9461-62 (Mar. 15, 2019).

[23] CY 2020 PFS final rule, 84 FR 62568, 62697-98 (Nov. 15, 2019).

[24] CY 2021 PFS final rule, 85 FR 84472, 84543-45 (Dec. 28, 2020).

The result was a framework in which the billing practitioner retains overall direction, control, and payment responsibility while clinical staff furnish defined components without the practitioner's physical presence. At no point in that sequence did CMS suggest, much less propose, that clinical staff must be direct employees, relying instead on the incident-to requirements and on the practitioner's accountability for supervising and billing the service. The CY 2021 policy is difficult to reconcile with the CY 2027 conclusion that contracted personnel cannot ensure adequate oversight, because CMS knew in 2020 that personnel could be employed, leased, or contracted, and it said so, incorporated those arrangements into its policy, and finalized general supervision after supportive public comment.

The governing regulation. Section 410.26 defines auxiliary personnel to include an individual acting under the practitioner's supervision regardless of whether that individual is an employee, a leased employee, or an independent contractor. It defines general supervision as the practitioner's overall direction and control, without requiring the practitioner's presence while the service is performed, and it permits designated care management services to be furnished under general supervision.[25] The proposal would carve a remote-monitoring-specific exception out of arrangements the general regulation expressly allows. If CMS proceeds, it owes the public an explanation of why a nurse who may lawfully furnish chronic care management or behavioral health integration incident to a practitioner's service becomes disqualified the moment that same nurse reviews monitoring data for that same patient, and it should do two practical things besides. The change belongs in conforming regulatory text rather than in preamble discussion or claims-processing instructions, because a substantive condition of Medicare payment must be promulgated by regulation.[26] CMS should also address the reversal directly, because it took the opposite position in the CY 2021 final rule when it confirmed that remote monitoring may be furnished by clinical staff under general supervision, and practices built their staffing around that answer.

Employment status does not measure clinical integration. The proposal assumes that direct employees are integrated into the practice and contracted personnel are not, and that assumption does not describe how care is actually organized. A direct employee in a large centralized department may follow a vendor-supplied script, lack access to the patient's broader history, communicate only through an automated task queue, and have essentially no contact with the billing practitioner. A contracted registered nurse may work inside the practice's own electronic health record through an integrated dashboard, be assigned to carry out a specific patient's plan of care, take part in regular case conferences, speak with the patient as a representative of the practice, escalate abnormal findings immediately, and work under detailed credentialing, privacy, security, and clinical governance obligations. Payroll placement tells CMS nothing about which of those two pictures is the real one.

The proposal would also disqualify a wide range of ordinary staffing arrangements that have nothing to do with the conduct CMS describes. A group practice that shares clinical staff across its sites, a health system running a shared services center, a clinically integrated network or accountable care organization that supports its participants centrally, a practice that engages a nursing agency to cover a leave of absence, a small employer that staffs through a professional

[25] 42 C.F.R. 410.26(a)(1), (a)(3), (b)(5).

[26] Social Security Act section 1871(a)(2), 42 U.S.C. 1395hh(a)(2). See also Azar v. Allina Health Services, 587 U.S. 566 (2019).

employer organization, and a practice affiliated with a management services organization would all fall outside the payment rule, even though section 410.26 permits every one of these arrangements today. CMS has offered no evidence that payroll classification predicts whether a practitioner meaningfully supervises remote monitoring, and it has not said how a practice would prove compliance or what documentation contractors would review.

Nursing staff employed by a hospital or medical center commonly furnish monitoring that is ordered and billed by a faculty practice plan or medical group that is a separate legal employer, so that clinicians and staff inside the same health system would be barred from working together on a service they deliver today. Other arrangements exist because state law requires them, as where a medical school may not own a hospital and post-discharge monitoring therefore runs through a partnership between the two. Academic health systems increasingly act as the monitoring partner for rural hospitals that could never staff the function alone, including under the Rural Health Transformation program that this rule elsewhere builds on. An employee-only rule would cut against that program directly, telling rural providers that the partnerships built to bring them innovative technology no longer qualify for payment.

The proposal also does not square with how CMS treats other non-face-to-face care management. For chronic care management and transitional care management, CMS revised section 410.26(b)(5) specifically to permit designated care management services under general supervision, explaining at the time that the standard kept the practitioner answerable for the service while giving practices the operational latitude that sustained non-face-to-face care requires. For behavioral health integration and the psychiatric collaborative care model, CMS expressly contemplated that the behavioral health care manager might be employed by **or under contract to** the billing practitioner, and reasoned that general supervision could facilitate utilization and extend the reach of a limited workforce. CMS has not explained why those considerations no longer apply when the service is remote monitoring.

The burden falls on small and rural practices. A functioning monitoring program requires someone to provision and configure devices, walk patients through setup and troubleshoot connectivity, review incoming data, reach out when transmissions stop, handle patient-reported responses, conduct the interactive communication the codes require, do so in the patient's own language, document the encounter, and escalate abnormal findings promptly. Many small and mid-sized practices cannot employ dedicated personnel for those functions, because patient volume is often insufficient to justify a full-time position and demand fluctuates month to month. Contracted staffing lets such a practice offer monitoring at all, while the treating practitioner retains responsibility for medical necessity, the plan of care, general supervision, and clinical decision-making.

An employee-only rule would cause many of these practices to stop offering monitoring, divert practitioner time to tasks qualified clinical staff could perform, or push patients toward larger, more distant organizations. Rural, independent, specialty, and lower-volume practices would be affected most, which is to say the practices serving the beneficiaries for whom remote monitoring most reduces travel burden and delay. CHI notes that CMS itself requests information on these questions in this rule, which confirms that the agency does not currently have a record establishing how many practices rely on contracted clinical personnel, what those personnel do, whether their quality or compliance differs from employee-based programs, or how the restriction would affect beneficiary access. CMS should develop that record before, not after, imposing a categorical prohibition.

What CHI recommends instead. CMS should retain the existing section 410.26 framework and address poorly integrated arrangements through functional standards directed at the conduct that actually matters. Specifically, CMS could require that:

- the billing practitioner, and no one else, determine medical necessity, order the monitoring, and make the clinical judgments the service calls for,
- the practitioner review the monitoring information, assess the beneficiary's progress, and adjust treatment accordingly, with a defined mechanism by which clinically significant findings reach the practitioner promptly,
- anyone furnishing components of the service have appropriate access to the plan of care and relevant clinical information, and record their activity in the practice's medical record,
- the practice hold a written agreement setting out the qualifications, functions, documentation duties, escalation procedures, and privacy and security obligations of any such personnel, and the supervisory structure they work within, and
- the claim carry the identity of the ordering or supervising practitioner, flag the service as one furnished incident to that practitioner, and, wherever it is feasible to do so, name the individual or organization that actually rendered it.

That last element is the one the OIG actually asked for, and it would close the information gap CMS says concerns it. The OIG asked CMS to build visibility into the claim by capturing the order and the identity of the ordering practitioner and by recording what health data is actually under observation, to use that visibility by running targeted analytics against anomalous billing patterns and following up where the analytics warrant it, to identify and monitor the companies that specialize in this line of business, and to educate the provider community so that compliant practices know what is expected of them. CHI supports every one of those measures and would work with CMS on implementing them. The recommendation about companies is worth a closer reading, because CMS concurred with the recommendation that it identify and monitor companies that bill for remote monitoring, and the OIG did not recommend that those companies be barred from furnishing the services at all. Not one of the OIG's recommendations requires prohibiting contracted clinical staff, and the prohibition delivers not one of them.

4. CMS Should Not Finalize the Proposed Crosswalks or Eliminate Treatment-Management Practice Expense

CMS proposes to revalue nearly every component of remote monitoring, starting with the setup and education codes, where it would replace the existing direct practice expense inputs with those of self-measured blood pressure training under CPT code 99473. The RPM device supply codes would take the direct PE inputs assigned to CPT code 99474, and the RTM device supply codes would take those assigned to the technical component of a thirty-day external electrocardiographic event recording service under CPT code 93270. For the treatment-management codes, CMS would eliminate the direct PE inputs entirely while retaining the physician work RVUs, on the stated view that the typical clinical workflow for those services does not involve clinical staff time. CMS explains that it has received very little invoice or pricing information for the specific devices used and is concerned the codes are overvalued.

CHI opposes each of these changes, which are not refinements. Based on the proposed RVUs in the CY 2027 Addendum B and the proposed non-facility conversion factor, they represent reductions on the order of twenty-six percent for setup and education, roughly fifty-five percent for RPM device supply, approaching eighty percent for several RTM device supply codes, and between

roughly forty-six and fifty-nine percent for the treatment-management codes, all effective January 1, 2027, with no transition period for practices that have built programs around the current rates.

The reference codes cannot describe the resource being valued. This is the central defect, and it is most acute for the device supply codes. CPT code 99474 and CPT code 93270, the two reference codes CMS selected for RPM and RTM device supply respectively, each carry direct practice expense composed **solely of clinical staff labor**. In each case the medical equipment component is zero and the supply component is zero. The codes being crosswalked to them, CPT codes 99445 and 99454 for RPM and CPT codes 98976, 98977, 98984, 98985, 98978, and 98986 for RTM, are practice-expense-only codes whose entire reason for existing is the supply of a medical device to a patient for use at home. It is not possible to value a device supply service using a reference code that contains no device. Whatever the correct valuation of these codes may be, a crosswalk to a zero-equipment, zero-supply reference produces a number that bears no relationship to it. The same objection applies, if less starkly, to the setup and education codes CMS would crosswalk to CPT code 99473, a self-measured blood pressure training service whose direct practice expense likewise consists of clinical staff labor alone and which does not involve provisioning, configuring, and dispatching a connected device.

The costs at issue are real and are specific to the individual patient. They include shipping the device to the beneficiary's home, reprocessing and updating software between patients, sterilization and repackaging, cellular connectivity for devices that transmit on their own, upkeep of the software the device needs to operate, upkeep of the interfaces that get device data into the record in a usable form, and the data transmission infrastructure itself. Without those elements the device does not arrive, does not work, does not communicate, and does not keep the patient safe. CHI notes that Medicare's longstanding reluctance to treat connectivity and software licensing as allocable direct costs, reflected in the CY 2019 decision to strip the monthly cellular and licensing fee out of CPT code 99454 as an indirect cost, is the same methodological problem discussed in section IV.a.7 above. RPM is an ambulatory service built on data from a device that travels with the beneficiary, so treating its connectivity as though it were office rent has never made practical sense, and using a reference code with no equipment in it compounds the error rather than correcting it.

The record on device information is not what CMS describes. CMS states that it has received very little invoice or pricing information, but the public record shows otherwise. CMS has solicited information about remote monitoring devices and their costs in almost every rulemaking cycle since CY 2018, including the CY 2021, CY 2022, CY 2023, CY 2024, and CY 2026 proposed rules, and it has received extensive responses describing device categories, acquisition and distribution models, service and support costs, and real-world utilization. CHI members have contributed to that record and stand ready to contribute further. If CMS believes the information it has received is not in a form its valuation methodology can use, the productive response is to specify what form it needs, not to adopt a crosswalk that assumes the devices cost nothing. CHI would welcome the opportunity to work with CMS on a structured data collection suited to subscription, lease, and bundled acquisition models, which the invoice-based convention was not designed for.

The treatment-management proposal contradicts the employment proposal. There is an irreconcilable tension within section II.D.3.c.(48). In one subsection CMS proposes to require that clinical staff furnishing these services be directly employed by the billing practice, while in another it proposes to eliminate clinical labor practice expense from the treatment-management codes on the stated ground that the typical workflow does not involve clinical staff time, and both cannot be

right. If clinical staff do not typically furnish these services, the employment condition regulates a workflow CMS says does not exist. If clinical staff do furnish them, as the code descriptors, the original RUC clinical model, CMS's own designation of these services as care management services, and years of general supervision policy all indicate, then removing the corresponding clinical labor input is unsupported.

The descriptors themselves refer to clinical staff, physician, or other qualified health care professional time. CMS described the relevant clinical labor activities in its own CY 2023 rulemaking, listing communicating with the patient, resolving technology concerns, reviewing data, updating and modifying care plans, and addressing lack of patient improvement as activities furnished by auxiliary personnel under general supervision. CHI is aware of no development since then that would justify the agency reversing its understanding of the workflow. And the inference CMS draws, that no clinical staff resource exists because physician work RVUs are also assigned, would if applied generally invalidate the practice expense component of most of the fee schedule.

CY 2026 was an interim step, not a finding. The CY 2026 rulemaking should not be read as a determination that these code families lack direct practice expense. The RUC did not obtain sufficient survey participation for several treatment-management codes at its January 2025 meeting and recommended that they be resurveyed once utilization data accumulated under the revised CPT structure. CMS proposed and finalized maintenance of the existing work RVU, work time, and direct PE inputs for the affected codes, grounding those decisions in the available record and in the expectation of a later, better-informed review. That was a decision to wait for data rather than a decision that the data would show zero.

The data CMS says it lacks is being collected. The review CHI and others have been pointing toward is no longer years away. In response to the concerns CMS raises in this proposal, the RUC has moved its examination of remote monitoring forward from January 2028 and will place all nineteen RPM and RTM codes on its next list of items for review, looking specifically at practice expense, in January 2027.[27] That is the same information CMS says is missing, gathered through the process built to gather it. CHI recognizes what the calendar means, since a January 2027 review cannot inform rates that CMS finalizes in the fall of 2026 and puts into effect on January 1, 2027, and CHI is not asking CMS to hold this rule open. We are asking CMS to do what it did one year ago, which is to carry the current values forward while the revaluation runs its course, and to bring the results back in the CY 2028 proposed rule. A cut adopted in this rule would take effect nearly a year before the evidence that is supposed to justify it is even reviewed, and once a value drops by half it is very hard to restore.

