ConnectedHealthInitiative

August 31, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, District of Columbia 20201
Submitted electronically via www.regulations.gov, Docket No. CMS-2026-2311

**RE: Comments of the Connected Health Initiative to the Centers for Medicare & Medicaid Services on the Medicare Program Calendar Year 2027 Home Health Prospective Payment System Rate Update and Related Requirements for the Home Health Quality Reporting Program, the Expanded Home Health Value-Based Purchasing Model, Medicare Provider Enrollment, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Policies (CMS-1844-P, 91 FR 41216)[1]**

Dear Administrator Oz:

The Connected Health Initiative (CHI), an initiative of the Association for Competitive Technology (ACT), appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services (CMS) on its proposed rule updating the Home Health Prospective Payment System (HH PPS) for calendar year (CY) 2027. CHI directs these comments to the provisions that determine whether, and on what terms, home health agencies (HHAs) and the beneficiaries they serve can use the connected health technologies available today. Those provisions include the agency's monitoring of home health services furnished using telecommunications technology at section II.B.1(g), the discussion of palliative care as a home health service at section II.F, the Request for Information (RFI) on the construction of a home health specific wage index at section II.G, the behavior adjustments at section II.C, the Home Health Quality Reporting Program (HH QRP) proposals and the measure concept RFI at section III, and the durable medical equipment (DME), DMEPOS, and provider enrollment provisions at section V. We also address the treatment of AI-enabled tools in home-based care, a subject the proposed rule does not raise.

[1] Medicare Program; Calendar Year 2027 Home Health Prospective Payment System (HH PPS) Rate Update; Requirements for the HH Quality Reporting Program and the Expanded HH Value-Based Purchasing Model; Medicare Provider Enrollment, Durable Medical Equipment (DME), and DME, Prosthetics, Orthotics, and Supplies (DMEPOS) Policies, 91 FR 41216 (July 6, 2026) (proposed rule) (CMS-1844-P, RIN 0938-AV80), Docket No. CMS-2026-2311. CHI notes that the regulations.gov docket caption for this rulemaking refers to a home infusion therapy services payment update. The proposed rule contains no such update, and these comments do not address one.

## I. Introduction & Statement of Interest

CHI is the leading multistakeholder policy and legal advocacy effort driven by a consensus of stakeholders from across the connected health ecosystem. CHI aims to realize an environment in which Americans can see improvement in their health through policies that allow for the potential of connected health technologies to enhance health outcomes and reduce costs. CHI members develop and use connected health technologies across a wide range of use cases, including in home-based care.

We are active advocates before Congress, numerous U.S. federal agencies, and states, where 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 artificial and augmented intelligence (AI) in care delivery. For more information, see www.connectedhi.com.

CHI is a longtime advocate for the increased use of digital health tools such as telehealth, remote monitoring, and AI across the Department of Health and Human Services (HHS), as well as before other agencies and the U.S. Congress. CHI is also engaged in leading public-private partnerships themed in responsibly advancing the use of digital health tools, including as a current appointed member of the American Medical Association's (AMA) Digital Medicine Payment Advisory Group, an initiative bringing together a diverse cross-section of nationally recognized experts that identifies barriers to digital medicine adoption and proposes comprehensive solutions revolving around coding, payment, coverage, and more.

Generally, CHI is committed to an HH PPS, and a broader Medicare program, that serves beneficiaries effectively by responsibly leveraging the full range of digital health tools available today, consistent with other major Medicare payment systems.

## II. Connected Health's Integral Role in the Future of Medicare and Home Health

Data and clinical evidence from a variety of use cases continue to demonstrate how connected health technologies improve patient care, prevent hospitalizations, reduce complications, and improve patient engagement, particularly for the chronically ill. A meta-analysis of 14 randomized trials covering 4,264 patients with chronic heart failure reported a 20 percent reduction in all-cause mortality and a 21 percent reduction in heart-failure-related hospital admission, though not in all-cause admission. The Whole System Demonstrator cluster randomized trial, covering 3,230 patients across 179 general practices, reported lower 12-month mortality and a lower proportion of patients admitted.[2] Connected health tools, including wireless health products, mobile medical

[2] Clark RA, Inglis SC, McAlister FA, Cleland JG, Stewart S, Telemonitoring or structured telephone support programs for patients with chronic heart failure, systematic review and meta-analysis, 334 BMJ 942 (2007) (fourteen randomized trials, 4,264 patients). The reported reduction in all-cause admission was not statistically significant. Steventon A et al., Effect of telehealth on use of secondary care and mortality, findings from the Whole System Demonstrator cluster randomized trial, 344 BMJ e3874 (2012). CHI's broader

devices, software as a medical device (SaMD), mobile medical apps, and cloud-based portals and dashboards, can fundamentally improve and transform American healthcare. That potential carries particular weight in home health, where the unit of service is a discrete visit to a beneficiary's residence and where an exacerbation, a misunderstood medication regimen, or a caregiver no longer able to manage at-home care frequently goes unrecognized between one scheduled visit and the next.

The randomized evidence specific to Medicare home health is thinner and more mixed than the evidence in these adjacent populations. One randomized study of remote monitoring in post-hospitalization home care for heart failure found no significant difference in hospitalization rates, length of stay, or cost, while agency-level evaluations have reported lower acute care hospitalization and emergency department use.[3] CHI regards that state of the literature as a consequence of the payment design at issue in this rulemaking rather than as an answer to it, because a payment system that does not recognize these services, and that treats their use as a reason to pay an agency less, does not generate the utilization, the cost data, or the trials that would settle the question.