CHI's recommendation. CMS should maintain the current work RVUs, direct practice expense inputs, and code structure for the remote monitoring families for CY 2027, exactly as it did for CY 2026 while a scheduled revaluation was pending. It should not finalize the proposed crosswalks, should not eliminate direct practice expense from the treatment-management codes, and should not create the G-codes discussed below. The specialty societies and the RUC take up these services in January 2027, which falls after this rule is final and in effect, so the results cannot inform CY 2027 rates no matter what CMS does now, though they can inform CY 2028. CMS should

[27] The RUC had scheduled its re-examination of the remote monitoring services for January 2028. In light of the concerns CMS raises in this proposed rule about the typical devices and the typical clinical staff workflow and time associated with these services, that review has been advanced to January 2027 and will cover all nineteen RPM and RTM codes, limited to practice expense.

carry the current values forward one more year and bring any revaluation or restructuring back in the CY 2028 proposed rule, where the underlying data will be on the table and the public can comment on it. When CMS does revalue these services, the exercise should separate recurring costs attributable to an individual patient from enterprise overhead, establish what equipment is typical for each category of monitoring, account for lease, license, and bundled acquisition models, measure the clinical staff workflow as it is actually performed, and evaluate each code on its own inputs rather than by reference to an unrelated service.

Recommending that the current values be carried forward is not an endorsement of every relativity within them. In the CY 2026 cycle CHI told CMS that paying the new shorter-increment supply codes at the same rate as the codes describing sixteen or more days of data does not reflect the difference between them, and we continue to believe the shorter-increment codes warrant differentiated valuation. Our point is about sequence, because the correction should come from the code-specific practice expense review and be proposed for CY 2028, not from a wholesale crosswalk adopted now that would reduce most of the family in a single year without data behind it.

5. CMS Should Not Replace the Remote Monitoring CPT Families With Four G-Codes

CMS solicits comment on collapsing the seventeen separately reportable remote monitoring codes into four new HCPCS G-codes, designated GRPM1, GRPM2, GRTM1, and GRTM2, with the monthly codes requiring device supply, at least two days of data, and treatment management including at least one real-time interactive communication totaling at least twenty minutes. CMS cites administrative burden and the OIG's finding that a substantial share of enrollees did not receive all three components of remote monitoring. Because the G-codes would carry the proposed crosswalk values, adopting them would put the device supply reductions into effect immediately.

CHI opposes bundling and urges CMS not to pursue it. The proposal would reduce the code set's descriptive precision, penalize partial performance, eliminate an increment of practitioner work, create rather than reduce administrative burden, and reverse a transition CMS required of safety-net providers only two years ago.

The premise does not hold, because the OIG's observation that many enrollees did not receive all three components is hard to square with the OIG's own acknowledgment, in the same report, that education and setup may be billed once per episode of care while device supply is billed every thirty days and treatment management monthly. Education and setup is furnished once for a given patient rather than every month, some devices require no patient education or setup at all, and where a beneficiary did not transmit enough days of data or the practitioner did not reach the required minutes, treatment management is correctly not reported for that month. Components that CMS's own billing rules do not allow to be reported together in a given month cannot be treated as evidence of misuse when they are not all reported in that month, and that pattern is instead evidence that practitioners billed the codes as CMS designed them. Much of the claims experience the OIG studied also comes from the COVID-19 public health emergency and the years immediately following, when utilization of every remote modality rose sharply as part of a broader shift in how care is delivered, and growth of that kind is not by itself a program integrity finding. And because the 2024 OIG report expressly excluded RTM from its scope, the report cannot support restructuring the RTM code family at all.

The structural consequences would be large, because conditioning a single monthly payment on completion of every listed element means a practice that furnishes the device, collects the data, and delivers nineteen minutes of treatment management receives nothing. The components were separated by the CPT Editorial Panel because they represent distinct technical, practice, and professional work, and because separating them permits CMS to see what was actually furnished. The proposal would also eliminate the "each additional" increment of practitioner work now described by CPT codes 99458 and 98981, removing payment for the extended management that the most complex patients require, and CMS does not explain how the contemplated structure would address that loss.

Replacing widely adopted CPT codes with Medicare-specific G-codes would also create the burden CMS says it is trying to reduce. The existing codes are embedded across practices, health systems, commercial payers, clearinghouses, and health information systems. Commercial payers may recognize HCPCS G-codes but frequently do not, and divergence between Medicare and commercial coding pathways for the same clinical service produces the administrative friction CMS wishes to avoid. CHI also notes that CMS proposed a comparable restructuring of the RTM treatment-management codes for CY 2023 and declined to finalize it, concluding that the range of interests presented by commenters warranted continued discussion before changes beyond supervision and documentation refinements. The considerations that led CMS to step back then apply with at least equal force now.

Finally, CHI observes that the proposed valuations for the G-codes inherit every defect of the crosswalks discussed above. GRPM1 and GRTM1 would be valued from CPT code 99473, and GRPM2 and GRTM2 would combine a work RVU crosswalk with the direct PE inputs of CPT codes 99474 and 93270. Bundling components together does not cure a reference code that contains no equipment and no supplies.

6. Implementing G-Codes in RHCs and FQHCs Would Reverse a Policy CMS Adopted Two Years Ago

CMS also asks for comment specifically on implementing the proposed G-codes in rural health clinics (RHCs) and federally qualified health centers (FQHCs). CHI opposes this, and the reason is one CMS is well positioned to appreciate.

In the CY 2025 rulemaking, CMS dismantled the bundled HCPCS code G0511 and required RHCs and FQHCs to bill the individual CPT and HCPCS codes describing care management services, including RPM and RTM. CMS explained that use of the bundled code had made it difficult to determine which care management service had actually been furnished, and concluded that identifying the actual services furnished and understanding their utilization was important.[28] CHI supported that change, and CMS acknowledged at the time that the transition was neither administratively trivial nor operationally simple, provided a transition period, and subsequently extended implementation twice in the face of claims processing difficulties.

RHCs and FQHCs accordingly rebuilt billing systems, workflows, documentation practices, staff training, and claims processing to accommodate the individual-code structure, which was a substantial organizational investment by providers with the least administrative slack in the

[28] CY 2025 PFS proposed rule, 89 FR 61596, 61782-83 (July 31, 2024). See also CY 2025 PFS final rule, 89 FR 97710, 98000-98010 (Dec. 9, 2024).

Medicare program. Requiring those same providers to reconfigure their systems again, for a new bundled structure, two years later, is not a reduction in administrative burden, because it recreates the bundled architecture CMS recently dismantled on the ground that it obscured what was furnished, and it imposes a second avoidable conversion on the providers serving the most vulnerable Medicare beneficiaries.

CHI has for many years urged CMS to support RPM and RTM use by RHCs and FQHCs at the front lines of care for America's most underserved populations, and we supported each of the steps CMS took to make that possible, which we now ask CMS not to undo. Whatever CMS concludes about the code structure generally, it should at minimum decline to impose a second coding transition on RHCs and FQHCs.

7. The Status and Valuation of CPT Codes 98978 and 98986

CHI asks CMS to clarify an apparent discrepancy in the treatment of CPT codes 98978 and 98986, which describe RTM device supply for cognitive behavioral therapy and are currently assigned to contractor pricing with a zero valuation under status indicator C. CMS explained in the CY 2026 cycle that it considered the technologies still evolving with significant pricing variability, and that it would continue working with its Medicare Administrative Contractors to understand the devices and costs encountered in claims review. Yet both codes now appear on the CY 2027 Addendum B with an active status indicator and assigned relative value units, 0.37 total RVUs for CPT code 98978 and 0.96 for CPT code 98986, and both appear on the list of codes proposed for crosswalk to CPT code 93270.

CHI asks CMS to state in the final rule whether it is proposing to activate these codes for separate payment under the PFS, whether the Addendum B entries reflect an inadvertent error, and, if activation is intended, whether CMS will provide an opportunity for comment on that proposal. Publication errors in this area are not unprecedented, and because two codes appearing in Addendum B with active status and assigned values, without any accompanying preamble discussion, is the kind of discrepancy that is far easier to resolve in a final rule than after the fact.

On the merits, CHI supports the direction of what CMS appears to be doing. Moving these codes off contractor pricing and onto the fee schedule with national values is the outcome CHI asked for in the CY 2026 cycle, and the change in status indicator is the right call, but the values themselves are not. Remote monitoring for cognitive behavioral therapy runs on an FDA-authorized device, the software platform that operates it, the connectivity that carries the data, the clinical labor that reviews it, and the practitioner time that acts on it. Values of 0.37 and 0.96 total RVUs do not cover any of that.

CPT code 93270 is also the wrong reference for these two codes. For the reasons given in section IV.c.4, the technical component of a thirty-day external electrocardiographic event recording service does not describe the resources involved in supplying a digital therapeutic device. If CMS intends to price 98978 and 98986 by crosswalk, the closer comparisons sit inside the RTM family itself. The respiratory device supply codes 98976 and 98984 and the musculoskeletal device supply codes 98977 and 98985 describe the same kind of service for a different body system, and the CY 2027 Addendum B proposes them at approximately 1.26 and 1.25 total RVUs. CHI recommends that CMS value 98978 and 98986 by reference to those codes rather than to 93270.

The Health Care Professionals Advisory Committee reviewed both codes and recommended that a digital therapeutic device be added to the CMS direct practice expense medical supply listing, supporting a fifty dollar monthly per-patient price on the basis of submitted invoices. CHI urged CMS to adopt that recommendation in the CY 2026 cycle and does so again. Cognitive behavioral therapy delivered through an FDA-authorized device is the kind of care where Medicare beneficiaries face the greatest access barriers, and a value set well below the cost of furnishing the service will keep it out of reach as surely as no payment at all.

8. Remote Monitoring Serves Patients and Episodes That Fall Outside the ACCESS Model

CMS launched the Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model in July 2026, and it is the vehicle CMS names in this rule when it explains how the proposed AI Improvement Activity fits its broader strategy.[29] CHI supports the model and has long argued for the shift it represents, which is paying for technology-supported chronic care on the basis of the outcomes it produces. The model and the fee schedule serve overlapping but different populations, and the difference bears directly on what the values in section II.D.3.c.(48) need to support.

ACCESS is voluntary, it is open only to beneficiaries in Original Medicare who choose to enroll with a participating care organization, and it is organized around four condition tracks covering early and established cardio-kidney-metabolic disease, chronic musculoskeletal pain, and depression and anxiety.[30] Those tracks reach a great many Medicare beneficiaries, and CHI expects the model to reach more of them over time. They do not reach everyone for whom remote monitoring is medically necessary, and the fee schedule is what stands behind the rest.

Part of the gap is clinical, since a beneficiary discharged after a heart failure or chronic obstructive pulmonary disease admission is monitored to keep the readmission from happening, and neither condition qualifies a beneficiary for an ACCESS track. Monitoring for atrial fibrillation and other arrhythmias, for obstructive sleep apnea and adherence to positive airway pressure therapy, for symptom and toxicity burden during and after cancer treatment, for graft function after a heart or lung transplant, for seizure frequency, for motor fluctuation in Parkinson disease, and for healing in a chronic wound all fall outside the four tracks as well. Much of RTM falls outside them too, since

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[29] CMS Innovation Center, Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model, https://www.cms.gov/priorities/innovation/innovation-models/access. The model began July 5, 2026 and runs for ten years as a national, voluntary model with rolling start dates. Beneficiaries in Original Medicare enroll voluntarily with a participating ACCESS care organization, and beneficiaries enrolled in Medicare Advantage, PACE, or hospice are excluded. CMS pays participants on an outcome-aligned basis measured against a minimum outcome attainment threshold, set at fifty percent for all participants through December 31, 2027, which CMS has said will be lower in a participant's first year and will rise in subsequent participation years up to a defined upper limit.

[30] CMS Innovation Center, ACCESS Model Request for Applications. The early cardio-kidney-metabolic track covers hypertension, or two or more of dyslipidemia, obesity or overweight with a marker of central obesity, and prediabetes. The cardio-kidney-metabolic track covers diabetes mellitus, chronic kidney disease stage 3a or 3b, and atherosclerotic cardiovascular disease. The remaining tracks cover chronic musculoskeletal pain and depression and anxiety. The qualifying cardiovascular condition is atherosclerotic cardiovascular disease, so heart failure and atrial fibrillation are not qualifying conditions even though they appear in the descriptive definition of cardio-kidney-metabolic syndrome.

the respiratory system status codes describe a use case no track covers, and the RTM treatment management codes are defined by therapy adherence and therapy response rather than by diagnosis, even though the device supply codes remain confined to three body systems, a limitation CHI addresses in subsection 9 below.

The gap is also a matter of timing, because a great deal of remote monitoring is a short, bounded episode rather than the management of a standing chronic condition, such as the thirty to sixty days of blood pressure or glucose readings a practitioner needs after changing a medication, or the surveillance that follows a surgical procedure or a hospitalization. Even where the beneficiary's underlying condition falls squarely within an ACCESS track, an episode of that kind begins and ends long before the model's twelve-month care period could be measured, so it is paid for through the codes in section II.D.3.c.(48) or it is not paid for at all.

Other limits are structural rather than clinical, since a beneficiary who declines to enroll or who is enrolled in Medicare Advantage is outside the model by definition, and so is any practice that cannot take outcome risk against a minimum attainment threshold that CMS has said will rise over time, which describes many solo, small, specialty, and rural practices. Suppliers of durable medical equipment and laboratory suppliers are excluded from participation outright. The model is national in design, but no beneficiary is reached until a participating organization is actually serving them.

The fee schedule values for remote monitoring therefore have to be adequate on their own terms, because for a large share of beneficiaries and a large share of clinically appropriate monitoring there is no other pathway, and there will not be one however successful the ACCESS Model proves. CHI would welcome the chance to work with CMS on drawing more remote monitoring into outcome-based arrangements over time, and we ask only that the fee-for-service foundation be kept sound while that work is done, since a reduction taken now would land hardest on the patients and the practices the model was never designed to reach.

9. Further CHI Recommendations on Remote Monitoring

CHI reiterates the following recommendations, several of which we have raised in prior cycles and which remain unaddressed:

- **RTM should not be confined to respiratory, musculoskeletal, and cognitive behavioral therapy use cases.** Therapeutic monitoring suits a far wider range of conditions, and limiting it to three categories works against beneficiaries. RPM is paired with a condition-agnostic supply code in CPT code 99454, and that code served as the model for the RTM supply codes. CMS should act now to avoid recreating in RTM the pattern that has characterized the Medicare Telehealth Services List, in which condition-specific codes have to be created and maintained one at a time.
- **The medical device requirement resolves data quality concerns.** CMS's requirement that monitoring use devices meeting the FDA's definition of a medical device under the Federal Food, Drug, and Cosmetic Act should resolve concerns about self-reported data, since such devices are used in the diagnosis, cure, mitigation, treatment, or prevention of disease. CHI supports the inclusion of patient-reported data in RTM where the data points cannot be corrupted by subjective or unreliable inputs.
- **Multi-device and multi-provider scenarios should not be artificially limited.** CHI continues to urge CMS to avoid limiting a beneficiary with multiple conditions and multiple

devices to a single clinician for medically necessary monitoring. Any per-patient, per-thirty-day limitation should apply only to the practice-expense-only supply codes, not to the treatment management services.

- **Software as a medical device used in monitoring is a direct practice expense.** RPM and RTM cannot function without the software that runs the monitoring system. That software is a device input whose updates and security patches do the same job as medical supplies, not an indirect, off-the-shelf computer expense. This is the same point developed in section IV.a.7 above, and it is nowhere more concrete than here.
- **Medicaid alignment.** CHI renews its request that CMS invest in technical and organizational support to help state Medicaid programs understand and implement RPM and RTM coding and policy changes, so that changes adopted in the PFS reach Medicaid beneficiaries without years of lag.

d. Psychiatric Collaborative Care Model and Behavioral Health Integration Add-On Codes (Section II.D.3.c.(51))

CMS proposes to increase the work RVUs for the psychiatric collaborative care model (CoCM) codes and the related advanced primary care management behavioral health integration add-on codes.[31] **CHI strongly supports these increases.**

The collaborative care model is one of the best-evidenced ways to bring behavioral health into primary care, and it is by its nature a technology-enabled, team-based service that depends on a registry to track a defined patient panel, on systematic outcome measurement, on frequent non-face-to-face contact, and on psychiatric consultation that is almost always delivered remotely. Undervaluing these codes has been a documented barrier to adoption, and correcting it is one of the most direct things CMS can do to expand behavioral health capacity without waiting on a workforce that will not arrive in time.

CHI offers three related recommendations. First, CMS should confirm that the behavioral health care manager may be employed by or under contract to the billing practitioner, consistent with the policy CMS established when it created these services. That confirmation matters on its own and as a marker of the inconsistency discussed in section IV.c.3, because CMS should not permit contracted care managers in collaborative care while prohibiting contracted clinical staff in remote monitoring, absent an explanation for the difference. Second, CMS should continue to allow CoCM and behavioral health integration services to be furnished alongside advanced primary care management without duplicative time documentation, and should permit practitioners billing advanced primary care management to furnish these services without separate time accounting. Third, CMS should ensure that RTM for cognitive behavioral therapy and the collaborative care model are treated as complementary rather than competing pathways, because a beneficiary receiving collaborative care may also benefit from an FDA-authorized digital therapeutic, and Medicare policy should not force a choice between them.

[31] Proposed rule, section II.D.3.c.(51), "Psychiatric Collaborative Care Model (CPT codes 99492-99494, G2214) and APCM BHI Add-On Codes (HCPCS Codes G0568-G0569)," 91 FR 43842.

e. Payment for Office and Outpatient Evaluation and Management Visits Furnished With a Global Procedure (Section II.D.3.c.(58))

Payment would be reduced where a separately identifiable office or outpatient evaluation and management (E/M) visit is furnished by the same physician, or by a physician in the same group practice, on the same day as a procedure carrying a 0-day, 10-day, or 90-day global period. The service with the highest payment rate would be paid in full and every other service on the claim, whether the procedure or the E/M visit, would be paid at fifty percent. CMS states that the fifty percent figure aligns with a proposal it made in the CY 2019 rule and matches the longstanding surgical multiple procedure payment reduction, and that the policy is meant to address the likely overlap and duplication between the E/M work already paid for within the global surgical package and any additional E/M service reported with modifier 25.[32]

CHI strongly opposes this proposal and urges CMS not to finalize it. The office and outpatient visit is where digital health enters a patient's care. It is where monitoring is ordered, where transmitted data is reviewed and discussed, where a digital therapeutic is prescribed, and where a plan of care is adjusted in light of what the data showed. Cutting payment for that visit in half whenever it happens to fall on the same day as a procedure will, over time, push those conversations out of the encounter or out of the practice altogether, and the beneficiaries most affected will be the ones managing several chronic conditions at once, for whom a single visit often has to do more than one job.

The proposal also rests on a hypothesis rather than on evidence. CMS says duplication is **likely**, but it does not show that duplication occurs or estimate how large it is, and the overlap it describes has already been addressed through the processes CMS itself relies on to value services. Codes typically furnished with a same-day visit have been identified and revalued through the potentially misvalued code initiative, and the survey and valuation methodology behind those values is built to exclude the work and practice expense associated with a separately identifiable E/M service reported with modifier 25.[33] Layering a second, across-the-board reduction on top of that would cut fifty percent from the entire lower-valued service, including physician work and professional liability, in order to reach an overlap that at most affects part of the pre-service and practice expense components. CMS also declined to finalize a substantially similar policy in CY 2019, and it does not explain what has changed since then.

Modifier 25 already carries a substantive test, since the visit must be significant and separately identifiable from the procedure, and a visit that meets that test is not the procedure's overhead. If CMS believes the modifier is being applied to visits that do not meet the test, the remedy is documentation review and analytics aimed at the practices misapplying it, or code-specific review through the established misvalued code process, which is the same targeted approach CHI recommends for remote monitoring in section IV.c.3. CHI also asks CMS not to extend the policy to

[32] Proposed rule, section II.D.3.c.(58), "Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods," 91 FR at 43908. CMS references its earlier proposal at 83 FR 35840 through 35841.

[33] Codes commonly reported with a same-day office or outpatient E/M service have been identified and reviewed through the potentially misvalued code initiative, and the survey instruments and valuation recommendations underlying those reviews are constructed to capture only the work and practice expense of the procedure itself, exclusive of any separately identifiable E/M service reported with modifier 25.

procedures furnished on the same day as inpatient or other E/M services, which would compound the problem without adding evidence.

There is a direct conflict inside this rule that CHI asks CMS to resolve. In section II.D.3.c.(48) CMS proposes to require a separately reportable, separately payable, face-to-face initiating visit before remote monitoring may begin. In section II.D.3.c.(58) CMS proposes to pay half rate for a separately identifiable office or outpatient visit furnished on the same day as a procedure with a global period. A practitioner who performs a minor procedure and, in the same encounter, evaluates the patient's chronic condition and starts remote monitoring would satisfy the first requirement and absorb the second reduction, while the practitioner who instead brings the patient back on another day would be paid in full for both. CHI urges CMS not to adopt the initiating-visit requirement at all, for the reasons given in section IV.c.2. If CMS nonetheless finalizes it, CMS should at a minimum exclude from any multiple procedure reduction an office or outpatient visit that serves as the initiating visit for remote monitoring, or that starts or substantially changes a care management service, because those are the visits CMS says elsewhere in this rule that it wants practitioners to furnish.

Finally, CHI notes that the reduction falls on office-based, independent practices, which absorb the full cost of the clinical staff, supplies, equipment, and infrastructure behind both services, and which are the practices least able to carry a fifty percent cut on a service they have already furnished. Those are also the practices with the least capacity to invest in remote monitoring, digital therapeutics, and the other tools this rule is otherwise trying to encourage, and CMS has said repeatedly that it wants to sustain them.

f. Software as a Medical Service Laboratory Analyses (Section II.D.3.c.(61))

CMS proposes to replace the term "software as a service" with "software as a medical service" (SaMS), defined to refer to software-based technologies that support clinical decision making through algorithmic analysis, including those providing clinical or diagnostic functionality. CMS proposes to move ten HCPCS codes describing secondary algorithmic analyses performed on previously generated laboratory data off the Clinical Laboratory Fee Schedule (CLFS) and to contractor-price them under the PFS, reasoning that these analyses are entirely computer-based, do not require a CLIA-certified laboratory, and are therefore other diagnostic tests under section 1861(s)(3) of the Social Security Act rather than clinical diagnostic laboratory tests. CMS further proposes that, for CY 2027 and subsequent years, any new code describing a SaMS analysis performed on a laboratory test be assigned to contractor pricing under the PFS, and it cross-references companion proposals in the CY 2027 hospital outpatient prospective payment system (OPPS) rule.[34]

CHI has urged CMS for years to develop a coherent Medicare framework for paying for clinical software, and we appreciate that the agency is engaging the question directly rather than through case-by-case crosswalks. We support the underlying instinct that software-driven clinical analysis deserves a defined place in Medicare payment policy, but the framework as proposed is not yet ready to bear the weight CMS would place on it, and CHI offers the following recommendations.

[34] Proposed rule, section II.D.3.c.(61), "Software as a Medical Service (SaMS) Laboratory Analyses." The discussion appears at approximately 91 FR 43916 et seq., with companion proposals in the CY 2027 OPPS proposed rule.

1. The Proposed SaMS Definition Requires Objective Inclusion and Exclusion Criteria

A technology that supports clinical decision making through algorithmic analysis describes a very large and fast-growing share of health information technology. As drafted, the definition does not tell a developer, a laboratory, a practice, or a contractor which characteristics make a service SaMS, which characteristics would put a service outside the category, or how to tell a stand-alone software analysis apart from software working as an integrated part of a laboratory, imaging, or other diagnostic service.

That imprecision would matter less if the label were descriptive, but it is not. Classification as SaMS determines whether an existing service stays on the CLFS or moves to contractor pricing under the PFS, and CMS proposes to make that classification govern future codes automatically. Under the companion OPPS proposal, an analogous classification affects ambulatory payment classification assignment, packaging, status indicator, and whether separate payment is made at all. A definition carrying those consequences should be capable of objective application.

CHI recommends that CMS publish criteria that tell stakeholders both what SaMS is and what it is not. At a minimum those criteria should address whether the computation is a discrete analysis or an inseparable step in a larger diagnostic process, whether the analysis can be run without the underlying test being performed by the same entity, what inputs it consumes, whether it yields a result that stands on its own as a reportable clinical or diagnostic finding, where the computation physically occurs, and how the practice or facility obtains the software. CMS should state which of these considerations control the classification and which are merely descriptive.

CHI notes that CMS expressly distinguishes SaMS from prescription digital therapeutics and from remote monitoring. That distinction is welcome and CHI supports it, because those categories describe different things clinically and are paid through different mechanisms, but drawing the line in the preamble is not the same as making it operable. CHI asks CMS to state in the final rule how it will treat a product that plausibly sits in more than one category, such as a monitoring platform that also performs an algorithmic analysis generating a separately reportable diagnostic output, and to confirm that a service properly described by the remote monitoring or digital therapeutic code families will not be redirected into SaMS classification and contractor pricing as those families evolve. That confirmation bears directly on the cognitive behavioral therapy device supply codes discussed in section IV.c.7, which CHI believes should be nationally priced.

2. CMS Should Clarify the Relationship Between SaMS and FDA-Regulated SaMD

The PFS and OPPS proposals state that some software functions used in SaMS are FDA-regulated medical devices, but neither says whether FDA regulatory status is required for a service to be SaMS, nor whether every FDA-regulated software function is SaMS. CHI asks CMS to settle this expressly, because the distinction is not a theoretical one for our members. A developer that has taken a product through FDA clearance, authorization, or approval has generated clinical evidence, accepted quality system and postmarket obligations, and assumed liability that a general analytics vendor has not. Medicare payment policy should not be indifferent to that difference, and a payment category that puts regulated and unregulated software on the same footing will send the wrong signal to developers.

CHI's broader recommendation, developed in section IV.a.7, is that SaMD used in medical practice be recognized as a direct practice expense. SaMS, as CMS has framed it, is a category built for a payment mechanism, while SaMD is a regulatory status conferred by FDA. The two should be defined in relation to one another rather than allowed to drift apart, and SaMS should not become shorthand for clinical AI generally, covering every algorithm that touches a clinical workflow.