Medicare has moved, program by program, toward treating the home as a place where clinical care happens. The home health benefit rests on that premise, as do remote physiologic and remote therapeutic monitoring, the hospital-level care Medicare now supports in the home, and the growing volume of diagnostic, infusion, and dialysis care furnished there. Across those programs, beneficiaries have fared well, and Medicare has spent less when the barriers to clinically appropriate care at home came down.

Further, CMS should seek to enable the use of health data and patient-generated health data (PGHD) through AI. There are varied applications of AI systems in healthcare such as research, health administration and operations, population health, practice delivery improvement, and direct clinical care. Payment and incentive policy should support the infrastructure, staff training, and ongoing maintenance that clinical AI requires, with an eye toward ensuring value. It should also reinforce the transparency, clinical validation, and qualified clinician oversight on which responsible use of AI in health care depends.[4]

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compilation of the evidence base is available at https://connectedhi.com/wp-content/uploads/2022/09/Connected-Health-Effectiveness-Appendix-v7-2022-update-1.pdf.

[3] Compare Pekmezaris R et al., The Impact of Remote Patient Monitoring (Telehealth) upon Medicare Beneficiaries with Heart Failure, 18 Telemedicine and e-Health 101 (2012) (randomized and matched-cohort studies in post-hospitalization home care finding no significant difference in hospitalization rates, length of stay, or cost to Medicare at 30 or 90 days), with Woods LW and Snow SW, The Impact of Telehealth Monitoring on Acute Care Hospitalization Rates and Emergency Department Visit Rates for Patients Using Home Health Skilled Nursing Care, 31 Home Healthcare Nurse 39 (2013) (lower acute care hospitalization and emergency department visit rates in a single-agency cohort).

[4] CHI, Policy Principles for Artificial Intelligence in Health, https://connectedhi.com/wp-content/uploads/2022/02/Policy-Principles-for-AI.pdf. See also CHI, Advancing Transparency for Artificial Intelligence in the Healthcare Ecosystem (Oct. 2021), https://connectedhi.com/wp-content/uploads/2022/02/AdvancingTransparencyforArtificialIntelligenceintheHealthcareEcosystem.pdf.

Despite the demonstrated benefits of connected health technology to the American healthcare system, statutory restrictions and CMS regulatory-level policy decisions, among other constraints, inhibit use of these solutions. CMS' coverage of remote monitoring began in CY2018, when it unbundled Current Procedural Terminology (CPT®) Code 99091. In the CY2019 and CY2020 Physician Fee Schedules (PFS), CMS took significant steps forward in activating and paying for four remote physiologic monitoring codes, followed beginning in CY2022 by a new family of remote therapeutic monitoring use cases. CMS also ensured utilization of remote monitoring in Medicare Advantage, where it has been eligible for inclusion as a basic benefit. Most recently, in the CY2026 PFS final rule, CMS priced a new set of remote physiologic and remote therapeutic monitoring codes recognizing device supply for as few as two days of data collection within a 30-day period and treatment management in 10-minute increments. Those codes sit alongside the existing ones, so payment no longer turns exclusively on the 16-day and 20-minute thresholds that had made these services unusable for episodic, short-duration, and post-acute monitoring.[5] In that same rule CMS eliminated the provisional and permanent distinction on the Medicare Telehealth Services List and made permanent its policy allowing virtual direct supervision through real-time audio-video communications. Through the CMS Health Technology Ecosystem initiative and the CMS Interoperability Framework, CMS has committed to a more open, standards-based flow of health data.[6]

The HH PPS is the Medicare payment system in which that progress has advanced least, and the reasons are specific and locatable. Section 1895(e)(1) of the Social Security Act assures an HHA that it may furnish services via a telecommunications system, provided those services do not substitute for in-person home health services ordered as part of a plan of care and are not considered a home health visit for purposes of eligibility or payment. That provision is framed as a rule of construction. CMS has carried both conditions into 42 C.F.R. § 409.43(a)(3)(i)(B), where they appear as flat prohibitions.[7] A separate regulation, 42 C.F.R. § 409.48(c), defines a visit as an episode of personal contact with the beneficiary. Allowable cost treatment at 42 C.F.R. § 409.46(e) is narrower than the definitions CMS applies in Part B and reaches only the collection of physiologic data. HHAs were also never eligible for the incentive payments that funded electronic health record adoption elsewhere in Medicare, so they begin from a weaker technology base than the hospitals and physician practices they coordinate with. Some of these constraints are statutory and some are not, and CHI's recommendations below are organized around that distinction.

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[5] Medicare and Medicaid Programs, CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies, 90 FR 49266 (Nov. 5, 2025) (CMS-1832-F).

[6] See CMS, Health Technology Ecosystem, https://www.cms.gov/priorities/health-technology-ecosystem, and CMS Interoperability Framework, https://www.cms.gov/initiatives/health-technology-ecosystem/overview/interoperability-framework.

[7] 42 U.S.C. § 1395fff(e)(1)(A) and (B). The provision is framed as a rule of construction, stating that nothing in section 1895 shall be construed as preventing a home health agency from furnishing services via a telecommunication system if the two stated conditions are met. See also 42 C.F.R. § 409.43(a)(3)(i)(B), which restates both conditions in mandatory terms, and 42 C.F.R. § 409.48(c), defining a visit as an episode of personal contact with the beneficiary.