3. CMS Should Publish a Code-by-Code Analysis Before Removing Services From the CLFS

CMS explains that it arrived at the ten codes by reading the descriptors and picking out those that mention no laboratory method and describe only a computational step. Applying that test to the descriptors CMS reproduces does not obviously produce the same list, since several of the listed codes describe analyses performed on digitized whole-slide images of formalin-fixed paraffin-embedded tissue, and one describes messenger RNA gene expression analysis across more than a hundred genes. In those cases the relationship between the coded service and the laboratory process that generated the underlying material is not apparent from the descriptor alone.

CHI recommends that CMS work through the codes one at a time and publish the result before finalizing any removal. For each one, CMS should say which element it treats as the free-standing software component, whether the whole coded service or only part of it could be performed apart from a laboratory, how the descriptor squares with the selection test CMS applied, and what specifically supports the conclusion that the service has stopped belonging on the CLFS. A statement about the category as a whole will not do that work, particularly where the consequence for beneficiaries includes new cost-sharing.

CHI also urges CMS to look at what the service is rather than at where a computer could in principle run it. Software-driven analysis is routinely embedded in laboratory workflows, and an algorithm can draw on data produced earlier in the same process and still form part of a result the laboratory develops and reports. The technical possibility of relocating one computational step off the laboratory premises does not answer whether the coded service, taken as a whole, is still a laboratory service. Where a descriptor names laboratory methods, or where the analysis remains embedded in a CLIA-certified laboratory's testing process, existing treatment should be preserved unless CMS can point to something specific about that service warranting reclassification. If CMS wishes to recognize genuinely free-standing analyses of previously produced data, a separate and narrowly drawn classification would serve that purpose better than a heading broad enough to hold materially different services.

4. Program Integrity Concerns Should Not Drive Classification

CMS supports the proposal in part by noting that CLFS tests are not subject to beneficiary cost-sharing or budget neutrality, which it says limits pricing transparency, and by pointing to limited transparency in the cost of proprietary algorithms and to the CLFS crosswalking and gapfilling methodologies. These are legitimate questions about how to develop an appropriate payment methodology, but they are not evidence about what kind of service a given code describes, and CHI cautions against allowing the former to determine the latter. If CMS finds that proprietary software costs are insufficiently transparent, it should specify the information it needs to value them, and where subscription, license, or per-use arrangements complicate cost reporting, it should design a data collection suited to those arrangements, an exercise CHI would gladly assist with. A

conclusion that a service is no longer a laboratory test should rest on the nature of the service itself.

5. CMS Should Not Assign All Future SaMS Laboratory Codes to Contractor Pricing

CMS states that bringing comparable algorithmic analyses within a common SaMS framework would promote stability, predictability, and consistency, yet proposes contractor pricing as the payment method. CHI does not believe those objectives and that mechanism go together, because contractor pricing is by its nature local and variable. Nothing in the proposal tells stakeholders what methodology a contractor would apply to value these services, what evidence would inform that judgment, what would keep comparable services from being priced differently in different jurisdictions, or how locally set rates would eventually give way to a national rate if CMS decided to establish one.

CHI has consistently urged CMS to adopt national payment rates for software-driven and AI-enabled services and to move away from contractor pricing, which produces divergent approaches among Medicare Administrative Contractors and leaves developers unable to tell beneficiaries and providers what a service will be paid. We renew that recommendation here, and at minimum CMS should not finalize automatic contractor pricing without first describing the methodology and explaining why local pricing is preferable to a national rate.

CHI separately opposes the forward-looking element of the proposal, under which assigning every future SaMS laboratory code to contractor pricing for CY 2027 and subsequent years would decide the payment treatment of technologies that do not yet exist, whose clinical function, relationship to laboratory processes, acquisition models, and resource profiles cannot be evaluated today. CMS should address future services through annual rulemaking, selecting a payment method after stakeholders have had a chance to describe the actual service.

6. New Technology APCs Are Not a Long-Term Answer Either

CMS mentions, as an alternative, direct crosswalks to the OPPS new technology ambulatory payment classification amounts for all, some, or specific analyses. CHI does not believe established SaMS services belong indefinitely in new technology APCs, and we note that the companion OPPS proposal would move roughly twenty-one codes into that series even though those services already have a payment history. CHI asks CMS to state the criteria governing each of the three relevant decisions, which are keeping an established SaMS service in a clinical APC, moving it temporarily into the new technology series, and graduating it back out. A methodology intended to last should turn on whether the service has accumulated real claims and cost experience, and should not treat a service as new merely because it is software.

7. CMS Should Publish a Cross-Setting SaMS Roadmap

The PFS and OPPS proposals cannot sensibly be evaluated in isolation, because CMS cross-references each while applying different payment approaches, proposing contractor pricing under the PFS and new technology APC assignment with separate payment under the OPPS. CHI asks CMS to publish a roadmap showing how one and the same SaMS service is paid when it is furnished in a physician office, in a hospital outpatient department, and in an ambulatory surgical center, particularly where the software is cloud-based or otherwise executed remotely from the practitioner or facility. Stakeholders need to know who submits the claim, how the site of service is

determined when the computation happens somewhere else entirely, what happens when the software service appears on a claim alongside other procedures, and whether separate payment holds up when the underlying diagnostic procedure was furnished in a different setting than the analysis. CHI recommends that CMS resolve these questions before extending SaMS to additional codes, and we would welcome the opportunity to help develop that framework.

g. Request for Information: Redesigning Primary Care To Make America Healthy Again (Section II.E)

CMS solicits comment on how Original Medicare can better incentivize high-value primary care in light of technological change, including generative and agentic AI, which CMS observes was not anticipated when the relative value units, time, and intensity inputs underlying the PFS were defined.[35] **CHI commends CMS for asking these questions.** CMS is right that the fee schedule's resource inputs predate the technologies now reshaping primary care, and that is the same point underlying CHI's longstanding practice expense recommendations.

1. Reconsidering the Relative Valuation of Primary Care (Section II.E.2)

CHI agrees that primary care is relatively undervalued in the PFS and supports CMS's interest in correcting that. Roughly six in ten U.S. adults live with at least one chronic disease, and chronic disease accounts for the overwhelming share of national health expenditure.[36] A payment system that undervalues the setting best positioned to prevent and manage those conditions works against the program's own interests.

Within a budget neutral fee schedule, raising the relative value of primary care is funded by lowering the relative value of something else, and in recent cycles that redistribution has repeatedly landed on the services and inputs digital health depends on. A meaningful investment in primary care that is financed entirely inside the fee schedule would, on the evidence of this rule, be paid for in part by the remote monitoring reductions discussed in section IV.c. CHI supports revaluing primary care and asks CMS to pursue payment approaches that do not require the fee schedule to fund the increase out of itself, including the prospective and outcomes-linked models CMS raises later in this same request for information.

CMS asks whether it should consider a two-track approach to care management services, with one track focused on technology-enabled care and the other on traditional care management. **CHI recommends against a two-track structure.** Technology enablement is increasingly a property of how care management is delivered at all rather than a distinct category of it, and nearly every practice furnishing chronic care management today uses a registry, an electronic record, secure messaging, and some form of remote data capture. A bifurcated code set would require practices and contractors to draw a line that has no clinical meaning, would create arbitrage between tracks, and would freeze in place a distinction that will look obsolete within a few years. It would also, in practice, penalize the practices least able to document their technology use rather than those least likely to use technology.

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[35] Proposed rule, section II.E, "Request for Information: Redesigning Primary Care To Make America Healthy Again." The discussion appears at approximately 91 FR 43923 et seq.

[36] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Chronic Disease, https://www.cdc.gov/chronic-disease/index.html.

The better approach is to value care management services according to the resources they actually consume, technology included, within a single code family, a methodological question that leads back to the direct practice expense recommendation in section IV.a.7.

2. The Care Management Code Family (Section II.E.3)

CMS reports limited uptake of the care management codes even after removing time counting and documentation requirements for advanced primary care management, and asks a series of questions about simplification, duplication, supervision, initiating visits, and data submission.

CHI offers the following responses:

- **On simplification.** CHI supports standardizing requirements across the care management family, particularly around consent, documentation, and supervision, where inconsistent rules across CCM, PCM, TCM, BHI, and advanced primary care management are a genuine source of confusion. We support reducing the number of codes only where the codes describe the same service, and oppose reducing codes where each describes a distinct resource. This distinction is the heart of CHI's objection to the remote monitoring bundling proposal, and CMS should apply the same analysis here.
- **On the initiating visit.** For the reasons developed in section IV.c.2, CHI recommends that any initiating-encounter requirement be satisfied by a range of qualifying encounters, including evaluation and management services, therapy evaluations, annual wellness visits, and transitional care management services, rather than by a discrete separately payable visit furnished just to start the service.
- **On supervision.** CHI urges CMS to retain general supervision for care management services and to retain the existing definition of auxiliary personnel at 42 C.F.R. 410.26, because tightening supervision requirements is a blunt instrument for a targeting problem. CMS's own reasoning when it extended general supervision to behavioral health integration, that doing so would facilitate utilization and extend the reach of a limited workforce, applies with full force to primary care today.
- **On data submission and guardrails.** CHI supports improving CMS's visibility into what was furnished and by whom, and we believe this is where the agency's program integrity energy is best directed. Claims should identify the ordering and supervising practitioner and, where practicable, the rendering personnel. CMS should also consider outcome-linked reporting through FHIR-based application programming interfaces, discussed in subsection 3 below, which would tell CMS considerably more than a supervision rule ever could.
- **On automated billing.** CMS asks how it can ensure that technology-enabled automated billing reflects care actually delivered. CHI shares this concern and suggests that the answer lies in requiring evidence of clinical action rather than in restricting automation. A monitoring or care management claim accompanied by structured evidence that data was reviewed, that the practitioner was notified of a clinically significant finding, or that the plan of care was modified, is verifiable in a way that a time attestation is not.

3. Payment Implications of Technology Enablement of Primary Care (Section II.E.4)

CMS observes that the clinician-facing AI tools in widest use today address administrative burden and clinical decision support, cites ambient documentation and evidence retrieval as examples, and asks whether that reflects current practice, how these tools affect resource costs and outcomes, how they are not captured in current coding and payment, what CMS can learn from private payers, and how outcomes data might be submitted.

CHI confirms that documentation support and clinical decision support are the most widely deployed categories, and adds that the field is broader and moving quickly. Our members' products in primary care settings also include AI-enabled retinal and dermatologic image analysis, cardiovascular risk stratification, sepsis and deterioration prediction, medication reconciliation and adherence support, care gap identification, prior authorization automation, patient-facing conversational tools that triage and educate between visits, and remote monitoring platforms that apply algorithmic analysis to continuous device data. CHI's Digital Health Evidence Resource curates published U.S. clinical studies across these categories and is available to CMS.

On resource costs, CHI's central message is that these tools are not free and that the current methodology cannot see them. A practice that licenses an ambient documentation system or a clinical decision support engine pays a recurring per-clinician or per-encounter fee, invests staff time in validation and workflow redesign, and bears ongoing governance obligations, yet under current methodology essentially all of that lands in indirect practice expense, where it is non-allocable and is measured against survey data from 2007 and 2008. **The single most useful thing CMS could do in response to this request for information is to recognize clinical software as a direct practice expense input where it is used to furnish an identifiable service.**

On productivity, CHI cautions against an assumption that time saved is time monetized. Where AI reduces documentation burden, clinicians overwhelmingly report using the recovered time for patient interaction, panel management, and reduced after-hours work rather than for additional visit volume. A payment policy that captures efficiency gains by reducing payment would penalize the adoption CMS is trying to encourage, and would do so based on a benefit, reduced burnout and attrition, that Medicare has every reason to want. CHI urges CMS not to treat AI-enabled efficiency as a basis for a downward valuation adjustment.

Outcomes-based approaches have CHI's support in principle, subject to three qualifications. First, outcome measures must be attributable, because primary care outcomes are multi-causal and long-horizon, and a technology should not be held to a standard no clinical intervention could meet. Second, CMS should evaluate both short-term measures, such as care gap closure, appropriate follow-up, and time to intervention, and longer-term measures such as avoided hospitalization. Third, submission via FHIR-based application programming interfaces is a promising mechanism and CHI supports developing it, provided CMS aligns the specification with the digital quality measurement work discussed in section VI.b, uses existing standards rather than a bespoke format, permits submission through existing certified health IT and through non-certified technology that meets the specification, and phases in the requirement with adequate lead time. Submission frequency should be no more often than quarterly for most measures.

As for private payer experience, commercial coverage of clinical AI has developed unevenly and largely through negotiated arrangements rather than published policy, which limits how much CMS

can learn from it directly. The more useful lesson is structural, in that where a payer has established a clear, published pathway with defined evidence expectations, adoption has followed. CMS is uniquely positioned to provide that clarity, and doing so would streamline coverage decisions across the market.

Finally, on privacy and safety, CHI's members operate under HIPAA, FDA quality system requirements where applicable, and state law. CHI has published a set of resources that CMS is welcome to draw on in framing its expectations, including our general policy principles for health AI, our recommendations on transparency for caregivers and patients, our good machine learning practices for AI meeting the FDA's device definition, and our framework allocating responsibility for efficacy and safety across the healthcare AI value chain.[37][38][39][40] CHI further encourages CMS to rely on the CPT Editorial Panel's Appendix S taxonomy, which classifies AI applications as assistive, augmentative, or autonomous, when framing payment policy, so that Medicare's vocabulary aligns with the coding system it uses.

4. Technology and AI Augmentation of the Annual Wellness Visit (Section II.E.5)

CMS asks whether advances in technology, including clinical AI, could improve the effectiveness, personalization, and experience of the Annual Wellness Visit (AWV), and whether such tools could transform the AWV from a point-in-time assessment into a more continuous, data-driven preventive function.

CHI supports this direction. The AWV's inconclusive evidence base is at least partly an artifact of its design as a single annual encounter, largely questionnaire-driven, producing a static personalized prevention plan that is rarely revisited. Components that could be delivered more effectively with technology include health risk assessment administered asynchronously in the beneficiary's preferred language and modality, cognitive screening with validated digital instruments, fall risk assessment informed by wearable-derived gait and activity data, medication reconciliation drawn from claims and pharmacy data, identification of care gaps against the beneficiary's full record, and continuous updating of the prevention plan as new data arrive. Activities requiring direct practitioner involvement include review and adoption of the prevention plan, clinical judgment on flagged risks, and the counseling conversation itself, and CHI does not suggest otherwise.

CHI also encourages CMS to consider at-home diagnostic specimen collection as a companion to a technology-enabled AWV. At-home collection lets beneficiaries provide samples conveniently and privately, complementing the visit and improving preventive care access for beneficiaries with limited mobility or in rural areas. Current practice expense methodology does not fully capture the associated costs, including kit shipping, specimen transport, and the collection devices

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[37] Connected Health Initiative, Policy Principles for Artificial Intelligence in Health, https://connectedhi.com/wp-content/uploads/2022/02/Policy-Principles-for-AI.pdf.

[38] Connected Health Initiative, Advancing Transparency for Artificial Intelligence in the Healthcare Ecosystem, https://connectedhi.com/wp-content/uploads/2022/02/AdvancingTransparencyforArtificialIntelligenceintheHealthcareEcosystem.pdf.

[39] Connected Health Initiative, Good Machine Learning Practices, https://connectedhi.com/2020-10-15-chi-releases-good-machine-learning-principles/.

[40] Connected Health Initiative, Health AI Roles and Interdependencies Framework, https://connectedhi.com/wp-content/uploads/2025/03/CHI-Health-AI-Roles.pdf.

themselves, and there are no codes for a number of at-home testing kits, a gap CHI recommends that CMS address.

On CMS's questions about technology-enabled organizations participating in AWV delivery, CHI's position is that Medicare should be modality-neutral and accountability-focused. A beneficiary should not receive a lesser preventive service because of who employs the clinician furnishing it. At the same time, the professional judgment at the center of the AWV must remain with an appropriately licensed clinician who is accountable for it, and CHI does not support arrangements in which a technology company's software effectively furnishes the visit while a clinician provides nominal review. CHI's health AI framework addresses this allocation of responsibility across the value chain, and we commend it to CMS as a starting point.

CMS also asks how to distinguish genuine improvement from increased volume, documentation completeness, coding intensity, or low-value downstream cascades, and CHI thinks that is the right question and encourages CMS to build the answer into any policy from the outset. Appropriate measures include completion of indicated preventive services, closure of identified care gaps, appropriate follow-up on abnormal findings, beneficiary-reported experience and activation, and, on the other side of the ledger, rates of low-value downstream testing. Volume of AWVs delivered and completeness of documentation are not outcome measures and should not be treated as such.

5. Prospective Primary Care Payment in the Shared Savings Program (Section II.E.6)

CMS asks how it should approach establishing prospective primary care payment (PPCP), first in the Medicare Shared Savings Program and then more broadly across Original Medicare, and how it should evaluate fee-for-service, outcomes-based, and prospective payment given the pace of technological change.

CHI supports prospective primary care payment and believes it is more compatible with digital health innovation than fee-for-service. A practice paid prospectively for a panel has an economic reason to deploy remote monitoring, asynchronous communication, and AI-enabled risk stratification, because the value of those tools accrues to the practice as avoided utilization rather than being trapped in a billing code that may or may not exist. Fee-for-service has consistently lagged behind digital health capability because each new modality requires a code, a valuation, and a coverage decision before it can be used.

CHI offers the following recommendations on design:

- Beginning in the Shared Savings Program is sensible, since participating ACOs already have the data infrastructure and accountability relationships PPCP presupposes.
- Prospective payment should not be constructed so that a practice loses the ability to report remote monitoring, behavioral health integration, or other services that fall outside a primary care capitation. CHI urges CMS to define the scope of any PPCP carefully and to preserve separate reporting for services that are not primary care.
- The prospective rate should reflect technology inputs, which returns again to the practice expense recommendation above. A capitated rate built from historical fee-for-service spending in a system that never paid for clinical software will systematically underfund technology-enabled practices.

- CMS should pair prospective payment with outcome and access measures that are meaningful to beneficiaries, so that prospective payment does not become an incentive to furnish less.
- Guardrails against fraud, waste, and abuse in a prospective model should focus on attribution integrity and beneficiary access rather than on the modality by which care is delivered.

h. Supporting Beneficiaries Planning for Future Medical Decisions (Section II.G)

CMS proposes advance care planning codes GACP1 and GACP2 and issues requests for information on community-based palliative care and on intensive lifestyle interventions to slow the progression of Alzheimer's disease.[41]

CHI supports the advance care planning proposals, and supports adding the codes to the Medicare Telehealth Services List as discussed in section IV.b.1. Advance care planning is among the clearest cases for virtual delivery, because the conversation benefits from the participation of family members who are often geographically dispersed, it does not require physical examination, and it frequently occurs when the beneficiary is least able to travel. CHI urges CMS to ensure that the resulting documentation is captured in structured, interoperable form so that advance directives and care preferences are available to treating clinicians across settings, including in an emergency, because a conversation documented only as narrative text in a single organization's record does not serve the beneficiary at the moment it matters most.

On community-based palliative care, CHI notes that serious illness care is heavily dependent on the connected health tools that are the subject of these comments, including telehealth for specialist consultation into the home, remote monitoring for symptom management, and secure asynchronous communication among a distributed care team. Any payment pathway CMS develops should assume those modalities rather than treat them as exceptions requiring separate authorization.

On intensive lifestyle interventions for Alzheimer's disease, CHI observes that intensive lifestyle programs are among the most successfully virtualized categories of care, as CMS's own experience with the Medicare Diabetes Prevention Program demonstrates. CHI supported the modernization of that program, including asynchronous online delivery, the removal of in-person delivery capability requirements for virtual suppliers, and the alignment of weight collection requirements with validated digital data capture. We encourage CMS to apply those lessons here from the outset rather than building an in-person program and virtualizing it a decade later. CHI also renews its recommendation that CMS ensure payment parity across delivery modalities in lifestyle intervention programs, because virtual suppliers bear substantial upfront costs, including connected devices supplied to participants, and outcomes data has not shown virtual delivery to be less effective.

i. Current Procedural Terminology Request for Information (Section II.H)

CMS requests information on how physician payment rates are set, including the role of the CPT coding system in the valuation of physician services, whether the cost of CPT licensure creates

[41] Proposed rule, section II.G, "Supporting Beneficiaries Planning for Future Medical Decisions," 91 FR 43842.

barriers to innovation, whether private competition could supplement CPT-4, whether payment could be based on ICD-10-PCS procedure codes, and what alternative governance structures could improve transparency, competition, and innovation.[42]

Our members are often the parties seeking a new code for a service that did not exist when the code set was last revised, and we have direct experience of how long that takes and what it costs. They are also among the heaviest consumers of the code set as data, because they build the software that reads, writes, and reasons over coded clinical information. CHI takes no position on the institutional questions, which are properly for the physician community.

Whatever the merits of what CMS raises, there is no alternative to CPT available today. Every claims system, clearinghouse, electronic health record, payer contract, prior authorization rule, quality measure specification, and clinical decision support rule in the country is built on it, and so is every billing and coding product our members ship. Pulling CPT out of that position, or splitting the function among competing code sets, would not produce competition in the near term, and would instead produce a long stretch in which claims do not adjudicate, measures do not compute, and covered care does not get paid for, with the cost of that disruption landing on practices and beneficiaries rather than on the parties debating the merits. Our members would have to rebuild their products against whatever replaced CPT, and they can estimate what that would cost.

The code set is national health data infrastructure, not only a payment tool. A single, clinically grounded vocabulary is what lets a service mean the same thing in an electronic health record, a claim, a quality measure, a registry, a prior authorization transaction, a research dataset, and a patient-facing application. Every interoperability policy CMS has built rests on that assumption, including the Interoperability and Patient Access rule, the Interoperability and Prior Authorization rule, the FHIR-based digital quality measurement transition CMS asks about elsewhere in this rule, and the diagnostic result-sharing standard CMS asks about in section III.I, all of which assume that coded service data means one thing wherever it travels. Introducing a competing code set would put that assumption in question and would require sustained new investment in mapping, governance, and system change across records, payer systems, APIs, quality programs, and longitudinal datasets simply to hold clinical meaning steady.

CHI notes that an AI model is only as reliable as the data used to develop, validate, deploy, monitor, and audit it, and coded service data is among the most heavily used inputs in healthcare AI. Inconsistent representation of the same service across competing code sets would reduce comparability, introduce ambiguity and bias, degrade model performance, and make post-deployment monitoring harder where monitoring matters most. CHI has spent years urging CMS to support the responsible use of AI in Medicare, and we would find it hard to square that agenda with a change that fragments the vocabulary those systems learn from. CMS should weigh the coding question against its own AI and interoperability commitments, and not only against the payment questions the request for information asks about.

Whatever CMS concludes, it should preserve what the current system does well for digital health. The CPT process produced the RPM and RTM code families, the CY 2026 restructuring that recognized shorter time and data increments, and Appendix S, which gives the field a shared vocabulary for classifying AI applications as assistive, augmentative, or autonomous and which

[42] Proposed rule, section II.H, "Current Procedural Terminology (CPT) Request for Information," 91 FR 43842.

was refined again in 2026.[43] Those are real achievements, and they came out of a clinically grounded, consensus-based process that a replacement lacking the same grounding would be unlikely to match for beneficiaries.

The problems CHI's members actually encounter are timing and evidence-standard problems more than governance problems. The interval between a technology becoming clinically useful and a code existing to describe it routinely runs to several years, and the interval to a stable national payment rate runs longer. During that interval the technology is unavailable to Medicare beneficiaries in practice, whatever its coverage status in theory. The pathway for closing that gap already exists in the form of Category III codes, which give an emerging service a reportable identity while its evidence base develops and which are released twice a year, and CHI encourages CMS to lean on that pathway rather than to treat the delay as an argument for replacing the code set. CHI also urges CMS to align the coding pathway with the RAPID coverage pathway that CMS and FDA announced in April 2026, so that a Breakthrough Device that reaches the market on an accelerated timeline is not left waiting on a code, and to make transparent what evidence a permanent code requires.

The current system already contains a workable answer to much of what concerns CMS. Where a service is new, or where the resource inputs behind a code are not yet well established, CMS crosswalks the code to a comparable service and pays it while the evidence develops. That mechanism is imperfect, and CHI criticizes particular crosswalks elsewhere in these comments, but the mechanism itself works and is well understood. It lets a service be paid before it has a valuation record of its own, and it does so inside the existing code set rather than requiring a new one. CHI encourages CMS to use crosswalking more deliberately and more openly for emerging digital health services, and to publish the reasoning behind each one, rather than treating gaps in the code set as evidence that the code set itself should be replaced.

On ICD-10-PCS, CHI does not believe it can serve this purpose. ICD-10-PCS is maintained by CMS for the reporting of inpatient hospital procedures, and the coding guidelines CMS publishes restrict it to that use. Its grammar describes something done to a body part in a facility, which leaves no place to record evaluation and management work, and no place at all for care management, counseling, care coordination, behavioral health integration, or remote monitoring, which are the services CMS has spent the last decade building into the fee schedule. It also has no provisional pathway comparable to Category III, so an emerging digital health service would have no way to be identified and tracked while its evidence develops. A code set built for inpatient procedures cannot describe services that are continuous rather than episodic, that combine a device, a software analysis, and practitioner interpretation, and that are often furnished without a face-to-face encounter at all.

Grouping and bundling raise a caution that runs through several parts of this rule, which is that bundled and population-based payment architectures sit on top of granular coding rather than replacing it. Ambulatory payment classifications group services that are still reported in CPT and HCPCS, episode models still require the underlying services to be coded before an episode can be constructed and reconciled, and capitated and total cost of care arrangements still depend on encounter-level coded data to attribute beneficiaries, set benchmarks, risk adjust, and measure

[43] The Appendix S taxonomy was further refined in 2026, and Category III codes for emerging technologies are released on a semi-annual cycle, which gives new digital health services a reportable code well in advance of any Category I conversion.

quality. Whatever aggregation CMS chooses, something underneath has to say what was actually done, which is the same reason CHI opposes collapsing the remote monitoring codes into four G-codes in section IV.c.5, and the reason we would caution against treating aggregation as a substitute for a granular code set here.

CPT licensure is a real expense for small digital health developers building billing and coding functionality, and CHI acknowledges that the burden falls hardest on the smallest firms. To the extent CMS explores alternatives, CHI encourages attention to that specific burden, and we note that the code set's steward has publicly committed to making CPT accessible to the developers and innovators building healthcare technology. We caution, however, that breaking up the national code set would impose far larger costs on those same firms, which have to interoperate with every payer, clearinghouse, and health IT system in the market.