Connected health technologies do things a visit-based benefit cannot, in that they let an HHA see changes in a beneficiary's clinical condition between visits and monitor adherence to the plan of care, which supports timelier review and alteration of that plan. They also extend the reach of a finite clinical workforce across a growing beneficiary population served by a shrinking number of agencies. It is essential that HHAs and the beneficiaries they serve be able to leverage the wide range of connected health tools and services available today, as well as those in development, to advance care and lower costs.

## III. Home Health Services Furnished Using Telecommunications Technology (Section II.B.1(g))

In section II.B.1(g), CMS reports its monitoring of the three G-codes HHAs use to report services furnished using telecommunications technology, and offers one sentence of commentary, which is that use of telecommunications services and remote patient monitoring reported on CY2025 home health claims has declined from the prior year's monitoring and is mainly associated with skilled nursing.[8] Telehealth visits reported across all disciplines fell by roughly half between CY2024 and CY2025, and remote patient monitoring days fell by roughly a fifth. The number of agencies reporting any remote patient monitoring in skilled nursing fell as well. Against approximately 7.7 million 30-day periods, these services still touch under 2 percent of home health care.

CHI reads those figures as a price response rather than as a clinical verdict, because neither the evidence base for remote monitoring and virtual encounters nor the three constraints described above changed between CY2024 and CY2025. An HHA that furnishes clinically appropriate remote contact takes on reporting burden and receives nothing for the service, and if that contact displaces an in-person visit the agency also risks falling below a low utilization payment adjustment (LUPA) threshold and being paid on a per-visit basis instead of at the full 30-day rate. CHI urges CMS not to read the CY2025 data as evidence of low clinical value, and to take the following steps in the final rule:

- **Leverage the regulatory room section 1895(e) provides.** Section 1895(e)(1) sets two conditions. Services furnished via a telecommunications system must not substitute for in-person home health services ordered as part of a plan of care and must not be considered a home health visit for purposes of eligibility or payment. Both are statutory, and CHI does not ask CMS to write either out of the regulation. We ask instead that CMS read the first condition according to its terms. A remote encounter that the plan of care itself identifies as the clinically appropriate contact does not substitute for an ordered in-person visit, because no in-person visit was ordered for that contact in the first place and nothing is displaced. CMS should say so in the final rule and should confirm that the presence of such an encounter on a plan of care is not by itself evidence that a period was inappropriately staffed or that an ordered visit went unfurnished. Recognition of this kind should carry

[8] 91 FR 41232-41234 (section II.B.1(g) and Tables 13 and 14). CMS began collecting these data pursuant to the CY2023 HH PPS final rule. Tables 13 and 14 are published as images, and the figures described here are read from them.

conditions, and CHI supports them, in that an identifiable clinician of record, identification of the encounter and its purpose on the plan of care, a prohibition on duplicate billing for the same service by an HHA and a Part B practitioner, and auditable records are the appropriate price of recognition and should be adopted alongside any change described here. Treating such an encounter as a home health visit for eligibility or payment is a different question, and CHI accepts that reaching it would require Congress to amend section 1895(e)(1)(B) rather than CMS to amend a regulation.

- **Do not allow the LUPA to penalize clinically appropriate remote care.** Nothing in section 1895(e) requires the LUPA to operate as it does. CMS should provide that a 30-day period is not subject to a low utilization payment adjustment on the basis that services identified on the plan of care under § 409.43(a)(3)(i)(B) were furnished during that period, while confirming in the same provision that those services are not counted as visits for purposes of eligibility or payment. Because a LUPA adjustment is a payment rule about visit volume within a period, declining to reduce a period in which a documented remote encounter was furnished is not the same thing as counting that encounter as a visit, and CMS has room to distinguish the two. CHI recognizes that the more direct approach, counting qualifying two-way audio-video encounters toward the LUPA thresholds themselves, sits closer to the line section 1895(e)(1)(B) draws, and we offer it as an alternative rather than as the primary request. Low-volume, rural, and small agencies, including many visiting nurse associations, feel this reduction first, and they are concentrated in the counties where a beneficiary may have access to at most one HHA.
- **Adopt a common definition of remote patient monitoring across Medicare programs.** Section 409.46(e) makes the costs of equipment, set-up, and service related to remote patient monitoring allowable as administrative costs, and it is worth noting that the same provision makes a visit furnished solely to supply, connect, or train a patient on the technology not separately billable. Section 409.46(e) defines remote patient monitoring narrowly, as the collection of physiologic data digitally stored or transmitted by the patient or caregiver to the HHA. That definition does not map onto the remote physiologic and remote therapeutic monitoring services CMS recognizes and pays for in Part B, and the mismatch leaves HHAs unsure which of the services they actually use fall within the allowable category. CMS should align the HH PPS definition with the definitions reflected in the CPT codes it has activated and paid for in the PFS, including the codes recognizing shorter data-collection intervals and shorter treatment-management increments priced for CY2026, and should work toward a common definition of remote patient monitoring across its beneficiary programs. One sentence added to § 409.46(e) would accomplish this, providing that remote patient monitoring and remote therapeutic monitoring under that paragraph have the meanings given the corresponding services recognized under section 1848 of the Act, including services furnished over a data collection period of fewer than 16 days and treatment management services furnished in increments of fewer than 20 minutes. Such an amendment would require no statutory change, would not alter what counts as a visit, and would cost the program nothing. CHI intends that alignment to run to the CPT code families as they exist today, and not to the four consolidated HCPCS G-codes on which CMS has solicited comment in the CY2027 PFS proposed rule.