CHI offers two practical observations about process and governance from the applicant's side. Any stakeholder may submit a coding application, and a substantial majority of applications come from parties outside the advisory structure, which means the door is open to our members in a way the request for information's framing may understate. And the body that reviews resource inputs recommends relative resources rather than setting payment, which remains CMS's decision through notice and comment rulemaking. CHI has consistently expressed confidence in that process and in the value of input from specialty societies and practicing clinicians, while also urging CMS to use its independent judgment where the record supports it. CHI notes that the CY 2027 remote monitoring proposals would depart from RUC-developed inputs in favor of crosswalks CMS built itself, which is a useful illustration that the quality of a valuation depends less on which body performs it than on the evidence behind it. To the extent CMS sees room to strengthen transparency and participation in code development and valuation, CHI supports that work and would take part in it.

V. CHI Recommendations on Other Provisions of the Proposed Rule (Section III)

a. Rural Health Clinics and Federally Qualified Health Centers (Section III.B)

CMS proposes conforming regulatory text changes for services that RHCs and FQHCs furnish using telecommunication technology, preventive services payment changes tied to the Make America Healthy Again commission and the Rural Health Transformation program, recognition of diabetes self-management training and medical nutrition therapy as stand-alone billable visits for RHCs, and an increase in the FQHC prospective payment system base rate.[44]

CHI supports these proposals. RHCs and FQHCs stand at the front lines of care for America's most underserved populations, and CHI has for many years urged CMS to ensure that they are not left behind as digital health capability advances in the rest of Part B. Recognizing diabetes self-management training and medical nutrition therapy as stand-alone billable visits is a meaningful step, and CHI urges CMS to confirm that both may be furnished through telecommunication technology and, where clinically appropriate, in a group or shared format consistent with the new shared medical appointment code discussed in section IV.b.1.

[44] Proposed rule, section III.B, "Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)," including section III.B.3, "Services Furnished Using Telecommunication Technology," 91 FR 43842.

CHI appreciates that non-behavioral-health telehealth payments for RHCs and FQHCs operating as distant sites are protected through the end of 2027, and reiterates its recommendation that these providers receive the maximum flexibility available to use digital health tools beyond mental health, including RPM and RTM, general care management, transitional care management, chronic care management, chronic pain management, general behavioral health integration, and psychiatric collaborative care. CMS should avoid imposing in-person requirements on RHCs and FQHCs using telehealth services, and should keep associated paperwork burdens to a minimum.

CHI must, however, connect this section to section IV.c.6, because whatever CMS finalizes elsewhere in this rule, it should not require RHCs and FQHCs to undertake a second remote monitoring billing conversion two years after requiring the first one. The resources these providers devoted to unbundling HCPCS code G0511 and implementing individual CPT and HCPCS reporting were resources not spent on patient care, and CMS itself extended that implementation twice in recognition of the difficulty. Consistency of policy toward safety-net providers is more than a formality, because it is what makes participation sustainable.

b. Clinical Laboratory Fee Schedule (Section III.C)

CMS proposes conforming regulatory changes implementing statutory revisions in the Consolidated Appropriations Act, 2026 to the CLFS data reporting period, the phase-in of payment reductions, and the data collection period, along with a technical correction.[45] CHI does not object to conforming changes implementing enacted statutory direction.

This section bears on section II.D.3.c.(61), because CMS proposes to move ten codes off the CLFS in the same rule in which it implements statutory revisions to CLFS data reporting. Those codes' payment histories under the CLFS are part of the evidence base for valuing them wherever they are ultimately paid, and CHI urges CMS to preserve and use that data rather than treating reclassification as a reason to start from zero. This reinforces the recommendation in section IV.f.3 that CMS conduct a code-by-code analysis before finalizing any removal.

c. Proposed Changes to the Ambulatory Specialty Model (Section III.D)

CMS proposes refinements to the Ambulatory Specialty Model (ASM), addressing definitions, mandatory participation and its exceptions, data submission, quality and Promoting Interoperability performance categories, collaborative care arrangements, final score, payment approach, and program waivers.[46] Digitally relevant elements include a low back pain imaging measure, a shift from the functional status change measure to a functional outcome assessment measure, an updated CEHRT definition, electronic prior authorization measures for the 2027 and 2028 performance years including a measure for prescription drugs, exclusions to the public health and clinical data exchange objective, and the security risk analysis measure.

CHI continues to support the ASM in concept. By focusing specialty care on longitudinal management of high-impact chronic conditions such as heart failure and low back pain, the model creates fertile ground for remote monitoring, wearables and PGHD, predictive analytics, and

[45] Proposed rule, section III.C, "Clinical Laboratory Fee Schedule (CLFS): Consolidated Appropriations Act (CAA), 2026," 91 FR 43842.

[46] Proposed rule, section III.D, "Proposed Changes to the Ambulatory Specialty Model (ASM)," 91 FR 43842.

interoperable records to demonstrate value in a setting where fee-for-service has not rewarded them. CHI also supports permitting incentives tied to management of the targeted condition, and the associated protection from liability under the Anti-Kickback Statute and the beneficiary inducements civil monetary penalty provision, as a practical means of enabling practices to supply beneficiaries with the devices and connectivity that make the model work.

CHI supports the shift to a functional outcome assessment measure, the low back pain imaging measure, and the electronic prior authorization measures. On the security risk analysis measure, CHI's position is the one stated in section VI.d below. The underlying security obligations are essential and independently enforced under HIPAA, and the duplicative attestation should be removed here as well. The shift to a functional outcome assessment measure is well suited to digital capture, because patient-reported outcome instruments administered through a portal or application, and objective function data derived from wearables, produce more frequent and more reliable measurement than periodic in-office assessment. A low back pain imaging measure is likewise appropriate, and CHI notes that reducing low-value imaging is the kind of outcome that interoperable access to prior results, addressed in section V.e, makes achievable. On electronic prior authorization, CHI supports the measures and addresses them more fully in section VI.d.

CHI reiterates the concerns we raised in the CY 2026 cycle, which the current proposals do not fully resolve. The model's financial structure, which redistributes a fraction of withheld funds using a tournament approach without an advance performance benchmark, ensures that more participants lose than gain and can produce reductions even where performance is uniformly strong. Savings should come from reduced avoidable utilization rather than from reduced professional payment. Mandatory participation for specialties in selected geographies remains inappropriate and should be voluntary. Basing adjustments on cohorts as small as twenty patients risks measuring noise, and tying adjustments to outperforming a median that is only known after the fact undermines the predictability that independent practices need in order to invest. CHI urges CMS to set clear advance performance standards so that specialists, particularly those in independent practice, can succeed without punitive reductions.

On the proposed provisions governing collaborative care arrangements between ASM participants and other clinicians who share a beneficiary, CHI asks CMS to draft the remuneration and documentation requirements with technology-enabled coordination in mind. Much of the coordination these arrangements contemplate will occur asynchronously, through shared care plans, event notifications, electronic consultation, and shared access to monitoring data, and the documentation expectations should be satisfiable through the electronic record rather than through a parallel paper trail. CHI also asks CMS to confirm that supplying a beneficiary with a monitoring device or connectivity in support of a collaborative care arrangement falls within the incentive allowance and the associated safe harbor discussed above, so that participants are not deterred by inducement concerns from doing what the model is designed to encourage.

Finally, CHI encourages CMS to make the ASM an explicit testbed for wearables and PGHD. The model should examine how wearable-derived data is protected, how its clinical validity is demonstrated, how it is integrated into treatment plans, and how its effectiveness is evaluated. Device engagement could be recognized within quality reporting, and chat-based and conversational tools that support beneficiaries between encounters could be incentivized through a tiered approach rewarding practices whose beneficiaries consistently engage with approved technologies.

d. Medicare Shared Savings Program (Section III.G)

CHI supports CMS's continuing efforts to improve the Medicare Shared Savings Program (MSSP) and urges CMS to recognize that digital health tools and services, both synchronous and asynchronous, must play a central role in a successful program.[47]

1. Beneficiary Assignment Methodology (Section III.G.2)

CMS proposes to modify the assignment methodology and to update the definition of primary care services used in assignment to align with the PFS payment proposals, including adding advance care planning codes, screening, brief intervention, and referral to treatment codes, and vaccine adverse effects management beginning in 2027. **CHI supports these additions.** Keeping the assignment definition current with the codes practitioners actually bill is essential, because where a service that constitutes real primary care is omitted, ACOs are penalized for delivering it. CHI supported the earlier inclusion of virtual check-in codes and of RPM treatment-management codes in the assignment definition for the same reason, and we urge CMS to continue reviewing the definition annually as the code set evolves, including with respect to RTM and advanced primary care management.

2. CEHRT Use Requirements and FHIR-Based Attestation (Section III.G.4)

CMS proposes to simplify the CEHRT use requirement by replacing the current obligation to report the full set of MIPS Promoting Interoperability measures with a choice among more flexible options, which include completely reporting at least one ACO-reported measure through the eCQM or Medicare eCQM collection type, using certified health IT to support reporting of at least one measure together with an attestation to using data from a FHIR-based application programming interface, and attesting to one of the certified technology use metrics covering electronic prescribing, health information exchange, or electronic access for patients. **CHI strongly supports this proposal**, and particularly the FHIR attestation pathway.

CHI has argued for years that CMS's programs place too much weight on CEHRT status as a proxy for interoperability and too little on demonstrated capability. Excessive and overly prescriptive certification requirements have driven electronic health record development toward measurement and reporting rather than toward clinician and patient needs, leaving program participants bound to products built primarily to satisfy CMS requirements. Allowing an ACO to demonstrate FHIR capability directly is a meaningful step away from that dynamic and toward an outcomes-oriented standard. CHI encourages CMS to extend the same logic across its programs, and to permit health IT that builds on top of CEHRT, including remote monitoring platforms and PGHD applications, to count toward interoperability expectations.

CHI asks CMS to ensure that the FHIR attestation pathway is genuinely available in practice. Many certified products expose read-only application programming interfaces, permitting data to flow out of the record but not back into it, and vendors have not implemented API technical standards consistently. If the attestation depends on capability an ACO's vendor has not enabled, the pathway will not be usable by the ACOs that would benefit most. CHI recommends that CMS state expressly that the attestation may rest on FHIR capability delivered through certified health IT in

[47] Proposed rule, section III.G, "Medicare Shared Savings Program," 91 FR 43842 (section III.G).

combination with connected applications, and that CMS monitor whether the pathway is being used.

CHI asks CMS to retain every pathway it has proposed rather than narrowing to one. Reporting an ACO-reported measure through the eCQM or Medicare eCQM collection type, using certified technology to support reporting of at least one measure together with an attestation to using data from a FHIR-based application programming interface, and attesting to one of the certified technology use metrics covering electronic prescribing, health information exchange, or electronic access for patients each demonstrate something real, and they suit different kinds of organization. A large integrated ACO may find measure reporting straightforward, while a smaller or newer ACO working across several unaffiliated practices may be able to show FHIR capability, or e-prescribing and exchange activity, long before it can produce a clean measure across its whole population. Narrowing to a single pathway would shut out organizations that are in fact interoperable.

CHI also supports retiring the current requirement that ACOs report the full set of MIPS Promoting Interoperability measures. That requirement asks an ACO to demonstrate uniformity across its participants rather than capability as an organization, and it does so through a category that, as discussed in section VI.b, is itself due for reconsideration. CHI further recommends that CMS carry the MIPS small practice exclusion into whatever requirement it finalizes, so that an ACO is not penalized for recruiting the small and rural practices the program is trying to attract, and that CMS treat an ACO as compliant in its first performance year while it brings new participants onto certified technology. A new ACO spends its first year building the capability the requirement measures, and holding it to the standard before it has had time to get there discourages the entrants CMS says it wants.

3. Request for Information on Applying Electronic Prior Authorization Measures to ACOs (Section III.G.4.c)

CHI supports extending electronic prior authorization measurement to ACOs. Prior authorization is among the most concrete administrative burdens clinicians face, it delays care, and it is well suited to automation using standards that already exist. Applying measurement to ACOs makes sense, because ACOs are accountable for both cost and beneficiary experience, and the burden falls on their participating clinicians.

CHI offers the following recommendations:

- Measurement should be aligned with the Promoting Interoperability measures discussed in section VI.d rather than constructed separately, so that a clinician participating in both an ACO and MIPS is not measured twice by different specifications.
- The measure should begin as a reporting measure and become performance-based only after CMS has evidence that payer-side capability is broadly available, because a clinician cannot submit an electronic prior authorization request to a payer that does not accept one.
- CMS should count electronic prior authorization conducted through any conforming technology, whether embedded in certified health IT or furnished by a connected application, consistent with CHI's general position on non-certified technology.
- CMS should consider extending measurement to prior authorization for digital health services and devices specifically, where administrative friction is a documented barrier to access.

4. Financial Methodology, Advance Investment Payments, and Beneficiary Cost-Sharing (Sections III.G.5 and III.G.7)

The financial methodology proposals would increase the sharing rate under Level E of the BASIC track from fifty to sixty percent, reduce the maximum weight on the regional adjustment for ENHANCED track ACOs, to add a growth adjustment that raises an ACO's benchmark in proportion to the share of its growth drawn from professionals without recent shared savings experience and from beneficiaries new to value-based care, to replace the risk-based methodology for advance investment payments with a per-beneficiary quarterly payment while adding a rural criterion and removing the Area Deprivation Index, to allow ACOs to reduce or eliminate Part B cost-sharing for certain items and services, and to establish a longitudinal care modifier increasing the associated evaluation and management payment for practitioners in participating ACOs.