- **Disaggregate technology costs on the cost report.** Worksheet A of Form CMS-1728-20 already carries a dedicated line for telecommunication technology costs, which CHI appreciates. We ask CMS to reaffirm that the full range of such costs is allowable there, including device supply, platform and software licensing, connectivity, installation and setup, and the clinical staff time spent reviewing transmitted physiologic data. A single undifferentiated line cannot tell CMS what agencies are spending, on what, or to what effect. CHI urges CMS to subscript that line so these categories are reported separately, which would make the cost of technology-enabled home health care visible in the data CMS uses to rebase and recalibrate.
- **Resolve the relationship between HHA remote monitoring and Part B remote monitoring and state a rule of decision.** Neither an HHA nor a community practitioner can determine in advance whose service is at risk when both are involved with the same beneficiary during a 30-day period, and that ambiguity deters clinically appropriate use independently of payment. CHI suggests the following rule of decision, under which remote monitoring furnished by or under arrangement with the HHA during a 30-day period is an HHA administrative cost under § 409.46(e) and is not separately billable under Part B by the HHA. A community practitioner managing a distinct clinical problem under a separate plan may bill the applicable Part B remote physiologic or remote therapeutic monitoring codes for that management, provided there is no duplicate claim for device supply covering the same device and the same period. The medical record must identify the ordering clinician and the clinical purpose in each case.
- **Address what happens when the 30-day period ends.** CHI members report that the 30-day period functions as a hard stop for monitoring as well as for payment. An HHA takes a beneficiary at hospital discharge, monitors closely across the period, and then discharges that beneficiary from the benefit with the underlying clinical risk unchanged and no defined path for the monitoring to continue. Members are deploying step-down models built for exactly this transition, in which a tablet with Bluetooth-connected peripherals, integrated video, and daily patient-reported outcome collection during the episode gives way after discharge to a cellular device tracking only the biometrics most predictive of deterioration for that beneficiary, and several of these programs are being tested with Rural Health Transformation Program funds. CMS should confirm in the final rule that discharge from the home health benefit does not itself bar remote physiologic or remote therapeutic monitoring furnished and billed under Part B for the same beneficiary, that a prior home health episode neither exhausts nor restarts the device supply and treatment management elements of those codes, and that an HHA or an entity affiliated with it may furnish that monitoring under arrangement with the billing practitioner. The HH QRP already scores agencies on the Potentially Preventable 30-Day Post-Discharge Readmission Measure and on Discharge to Community, both of which turn on what happens to a beneficiary in the month after the episode closes, so monitoring that ends at discharge leaves agencies accountable for an outcome they have been given no means to influence.
- **Do not import remote monitoring payment restrictions into this benefit through the back door.** CMS has solicited comment elsewhere, in the CY2027 PFS proposed rule and not in this one, on consolidating the remote monitoring code families and on conditioning

payment on the employment status of the clinical staff who furnish the service.[9] CHI is opposing both of those proposals in that docket, and raises them here because this rule ties HH PPS cost treatment to the Part B definitions. Vendor-supported and contracted clinical staffing is how monitoring is furnished in the home, particularly by the small and rural agencies with no capacity to staff a monitoring function internally. If CMS narrows the Part B definitions, it should state in this rulemaking what that means for allowable cost treatment under § 409.46(e), rather than leaving HHAs to discover the answer on audit.

- **Keep the G-codes and make them worth reporting.** CHI supports retaining G0320, G0321, and G0322 and asks CMS to say so in the final rule, because an agency deciding whether to keep reporting needs to know the codes will still exist. Beyond that, CMS should add a reporting mechanism for remote therapeutic monitoring, which G0322 does not capture, and should publish a crosswalk between the three G-codes and the corresponding Part B CPT codes, so that a single service is described the same way on both sides of the program. CMS should release the monitoring results as a machine-readable public use file rather than as images in the preamble, stratified by rural and urban location, dual eligibility, clinical group, comorbidity level, and agency size. CHI further supports CMS applying modality-neutral analytics to this data for program integrity purposes. An agency reporting monitored device days on claims is more visible to CMS than one furnishing the same care and reporting nothing, and CMS should not lose that visibility.
- **Reduce the documentation friction that surrounds these services.** CMS should reaffirm that verbal orders may be used consistent with §§ 484.60(b) and 409.43(d), including for the addition of remote monitoring or another technology-supported service to an existing plan of care mid-period, and should confirm that such an addition does not require a new or amended plan of care to be signed before the service may begin. CMS should also confirm that technology identified on the plan of care need to be described only in terms of how its use will help achieve the goals stated in that plan, without a separate documentation standard applied to remote delivery that is not applied to in-person delivery.
- **Treat connectivity as a condition of access and preserve audio-only where video is not feasible.** A beneficiary whose residence lacks adequate broadband, or who cannot afford service, cannot be supported by technology that depends on data transmission. CMS should coordinate with the National Telecommunications and Information Administration and the Federal Communications Commission so that beneficiaries receiving home health services are recognized in federal connectivity programs. CMS should also ensure that audio-only contact remains available and recognized where two-way video is unavailable or declined. For a beneficiary with no broadband and no suitable device, audio-only contact may be the only clinical contact available between visits.

[9] Medicare and Medicaid Programs, CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies, 91 FR 43842 (July 16, 2026) (CMS-1848-P, RIN 0938-AV82), Docket No. CMS-2026-2377. CMS there seeks comment on consolidating seventeen remote physiologic and remote therapeutic monitoring CPT codes into four G-codes, and on requiring that the clinical staff furnishing these services be direct employees of the billing practitioner or practice. CHI is submitting separate comments in that docket.

## IV. Other Provisions of the Proposed CY2027 HH PPS

- **Palliative Care Services as Home Health Services (Section II.F).** CHI supports CMS' objective of expanding access to community-based palliative care under the home health benefit, and supports CMS' intention to add palliative care examples of skilled care to chapter 7 of the Medicare Benefit Policy Manual after the final rule publishes.[10] The services CMS describes include medication and symptom management for pain, anxiety, constipation, nausea, or dyspnea, education and caregiver training on managing symptoms at home, assessment of caregiver burden and psychosocial distress, and skilled therapy for non-pharmacologic pain management. Each of those depends on knowing what is happening between visits, which is what connected health technology supplies. CHI recommends that CMS:
    - Include, among the examples added to the Benefit Policy Manual, cases in which the skilled service is supported by connected health technology. Monitoring of symptom and physiologic trends between visits, remote support for the titration of symptom-directed regimens, caregiver training and teach-back furnished through two-way audio-video technology, and electronically captured patient-reported symptom and function data feeding into the plan of care all belong in that set.
    - Make clear that these examples describe how a skilled service may be furnished and supported, and that they do not create a separate benefit or a separate documentation standard. Remote support of a skilled service should not be held to documentation expectations exceeding those applied to in-person delivery.
    - Confirm that audio-only contact is recognized where a beneficiary lacks video capability. The palliative population in home health skews older, frailer, and less digitally connected than the beneficiary population as a whole. A policy that recognizes only video will systematically exclude the beneficiaries this initiative is meant to reach.
    - Ensure that goals-of-care and advance care planning information captured in this context is recorded as structured, machine-readable data that travels with the beneficiary across care transitions, and not as narrative text or a scanned document that must be re-collected at every setting.
- **Request for Information on the Construction of a Home Health Specific Wage Index (Section II.G).** CHI takes no position on whether CMS should move from the hospital pre-floor, pre-reclassified wage index to Bureau of Labor Statistics occupation-level data, home health cost report data, or some combination.[11] We offer the following observations from a technology perspective:

[10] 91 FR 41216, section II.F (Palliative Care Services as Home Health Services). See also Medicare Benefit Policy Manual, ch. 7.

[11] 91 FR 41216, section II.G (Request for Information on the Construction of a Home Health Specific Wage Index).

- A wage index measures labor and nothing else, and as home health delivery becomes more technology-enabled a growing share of the cost of furnishing a 30-day period sits in non-labor inputs such as devices, platforms, connectivity, integration, and security that no wage index will capture. Whatever CMS concludes about geographic labor adjustment, it should not treat that adjustment as a complete account of how the cost of home health care varies.
- If CMS intends to use home health Medicare cost reports as a data source, it should first ensure those reports capture technology costs discretely, as recommended above. Building a new geographic adjustment on cost reports that do not identify a growing category of cost would embed that blind spot in the payment system for the life of the methodology.
- Any setting-specific occupational mix should reflect the roles home health actually uses, including clinical staff whose time is spent reviewing transmitted physiologic data, triaging alerts, and conducting remote encounters, rather than a labor mix inferred from in-person visit patterns.
- Phase in any new methodology with a transition period and a cap on year-over-year decreases and publish the underlying data and methodology in machine-readable form, so that stakeholders can replicate CMS' results.

- **Behavior Adjustments (Section II.C).** CHI notes that a temporary adjustment of the magnitude proposed for CY2027, applied to a payment system that does not yet recognize the cost of the technology that makes efficient home-based care possible, discourages the investments most likely to reduce future expenditures. To the extent CMS' behavior analysis attributes changes in visit patterns to agency behavior, CMS should separate changes that reflect substitution of remote for in-person contact, which its own payment policy currently discourages, from changes that reflect coding, admission, or case-mix practice. Stated concretely, a decline in in-person visits within periods that also carry reported telecommunications technology use should not be scored as a coding-behavior gain in the recalibration of case-mix weights or LUPA thresholds. It is at least as likely to be substitution that CMS' own rules already leave unpaid.

## V. The Home Health Quality Reporting Program and the Expanded HHVBP Model

- **Revised HH QRP Data Submission Deadlines (Section III.E.1).** CHI supports CMS' proposal to require completion of data submissions and corrections no later than the 15th day of the second month following the end of the calendar quarter and agrees that reducing the public reporting lag serves beneficiaries choosing among agencies. CMS' own data show that 99.27 percent of CY2024 OASIS assessments were already submitted within 45 days.[12] The proposal therefore codifies existing practice and does not impose a new operational burden. CHI recommends the following safeguards:

[12] 91 FR 41216, section III.E.1.a. See 42 C.F.R. § 484.245.

- A published system availability and downtime policy for the CMS designated data submission system, with an automatic extension where the system is unavailable in the days preceding a deadline.
- A documented and non-discretionary extraordinary circumstances exception process.
- Continued investment in standards-based, programmatic submission, so that a compressed deadline does not concentrate manual effort into a narrower window.