CHI supports the increased sharing rate and the longitudinal care modifier, both of which improve the return on investment in the care coordination infrastructure that digital health tools support. CHI supports the flat per-beneficiary advance investment payment with a rural criterion, because predictable upfront funding is what allows a new ACO to acquire the data infrastructure, remote monitoring capability, and analytics that make shared savings achievable, and because a formula that is simple to model is more useful to a small organization than one that is theoretically better targeted. CHI recommends that CMS expressly confirm that advance investment payments may be used for health information technology, remote monitoring equipment, connectivity, and data analytics capability.

CHI supports the proposed growth adjustment. By adjusting an ACO's benchmark upward in proportion to the share of its growth that comes from professionals without recent shared savings experience and from beneficiaries new to value-based care, the adjustment rewards the recruiting that actually expands the program rather than the reshuffling of clinicians who are already in it. That matters for connected health specifically, because the practices that have never participated in an accountable care arrangement are, as a rule, the practices that have never had access to shared infrastructure such as remote monitoring, event notification, population analytics, and interoperable records, and bringing them inside an ACO is often the only realistic way they acquire it. CHI encourages CMS to pair the adjustment with clear guidance that advance investment payments and shared savings may be spent on standing that infrastructure up for new participants.

CHI strongly supports allowing ACOs to reduce or eliminate Part B cost-sharing for certain items and services, and urges CMS to include digital health services within scope. Coinsurance on a monthly remote monitoring service is a recurring, visible cost that leads beneficiaries on fixed incomes to decline or discontinue monitoring their clinician has determined they need. Permitting an ACO that bears financial risk to waive that cost-sharing aligns the beneficiary's incentives with the ACO's and with the program's.

CHI further recommends that CMS accelerate digital health adoption in ACOs through a coordinated set of measures, including higher shared savings rates for ACOs demonstrating successful digital implementation, permission for digital health investments to count toward risk-bearing requirements, and bonus payments linked to beneficiary engagement through digital platforms. These would support deployment of real-time event notification, automated quality reporting, predictive analytics, telehealth, and the integration of diverse data sources including electronic records, claims, and patient-reported outcomes.

Finally, CHI renews a recommendation we have made in successive cycles, which is that CMS should exercise its statutory authority to waive payment and program requirements as appropriate to permit digital health use in the MSSP.[48] Medicare currently provides telehealth waivers for two-sided risk ACOs using prospective attribution, which limits the flexibility to a small minority of MSSP participants, and all ACOs, regardless of risk track or attribution methodology, should have it. CMS should likewise waive the telehealth restrictions in section 1834(m) of the Social Security Act for all shared savings programs and alternative payment models, including payment bundles and medical home demonstrations.

5. Request for Information: Specialty Care in the Shared Savings Program (Section III.G.10)

CMS solicits comment on specialty care in the MSSP across meaningful engagement, CMS-delivered tools and support, attribution and assignment modifications, benchmarking, specialty performance measures, waiver flexibilities, and burden. CHI offers the following input from the digital health perspective.

- **Meaningful engagement.** Specialists engage with an ACO when they can see the beneficiary's full picture and when their contribution is visible, and both are information problems. CMS should prioritize bidirectional data sharing between ACOs and specialists, including admission, discharge, and transfer notifications, shared care plans, and access to remote monitoring data generated in primary care.
- **CMS-delivered tools and support.** CHI encourages CMS to deliver data to ACOs through FHIR-based application programming interfaces rather than periodic file transfers, so that ACOs can integrate CMS data into the workflows clinicians actually use.
- **Specialty performance measures.** Measures should capture outcomes and appropriateness rather than process, and should be capable of digital capture. Patient-reported outcome measures and device-derived functional measures, as in the ASM, are the most promising direction.
- **Waiver flexibilities.** The telehealth waiver recommendation above applies with particular force to specialty care, where access is most geographically constrained. CHI also recommends that CMS consider waivers permitting ACOs to supply beneficiaries with monitoring devices and connectivity without triggering beneficiary inducement concerns.
- **Burden.** Any specialty engagement structure should rely on data already flowing through certified health IT and claims rather than creating new reporting obligations.

e. Request for Information on Duplicate Laboratory Testing, Imaging, and Result Sharing and Interoperability (Section III.I)

CMS requests information on duplicative laboratory testing and imaging, result sharing, and interoperability. CMS is considering clarified billing instructions defining duplicate services, contractor payment edits, expanded payment integrity tools, and frequency limitations, while recognizing that repeat testing is often medically necessary. CMS also frames duplicate testing as a symptom of interoperability gaps, citing continued reliance on physical media, fragmented

[48] Social Security Act section 1899(f) (42 U.S.C. 1395jjj(f)), which authorizes the Secretary to waive such requirements of sections 1128A and 1128B of the Act and of title XVIII of the Act as may be necessary to carry out the provisions of section 1899.

patient portals, inconsistent implementation of national standards, and limited adoption of API-enabled technology, and asks about incentives, conformance testing, accountability policies, whether Medicare should establish a minimum national standard for sharing laboratory and imaging results as a condition of payment, and whether participation in a national interoperability network should become a condition of participation for hospitals.[49]

CHI strongly agrees with CMS's diagnosis. Duplicate testing is overwhelmingly a symptom of an information failure rather than a billing failure, because a clinician who cannot retrieve a result in the time available orders the test again, and does so for defensible clinical reasons. That is why CHI urges CMS to lead with the interoperability half of this request for information and to treat payment mechanisms as secondary.

On payment mechanisms, CHI counsels caution. Frequency limitations and automatic contractor edits operate on claims, which do not carry the clinical context that distinguishes a wasteful repeat from a necessary one. CMS itself recognizes that repeat testing is often appropriate in trauma, emergency care, and rapidly evolving clinical situations, and the same is true of monitoring a therapeutic response, evaluating an abnormal result, and repeating a test because a prior result could not be obtained. If CMS proceeds, CHI recommends that it begin with education and feedback rather than denial, provide clear clinical exceptions and a modifier to invoke them, exclude any test the ordering clinician could not have retrieved through available means, and pilot the approach on a narrow set of services before broader application. A clinician should never face a payment penalty for ordering a test because the health system that performed it first would not share the result.

On interoperability, CHI supports strong action. Specifically:

- **CHI supports a minimum national standard for sharing laboratory and imaging results, including structured FHIR R4 diagnostic reports through a USCDI+ framework.** A national floor is what has been missing, and CHI recommends that CMS align the standard with the Trusted Exchange Framework and Common Agreement and with the work of the Assistant Secretary for Technology Policy, rather than creating a parallel Medicare-specific specification, and that it include imaging within scope, since imaging result sharing lags laboratory result sharing substantially.
- **CHI supports conformance testing and certification tooling**, because standards without conformance testing produce implementations that claim compliance and do not interoperate. CHI members have long reported that certified products implement API standards inconsistently, which forces custom integration work and adds unnecessary cost.
- **CHI supports accountability for providers that fail to share results**, coordinated with the information blocking framework rather than duplicating it. CHI has long supported vigorous information blocking enforcement, and enforcement paired with practical data sharing standards is what converts policy into better care.
- **On a condition of participation.** CHI supports the objective and recommends that CMS phase implementation, define network participation broadly enough to include qualified health information networks and TEFCA participants, and account for what small, rural, and critical access facilities can actually do, because a condition of participation that goes

[49] Proposed rule, section III.I, "Request for Information (RFI) on Duplicate Laboratory Testing, Imaging, and Result Sharing and Interoperability," 91 FR 43842.

beyond the technical capacity of the providers subject to it will reduce access rather than improve the flow of information.

- **Bidirectional flow and PGHD.** CHI urges CMS to ensure that any national standard supports data flowing into the record as well as out of it, and to include patient-generated health data within scope. Data generated by patients outside the traditional care setting is a growing share of the clinically relevant record, and an interoperability framework built only around institutionally generated results will be incomplete on the day it is finished.

VI. CHI Input on the Proposed Quality Payment Program (Section IV)

With the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress directed CMS to evolve Medicare to emphasize care quality over quantity, requiring enhancements that connected health technologies are well positioned to facilitate.[50] More than a decade later, digital healthcare technologies remain underutilized as a means of advancing value-based care. CHI urges CMS to use every opportunity available to move away from legacy technology mandates and toward a genuinely connected continuum of care.[51]

a. Transition to MIPS Value Pathways and the Sunset of Traditional MIPS (Section IV.A.3)

CMS proposes to establish MIPS Value Pathways (MVPs) as the primary reporting framework and to sunset traditional MIPS, with MIPS-eligible clinicians transitioning to an MVP by the end of 2028 unless they participate in a MIPS APM and report the APM Performance Pathway. CMS proposes three new MVPs focused on diabetes, hypertension, and hospital-based care, and states that the inventory would then offer a relevant option for approximately ninety-eight percent of specialties. CMS also proposes new MIPS Core Measures under which every clinician would report at least one measure fundamental to their specialty and patient population, with an exemption for small practices.[52]

CHI has supported the MVP concept from the start, because MVPs have the potential to help CMS capture savings, particularly from preventive care, and to serve as a glide path from the four siloed reporting categories toward alternative payment models. CHI generally supports CMS's proposals to revise existing and advance new MVPs with tailored episode-based cost measures, and supports the diabetes and hypertension MVPs specifically. A diabetes MVP aligns objectives across all MIPS categories by helping beneficiaries avoid costly diabetes care and its renal, ophthalmic, and other sequelae, and clinicians participating in such an MVP would naturally reach for digital tools that track and engage patients toward the goals of the Medicare Diabetes Prevention Program rather than simply satisfying Promoting Interoperability measures.

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[50] Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10 (2015). Section 101(c)(2)(B)(iii)(III) identifies care coordination as a subcategory of clinical practice improvement activities and names the use of remote monitoring or telehealth among the activities it comprises.

[51] Connected Health Initiative, The Value-Based Care Revolution Will Stall Without Health Tech, https://www.connectedhi.com/blog/2021/7/14/the-value-based-care-revolution-will-stall-without-health-tech.

[52] Proposed rule, section IV.A.3, "Transforming MIPS: MIPS Value Pathway (MVP) Strategy." The Quality Payment Program discussion begins at approximately 91 FR 44100.

CHI also supports the proposed MIPS Core Measures, under which every clinician would report at least one measure fundamental to their specialty and patient population, with an exemption for small practices. A small, clinically meaningful core is preferable to a large menu from which clinicians select the measures easiest to satisfy. CHI asks that the core measure available to each specialty be one that can be reported from data the clinician already captures, including through remote monitoring and patient-reported outcome instruments, rather than one requiring a separate abstraction workflow.

CHI notes that this support is not in tension with its objection, in section V.c, to mandatory participation in the Ambulatory Specialty Model, because the two mandates differ in kind. The MVP transition changes the framework through which a clinician reports on care they are already furnishing and being paid for, whereas the Ambulatory Specialty Model places a clinician's payment at risk under a model they did not choose, using a methodology under which most participants lose. CHI supports requiring coherent reporting, but it does not support compelling participation in a payment experiment.

CHI offers three cautions on the transition. First, the two percent of specialties without a relevant MVP option are real clinicians with real patients, and several of them disproportionately serve beneficiaries who rely on virtual care. CMS should preserve a reporting path for them rather than defaulting them into a poorly fitting MVP. Second, MVPs should allow flexibility to move away from measure templates built around a one-year measurement period, which does not capture the value of preventive interventions whose benefits accrue over longer horizons. Third, CHI encourages CMS to ensure that MVP measure sets across specialties include measures that can be satisfied through remote monitoring, asynchronous communication, and PGHD capture, so that the transition to MVPs advances rather than resets the digital health progress made in MIPS.

CHI does want to register one broader concern about the direction of travel, because changing the reporting framework is not by itself a reduction in burden. Under the proposal a clinician would still have to assemble a measure set, collect and validate the underlying data, attest across multiple categories, and pay a vendor or registry to submit it, and would now do all of that under a structure the practice has to learn from scratch. Multispecialty groups face an additional problem, because they cannot report an MVP as a single group and would have to form subgroups and run several in parallel, which means reconfiguring the reporting technology they already paid to implement. CHI supports the goal of coherent, specialty-relevant reporting while asking CMS to pair the transition with a real reduction in how much has to be reported, rather than reorganizing the same volume under a new name. Every dollar and hour a practice spends re-plumbing its reporting stack is a dollar and an hour not spent on the monitoring, analytics, and patient-facing tools that actually change outcomes, so CHI also asks CMS to publish its estimate of the per-clinician compliance cost of the transition.

b. Request for Information on FHIR-Based Digital Quality Measurement (Section IV.A.4.c)

CMS requests information on transitioning the QPP and other CMS quality programs to FHIR-based digital quality measurement, framed as a two-year transition beginning with the 2028 performance period, with additional consideration of the Shared Savings Program.[53]

CHI supports this transition. Standardized, API-mediated quality measurement is the direction health information exchange as a whole is moving, and a measurement infrastructure built on FHIR is a precondition for the outcomes-based payment approaches CMS explores elsewhere in this rule. CHI has long supported CMS's focus on advancing digital quality measurement in the context of FHIR and the Trusted Exchange Framework and Common Agreement, and we support CMS's efforts to align with the Assistant Secretary for Technology Policy and other agencies while minimizing compliance burden.

CHI supports the destination and asks CMS to be realistic about the timeline. Under the approach CMS describes, reporting would become mandatory with the 2030 performance period. The specifications, the certified technology, the vendor tooling, and the internal data governance that FHIR-based measurement assumes are not uniformly in place today, and a transition that starts before they are will produce measure results that reflect data readiness rather than quality of care. CHI encourages CMS to treat the proposed schedule as a target rather than a commitment, to publish the readiness criteria it will assess before requiring reporting, and to allow more time if those criteria are not met.