- **Reconsiderations and the Move to a Single Electronic Channel (Section III.E.4).** CHI supports CMS' objective of improving the digital transfer of information in the reconsiderations process and supports replacing the non-compliance letter with an electronic notification. We urge caution, however, about the proposal to eliminate the United States Postal Service and Medicare Administrative Contractor email as channels and to rely on the CMS designated data submission system alone. That would make one system the sole point of delivery for a notice that starts a 30-day clock and carries a two-percentage-point payment consequence, for a provider community that is disproportionately small and that has never received federal support for health information technology adoption. CMS has articulated the design expectations below elsewhere in the health technology ecosystem, and they should apply here as well. CHI recommends that CMS:
  - Send an automated alert to the HHA's registered contacts whenever a non-compliance notification or a reconsideration decision is posted, by email and, at the agency's election, by text message, with the notice itself still retrieved from the system.
  - Record an auditable availability and retrieval event for each notification and provide that the 30-day period runs from the date the notification is available and the HHA has been alerted to its availability.
  - Toll the 30-day period for any documented period of system unavailability.
  - Provide account management functionality allowing an HHA to designate multiple authorized users and to update its contacts, so that a staff departure does not interrupt notice.
  - Ensure the system and its notifications conform to Section 508 and recognized accessibility standards.
  - Make the notification content available in a structured, machine-readable form as well as a human-readable one, so that agencies can ingest it into their compliance systems.
- **HH QRP Measure Concepts Under Consideration for Future Years, Advance Care Planning (Section III.F).** CHI supports CMS' consideration of quality measure concepts related to advance care planning. The value of advance care planning information depends almost entirely on whether the next clinician who needs it can find it, which makes this as much a question about data exchange as about measurement. CHI recommends that CMS:

- Prioritize measurement of whether care was goal-concordant over measurement of whether a conversation occurred. A process measure capturing the existence of a documented discussion can be satisfied without changing the care a beneficiary receives, and CMS has stated its intention to prioritize evidence-based outcome measures that promote person-centered care.
- Require that advance care planning information be captured as structured, machine-readable data using recognized standards and data classes. Those include the beneficiary's goals, treatment preferences, the existence and location of an advance directive, and the identity of a health care agent. Information recorded as narrative text or a scanned image cannot be exchanged, and so cannot support goal-concordant care at the moment it matters.
- Ensure that this information travels with the beneficiary across care transitions through the same national exchange infrastructure other providers already use, including the electronic patient event notifications that follow a beneficiary through a hospital stay, rather than being re-collected in each setting. HHAs are frequently left out of the provider directories used to route those notifications, a gap that traces in part to their exclusion from the federal programs that funded health information technology adoption elsewhere in Medicare. Where preferences must be re-elicited from a seriously ill beneficiary because the prior record could not be retrieved, that reflects a failure of health information exchange, and CMS should say so in the measure specification.
- Where any component of the measure is patient-reported, specify from the outset that it may be administered electronically as well as on paper, including through patient portals, tablets, and the same remote platforms beneficiaries already use at home, and that multi-modal administration is permitted. Electronic patient-reported outcome collection improves response rates and shortens the interval between response and clinical action. Any electronic administration should be designed to recognized accessibility standards, and a non-electronic option should always remain available, so that a measure intended to capture patient voice also reaches beneficiaries with limited digital access.
- Align the concept with advance care planning measurement in other post-acute settings and with the CMS Universal Foundation, so that HHAs are not asked to report the same construct twice in different forms.

- **Digital Quality Measurement More Broadly.** Beyond advance care planning, CHI encourages CMS to pursue digital quality measures computed from standards-based data already generated in the course of care, including through bulk FHIR export, instead of measures that depend on separate manual abstraction and submission. A report-once, use-many-times approach reduces burden and shortens the interval between care and measurement. CHI further encourages CMS to develop measure concepts that capture the appropriate use of telecommunications technology and remote monitoring in home health, and patient-reported outcomes collected electronically, so that agencies investing in these capabilities can demonstrate their effect.

- **Alignment Between the HH QRP and the Expanded HHVBP Model (Section III.D).** CHI notes that CMS states it is not seeking comment on its list of alignment opportunities while proposing, in the same rule, the annual payment update reporting period change that is among the principal mechanisms for achieving that alignment.[13] We offer two observations for CMS' consideration. First, alignment decisions of this consequence, covering measure sets, performance periods, and scoring methodology, should be made through notice and comment rather than through technical expert panels and subregulatory guidance alone, so that the agencies and technology developers who must implement them can be heard. Second, CMS should provide a clear endorsement for expanded HHVBP Model participants to flexibly and scalably use the broadest range of medically appropriate digital health tools in pursuit of the Model's measures, together with confirmation that doing so is consistent with the Model's requirements.

## VI. Durable Medical Equipment, DMEPOS, and Home Infusion

- **DMEPOS Encounter Requirements for Identical Replacement Items (Section V.B).** CHI strongly supports CMS' proposal to clarify at 42 C.F.R. § 410.38(d)(2)(iii) that a new face-to-face encounter is not required to support payment for a replacement item identified by the same HCPCS code, where the original item has been in continuous use for its reasonable useful lifetime or has been lost, stolen, or irreparably damaged.[14] CMS is correct that the current requirement is burdensome and redundant. The beneficiaries most affected by it are those least able to arrange an additional appointment to reauthorize equipment they are already using. CHI recommends the following additions:
    - Build on the recognition already reflected at § 410.38(d)(2)(ii), and in section 1834(a)(11)(B) of the Social Security Act, that a required face-to-face encounter may be furnished through telehealth. CMS should confirm that it will not construe residual originating-site, geographic, or facility-fee constraints to require an in-person encounter where a telehealth encounter is clinically adequate, so that the flexibility Congress provided is available in practice and not only on paper.
    - Confirm that documentation of continuing medical need may be satisfied in part by data generated by the item itself or by associated remote monitoring, where available. Device-generated utilization and adherence data speak directly to continuing need, and CMS should accept them in place of an encounter arranged solely to document that need.
    - Apply the same reasoning to other periodic recertification requirements. Where remote monitoring demonstrates ongoing medical necessity through continuously collected data, an annual certification duplicates information CMS already has. CMS should also address the treatment of items whose HCPCS code changes for

[13] 91 FR 41216, section III.D (Opportunities for Potential Alignment Between the HH QRP and the Expanded HHVBP Model).

[14] 91 FR 41216, section V.B (DMEPOS Encounter Requirements for Identical Replacement Items), proposed 42 C.F.R. § 410.38(d)(2)(iii).

reasons unrelated to any change in the beneficiary's condition, such as the recoding of a connected device, so that a coding action does not silently trigger a new encounter requirement.

- **DME Benefit Expansion for Infusion Pumps and Drugs (Section V.D).** CHI supports CMS' proposed revision of the definition of durable medical equipment at 42 C.F.R. § 414.202 to implement section 6222(a) of the Consolidated Appropriations Act, 2026, which expands what Medicare recognizes as care that can be furnished at home.[15] CHI recommends that CMS:
    - Take care that the preamble does not freeze the older test more broadly than section 6222 requires. CMS has long read the requirement that equipment be appropriate for use in the home to mean that an item qualifies only if it can be used safely and effectively without the assistance of a health care professional. Congress has now directed otherwise for a class of infusion equipment. CHI's narrow request is that CMS implement section 6222(a) without restating that older reading as a general principle governing everything the provision does not reach, because preamble language of that kind is cited back at developers for years afterward. CHI's broader position, which we recognize this statute does not itself compel, is that the test should be whether care can be furnished safely and effectively in the home, and that applied consistently it reaches software, connected devices, and wearables prescribed for medically necessary use there.
    - Confirm, in defining health care professional, that supervision requirements described in FDA-approved prescribing information may be satisfied through real-time audio-video technology where clinically appropriate and consistent with that labeling, and should not be presumed to require physical presence in the home.
    - Clarify that remote physiologic and remote therapeutic monitoring codes activated in Part B may be billed by eligible professionals while their patients are receiving the home infusion therapy services benefit.
- **Broader DME Recommendations.** Consistent with positions CHI has advanced in prior comment cycles, we again urge CMS to:
    - Establish a regulatory pathway under DME for software or applications primarily used for a medical purpose that operate on general-purpose devices such as laptops, smartphones, and tablets, without requiring that the device be exclusively dedicated to a medical purpose.
    - Cover software that is clinically essential and integral to the proper functioning of covered DME as a supply, and support clinically significant software updates, while treating routine updates as part of standard service and maintenance.
    - Establish a framework for coverage of wearables and linked software intended for medically necessary use and prescribed by a physician or allowed practitioner.

[15] 91 FR 41216, section V.D (DME Benefit Expansion for Infusion Pumps and Drugs). See Consolidated Appropriations Act, 2026, § 6222(a), and proposed revisions to 42 C.F.R. § 414.202.

- Correct the treatment of continuous glucose monitors used with a smartphone- or tablet-compatible mobile medical application, so that the supply allowance is available alongside the DME component notwithstanding contrary contractor interpretations.
- Use terminology precisely, and in particular avoid conflating software as a service, which describes how software is delivered, with software as a medical device, which is an FDA-regulated category. Coverage and payment policy that turns on the delivery model rather than on the regulatory character and clinical function of the software produces arbitrary results.

- **Country of Origin Under the DMEPOS Competitive Bidding Program (Section V.E).** CHI supports transparency for beneficiaries and supports CMS' judgment that this information should be collected from contract suppliers during the period of performance and not from all bidders at bid submission, and that it should be limited to the lead item.[16] CHI's recommendation concerns connected items specifically. A connected DMEPOS item is an assembly of components, firmware, and software frequently sourced across multiple jurisdictions, and a single country-of-origin field for a lead item cannot describe that supply chain. CMS should present the field on the Supplier Directory in a way that does not invite beneficiaries to draw inferences it cannot support and should confirm that the origin of software and firmware is outside the scope of the collection.

## VII. Provider Enrollment and Program Integrity

CHI shares CMS' objective of protecting the Medicare program from fraud, waste, and abuse, and has consistently supported strong program integrity. CHI's standing position is that the use of connected and digital health modalities, including remote monitoring, does not inherently mean greater waste, fraud, and abuse. Real-time and near real-time data analytics in fact make program integrity easier to police, and CMS should apply existing and developing program integrity tools and metrics in a modality-neutral manner. The G-code data CHI asks CMS to keep and improve above is the kind of data that supports modality-neutral analytics, which CHI supports CMS using for that purpose. CHI offers the following recommendations on CMS proposals that bear directly on how technology-enabled providers and suppliers are screened, described, and documented:

- **High-Risk Enrollments (§ 424.535(a)(24)).** CMS proposes a new revocation ground for enrollments presenting a high risk of fraud, waste, or abuse by reason of their location in a limited geographic area with an excessive number of providers and suppliers. The proposal does not define high risk, identify the factors CMS would weigh, or require any finding of misconduct by the enrollee. An entity that serves beneficiaries remotely, or that furnishes monitoring and support from a single location rather than through a network of storefronts, has no operational reason to spread its addresses, and it is more likely than a traditional supplier to share a building or a suite with other small firms. A revocation ground keyed to address density will select for that model whether or not anything is wrong with it. At a

[16] 91 FR 41216, section V.E (DMEPOS Competitive Bidding Program, Country of Origin). See OMB Control Number 0938-1408 (CMS-10744).

minimum, CMS should define the criteria and publish them in advance, require an individualized finding as to the particular enrollee rather than as to its neighbors, provide notice and a meaningful opportunity to rebut before revocation rather than only on appeal, and exclude density that reflects legitimate market entry or a concentration of specialized providers. Revoking on the basis of provider density would remove compliant providers from the areas where beneficiaries have the fewest alternatives.