The burden also falls unevenly, and it falls hardest on small practices. A practice that reports through claims today has no measurement infrastructure to convert, because claims are a byproduct of billing rather than a separate reporting system. Moving that practice to FHIR-based reporting means new technology, new workflows, and in most cases a new vendor relationship, all in order to report measures it is already reporting. Rather than exempting those practices from digital reporting indefinitely, which would only leave them further behind, the more useful answer is to let the capability reach them without requiring each of them to buy and run it. CHI recommends that CMS allow a qualified intermediary, such as a registry, a clinically integrated network, or a health IT partner, to perform the FHIR conversion on a small practice's behalf and to submit on its behalf, that CMS keep claims-based reporting available until that route is demonstrably working, and that CMS help underwrite the conversion where a practice does take it on itself.

CHI offers the following recommendations:

- **Data sources should not be limited to certified health IT.** A great deal of clinically meaningful data now originates outside CEHRT, in remote monitoring platforms, patient-facing applications, and connected devices. A digital quality measurement framework that can only ingest data from a certified record will systematically undercount the care that digital health tools deliver. CHI urges CMS to design the FHIR framework to accept conforming data regardless of source.

[53] Proposed rule, section IV.A.4.c, "Fast Healthcare Interoperability Resources-Based Digital Quality Measurement in the Quality Payment Program and Other CMS Quality Programs, Request for Information," 91 FR 43842.

- **Patient-generated health data should be within scope from the beginning.** CHI has consistently urged CMS to recognize PGHD in its programs, and a new measurement architecture is the natural place to do so rather than an afterthought.
- **The timeline should account for vendor readiness.** A two-year transition beginning with the 2028 performance period is achievable only if health IT developers have final specifications well in advance. CHI recommends that CMS publish specifications no later than the CY 2028 final rule and commit to a stability period thereafter.
- **Alignment across programs is essential.** MIPS, the Shared Savings Program, the ASM, and the outcomes reporting contemplated in the primary care request for information should use a common specification. Divergent FHIR profiles across CMS programs would recreate, in a new technology, the fragmentation the transition is meant to end.

Finally, CHI encourages CMS to name what this transition replaces, since the Promoting Interoperability performance category exists because CMS needed a way to confirm that clinicians were using certified technology and exchanging information. A working FHIR-based measurement program confirms much of that directly, because a clinician who submits conforming measure data through an application programming interface has already demonstrated the capability the category was built to detect. Running both in full is redundant, and the redundancy is not free. CHI recognizes that the category itself is established by statute and carries a statutory weight that the Secretary may reduce only to a floor, so CMS cannot simply remove it.[54] Within that constraint, CHI recommends that CMS reduce the category to its statutory floor as digital quality measurement becomes operational, retire the measures that the new reporting duplicates rather than running them in parallel, publish the criteria and schedule for doing so, and support a legislative change that would let the category be retired outright. Naming the endpoint now would let practices and health IT developers invest toward it rather than toward a category that is winding down.

c. Improvement Activities and the Proposed AI Improvement Activity (Section IV.A.4.d.(3))

CMS proposes a new Improvement Activity in the Advancing Health and Wellness subcategory, titled "Clinician Use of Artificial Intelligence (AI) to Improve Patient Care," allowing MIPS-eligible clinicians to implement and participate in structured organizational initiatives that improve patient care through the responsible and transparent use of AI in clinical and operational workflows. Participants would establish and maintain organizational policies and procedures governing evaluation, deployment, and monitoring of AI-enabled tools, incorporating fairness, appropriateness, validity, and effectiveness as criteria, and would engage in or support initiatives creating, piloting, or enhancing AI-enabled tools and workflows. CMS states that the activity aligns with the AI-related goals of the CMS ACCESS Model.[55]

CHI supports this activity, which reflects the approach CHI has advocated of recognizing responsible AI governance and adoption as an improvement to care delivery, framed around what clinicians and organizations actually do rather than around a particular product or vendor. CHI

[54] Social Security Act section 1848(q)(2)(A)(iv) and (q)(5)(E)(ii) (establishing the meaningful use of certified EHR technology performance category and permitting the Secretary to reduce its weight to a floor of fifteen percent).

[55] Proposed rule, section IV.A.4.d.(3), Improvement Activities Performance Category. The proposed activity appears at approximately 91 FR 44245.

particularly appreciates that the activity is available both to organizations establishing governance and to those participating in development and piloting, which acknowledges that responsible adoption takes different forms in a large health system and in a small practice.

CHI recommends the following refinements:

- **CMS should assign the activity high weighting.** Standing up genuine AI governance, including inventory, validation against local performance, monitoring for drift, escalation pathways, and clinician training, is substantial work, and medium weighting would understate it and would blunt the incentive.
- **CMS should align its expectations with established frameworks rather than creating a bespoke standard.** CHI's health AI policy principles, our transparency recommendations, our good machine learning practices, and our roles and interdependencies framework allocating responsibility for efficacy and safety across the AI value chain are all publicly available and were developed with the participation of clinicians, developers, and health systems. CMS should also draw on the CPT Editorial Panel's Appendix S taxonomy. A clinician who has implemented governance consistent with a recognized framework should be able to attest on that basis without mapping to a new CMS-specific rubric.
- **The attestation should remain flexible and should not become a documentation exercise.** CHI urges CMS to keep the reporting burden proportionate and to avoid requiring submission of policy documents, which would advantage large organizations with compliance staff over the small practices CMS says it wants to reach.
- **The activity should remain technology-neutral in its safety orientation.** CHI objected in the CY 2026 cycle to a proposed patient safety improvement activity that would have singled out AI-attributable events for separate reporting, on the ground that patient safety reporting should address risk regardless of which technology is involved, since the safety considerations raised by a documentation error are the same whether the note was drafted by a human scribe, a remote scribe, or an AI tool. CHI is pleased that the CY 2027 activity takes a constructive rather than a technology-singling approach, and we urge CMS to maintain that orientation as it finalizes the activity and considers related measures.

More broadly, CHI encourages CMS to build on Improvement Activity IA_BE_14, which CHI proposed and CMS adopted, incenting providers to use digital tools for patient care and assessment outside the four walls of the practice and to ensure that devices collecting PGHD do so as part of an active feedback loop. CHI also urges CMS to recognize the use of secure, evidence-based conversational and messaging platforms as an improvement activity, and, for as long as the Promoting Interoperability category remains in place, to tie such use to higher performance within it, since these tools enable continuous engagement, adherence support, and timely intervention in chronic disease management.

d. Promoting Interoperability and Electronic Prior Authorization (Section IV.A.4.d.(4))

In this category CMS would modify the definition of CEHRT, remove the Security Risk Analysis measure beginning with the 2027 performance period, remove the ONC direct review and certification body surveillance attestations, adopt a new electronic prior authorization for prescription drugs measure beginning with the 2028 performance period, and modify the electronic

prior authorization measure, making it optional for 2027 and required beginning in 2028, along with a request for information on future performance-based measures.[56]

CHI supports the removal of the Security Risk Analysis measure and the surveillance attestations as reporting requirements. The underlying security obligations remain essential and are independently enforced under HIPAA, so what CMS is removing is a duplicative attestation rather than the duty itself. CHI strongly supports incentives for the secure exchange of information and the use of the strongest available technical protection mechanisms, including end-to-end encryption and multi-step authentication, and we encourage CMS to endorse such mechanisms directly while recognizing the resource constraints of small, solo, and rural practices in a holistic risk management process.

CHI supports the electronic prior authorization measures, including the new prescription drug measure, and supports the phased approach making the measure optional for 2027 before requiring it in 2028. CHI recommends that CMS confirm that electronic prior authorization conducted through any conforming technology counts, whether the capability is embedded in certified health IT or delivered by a connected application, and that CMS coordinate the MIPS measures with the ACO measurement contemplated in section V.d.3 of these comments and with the Ambulatory Specialty Model measures addressed in section V.c, so that a single clinician is not measured under three different specifications.

On the request for information regarding future performance-based measures, CHI supports an eventual move to performance-based measurement but urges CMS to condition it on evidence of payer-side readiness, because a performance threshold that a clinician cannot meet on account of counterparties that do not support electronic transactions measures the wrong party.

CHI offers the recommendations below on the understanding that Promoting Interoperability should not remain a permanent feature of the program, and that for the reasons given in section VI.b it should be wound down as FHIR-based digital quality measurement becomes operational. Until that happens, the changes below would reduce burden without reducing accountability, and CHI asks CMS to weigh any new Promoting Interoperability requirement against how long the category is expected to last.

CHI reiterates several longstanding Promoting Interoperability recommendations that remain unaddressed:

- **Apply the 50-point scoring standard used in other CMS beneficiary programs.** Clinicians earning 50 points or higher in Promoting Interoperability should be deemed to have satisfied the category and should receive full credit toward the composite score. Aligning requirements across CMS programs provides simplicity and certainty for connected health stakeholders and reduces provider burden.
- **Move away from measure-level numerator and denominator scoring** toward objective-level scoring and yes-or-no attestation, which HITECH permits and which would substantially reduce burden without reducing accountability.
- **Grant credit for capturing PGHD, including through non-certified technology.** Over the past decade FDA has cleared and authorized a wide array of technologies that capture and transmit PGHD on which clinicians may act. Further pilots to study the role of PGHD in

[56] Proposed rule, section IV.A.4.d.(4), MIPS Promoting Interoperability Performance Category, 91 FR 43842.

Medicare are unnecessary and duplicative, and CHI is glad to provide the evidence. CMS should reward practices that capture PGHD and incorporate it into the record using a standards-based approach, and should recognize that the Promoting Interoperability category's exclusive focus on CEHRT is inconsistent with the Improvement Activities category's recognition of both certified and non-certified technology.

- **Continue granting bonus credit for using CEHRT to accomplish improvement activities**, or apply such credit at the composite score level, so that practices that adjusted workflows to earn the former bonus are not required to reinvent them. CHI would support applying high weighting to any improvement activity employing certified technology, or comparable non-certified technology meeting the same functional specification.
- **Align Health Information Exchange options beyond TEFCA alone.** CHI supports participation in the Trusted Exchange Framework and Common Agreement counting toward the Health Information Exchange objective, and recommends that CMS recognize comparable trust agreements as well.
- **Avoid HIPAA conflicts.** CMS rules should not create uncertainty about what may be shared, and should not place a party in the position of choosing between satisfying a Promoting Interoperability disclosure requirement and honoring HIPAA's minimum necessary standard.
- **Align Medicaid policy.** CHI urges CMS to take all practicable steps to align Medicaid policies with Medicare changes that enable flexible use of telehealth and remote monitoring technologies.

e. Digital Health Innovation in Advanced Alternative Payment Models (Section IV.F)

CMS proposes to change how the APM incentive payment is directed so that incentives reach clinicians actively delivering value-based care, and CHI supports directing incentives to clinicians genuinely participating in alternative payment models.

CHI shares CMS's goal of a vibrant APM program, and we continue to observe that despite more than a decade of effort, many clinicians in particular geographies, specialties, and practice settings lack viable APM options, and that the existing suite of Advanced APMs does not adequately embrace innovative technological care delivery mechanisms. Value-based models currently in place generally do not provide the flexibility to incorporate the full range of virtual care modalities beyond live voice and video into digitally enabled care models.

CHI accordingly urges CMS to endorse the use of digital medical technologies, including wearables and AI drawing on PGHD for both prevention and treatment, in APMs. The Physician-Focused Payment Model Technical Advisory Committee has evaluated dozens of proposed models and recommended action on many of them, several of which turn on digital health-driven efficiencies, and CHI encourages CMS to draw on that work. In the near term, CHI recommends that the CMS Innovation Center test a digital-first model comparing AI-enabled approaches with traditional ones, using the outcomes framework described in section IV.g.3, to show the value these tools bring to providers and patients and how AI can be built into routine care. CHI notes that the ACCESS Model referenced in CMS's proposed AI Improvement Activity is a promising vehicle for this kind of demonstration, and we encourage CMS to structure its evaluation so that technology-supported chronic care is judged on outcomes rather than on modality, while recognizing, as discussed in section IV.c.8, that a voluntary condition-track model will always sit alongside a fee schedule that has to carry the monitoring it does not reach.

Finally, CMS should waive payment and program requirements as appropriate to provide flexibility for digital health innovation in APMs. Congress has granted CMS broad authority to permit telehealth use in APMs, and the agency has been reluctant to exercise it fully. All participants, regardless of risk selection or attribution methodology, should have that flexibility.

VII. Conclusion

CHI appreciates the opportunity to submit these comments and urges CMS's thoughtful consideration of the input above. The CY 2027 rule contains genuinely forward-looking proposals that CHI supports without reservation, including the reconsideration of practice expense methodology, the FHIR attestation pathway in the Shared Savings Program, the interoperability standard contemplated in the duplicate testing request for information, and the new Improvement Activity recognizing responsible clinical AI use. It also contains proposals in section II.D.3.c.(48) that would, if finalized, reverse nearly a decade of deliberate policy development and substantially reduce Medicare beneficiaries' access to remote monitoring. CHI urges CMS not to finalize those proposals, and to pursue its program integrity objectives through the claims transparency measures the Office of Inspector General actually recommended, which CHI supports and stands ready to help implement.

We look forward to the opportunity to work further with CMS and other stakeholders toward the most successful PFS and QPP possible, and we would welcome the chance to discuss any of these recommendations in greater detail.

Sincerely,

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