- **Algorithmic and Model-Derived Risk Determinations.** To the extent CMS uses predictive models, risk scoring, or other automated analytics to identify high-risk enrollments or to support any other denial or revocation determination, CHI urges CMS to hold itself to the standards it would expect of others. Those include transparency about the categories of data and the factors used, review by a qualified human reviewer before any adverse determination, an explanation sufficient to permit a meaningful rebuttal, a functioning appeal, and periodic audit of the model for accuracy and for disparate impact on small, rural, and safety-net participants. Responsibility for an enrollment determination should rest with the agency making it and not with a model, and no provider should lose its billing privileges on the basis of a score it cannot see and cannot contest.
- **Signage and the Definition of Operational (§§ 424.510(f) and 424.502).** CHI appreciates CMS' recognition that a signage requirement may not be practicable in all circumstances. CHI urges CMS to place that recognition in the regulation text and not in the preamble alone, and to confirm that the requirement does not apply to a location that is not held out to beneficiaries as a place to obtain services, including the locations of practitioners furnishing services through telecommunications technology and of entities that furnish services to beneficiaries in their homes. Relatedly, CMS should apply the definition of operational in a modality-neutral manner. A definition built around an accessible physical location, posted business hours, and staff present to receive beneficiaries will produce the wrong answer for entities whose beneficiaries never present in person, and CMS should state that such a model is not evidence of non-compliance.
- **Retention and Furnishing of Documentation (§ 424.516).** CHI supports CMS' emphasis on the availability of documentation and urges CMS to confirm that records may be retained and produced electronically, to specify accepted electronic formats and a secure transmission channel, and to provide a reasonable and defined production period before non-production becomes a revocation ground carrying a retroactive effective date. The existing seven-year retention obligation should be capable of being met with modern, secure electronic records management rather than presuming paper.
- **Affiliations.** If CMS removes the five-year lookback and adds an affiliation category covering marketing, business, fulfillment, financial, managerial, or beneficiary relationships, it should define that category with care. As described, the category could reach routine commercial vendor relationships, including the technology and service vendors on which nearly every HHA depends, which would make complete disclosure impracticable while producing information of little integrity value.

## VIII. Artificial Intelligence in Home-Based Care

AI-enabled tools are moving quickly into clinical care and into post-acute operations, and HHS has recently sought public input on accelerating their adoption and use as part of clinical care. The alternative to considering them now is for CMS to confront them in this benefit for the first time after they are in widespread use.

- **CMS should clarify the payment treatment of AI-enabled software.** HHAs and developers need to know how such software used in furnishing home health services is treated under the HH PPS, including whether and under what circumstances it is an allowable cost, which at present they are left to infer.
- **Any evidence standard should be proportionate to the risk a given tool presents.** It should require disclosure of the tool's intended use, intended population, limitations, and validation evidence in the population and practice setting where the tool will be deployed, together with monitoring of continued performance after deployment. Pre-deployment validation does not establish real-world performance, and CMS should expect evidence of both.
- **CMS should preserve qualified clinician oversight of the clinical decisions an AI-enabled tool informs.** CHI's consistent position is that responsibility for managing risks should be shared among developers, vendors, and providers according to their knowledge of, and ability to address, those risks, and that policy should not shift liability onto clinicians who rely in good faith on tools whose limitations they have no practical ability to inspect.[17]
- **The same expectations should govern CMS' own use of these tools.** Wherever AI or automated processes inform coverage, payment, or quality determinations affecting beneficiaries or HHAs, the safeguards CHI describes above in connection with enrollment should apply with equal force. A beneficiary or an agency on the receiving end of such a determination should be able to learn what drove it and to contest it.
- **CMS should use consistent terminology, including the taxonomy reflected in CPT Appendix S.** The distinction that taxonomy draws among assistive, augmentative, and autonomous services would let CMS, FDA, and coding conventions describe the same technology in the same terms.
- **CMS should coordinate with the agencies and bodies that already hold this expertise.** The Assistant Secretary for Technology Policy, the FDA, and the relevant clinical specialty societies are best positioned to identify the uses of AI-enabled technology most appropriate to home-based care. Existing sectoral authorities and recognized risk management frameworks should carry the weight here, and CMS should avoid building parallel program-specific requirements that duplicate them.

[17] CHI, Health AI Roles & Interdependency Framework, https://connectedhi.com/wp-content/uploads/2025/03/CHI-Health-AI-Roles.pdf.

## IX. Conclusion

CHI appreciates the opportunity to submit these comments and urges CMS' thoughtful consideration of the input above. Given that CMS has committed, through the ACCESS Model and the Rural Health Transformation Program, to paying for technology-supported chronic care and to rebuilding rural capacity,[18] home health is the most prominent program in which that commitment has not yet been reflected. We would welcome the opportunity to work with CMS and other stakeholders on the questions raised here, and to discuss any of the regulatory language proposed above. Please do not hesitate to contact us with any questions.

Sincerely,

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[18] See CMS, ACCESS (Advancing Chronic Care with Effective, Scalable Solutions) Model, https://www.cms.gov/priorities/innovation/innovation-models/access, and CMS, Rural Health Transformation Program, https://www.cms.gov/priorities/rural-health-transformation-rht-program/overview. See also CHI, Recommended Measures for States' Rural Health Transformation Program Grants (June 2026), available at www.connectedhi.com.