September 14, 2026

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue Southwest
Washington, District of Columbia 20201

RE: Multi-stakeholder Comments re: *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)

We represent a diverse coalition of stakeholders that span the healthcare and technology sectors, all of whom support the necessary expanded use of digital and connected health technologies. A growing evidence base continues to demonstrate that the responsible use of digital health solutions produces better patient outcomes, reduces costs, augments population health management, and improves the healthcare workforce experience. Digital health tools, increasingly powered by software as a medical device (SaMD) that includes artificial intelligence (AI), draw on patient-generated health data (PGHD) and include cloud-enabled wireless remote monitoring solutions that support clinical decision-making and both chronic and acute care management. These tools are also vital in supporting unserved and underserved populations' access to prevention, diagnosis, and treatment.

Based on our commitment to the responsible use of digital health innovations, we offer the following specific comments on CMS' proposed CY 2027 PFS for CMS' consideration:

- Remote Physiologic and Remote Therapeutic Monitoring (RPM/RTM): we strongly urge CMS not to finalize the coverage restrictions and revaluations proposed for vital remote monitoring services, which would particularly harm beneficiaries who rely on rural and safety net providers. CMS proposes to retain the established-patient limitation for RPM and extend it to RTM, to condition payment on a separately reportable initiating visit, and to require that clinical staff be direct employees of the billing practice. CMS' proposed changes to Part B remote monitoring policies will force independent, rural, and safety net providers to stop offering these services. Notably, CMS' proposed employment conditions would undermine the partnerships health systems rely on to serve rural hospitals under the Rural Health Transformation Program. CMS' proposed changes also run counter to the goals of the Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model, which aims to expand access to new technology-supported care options that help people improve their health and prevent and manage chronic disease.

  With respect to valuation, CMS proposes to crosswalk RPM/RTM services to reference codes carrying no equipment cost and to strip direct practice expense out of the treatment management codes. Further, CMS solicits comment on consolidating seventeen separately reportable RPM and RTM codes into four G-codes, with payment falling by roughly twenty to nearly eighty percent depending on the code. We urge CMS to withdraw the proposed revaluations and the G-code consolidation because the device and workflow data CMS says it lacks is being collected now, in a practice expense review set for January 2027. CMS should carry the current values and code structure forward for CY 2027, as it did for CY 2026, and address any revaluation for CY 2028. We support CMS activating CPT codes 98978 and 98986, now contractor-priced, and assigning them national values, though the proposed levels understate what those services cost to furnish.
- Recognize Clinical Software and AI as a Direct Practice Expense and National Pricing: we support CMS' work to modernize practice expense methodology, which still rests on 2007-2008

survey data predating nearly every digital health technology in use today. To finish that work, CMS should classify SaMD as a direct practice expense aligned with medical equipment, not as an indirect computer software cost, and price it from invoices instead of crosswalks to services that contain no software. The proposed software as a medical service (SaMS) classification needs objective criteria. CMS should also publish a code-by-code analysis before removing any code from the Clinical Laboratory Fee Schedule (CLFS), and should set national rates for these services, including future codes, instead of contractor pricing.

- Medicare Telehealth Services: we support the five G-codes proposed for the Medicare Telehealth Services List and the streamlined addition and removal process. While Congress considers permanence for the geographic and originating site flexibilities, CMS should use its administrative authority fully. Rural health clinics and federally qualified health centers need maximum flexibility to use remote monitoring and chronic care management, and should not face a second billing conversion two years after the first. Regarding new BB and BC claims modifiers directed by the Consolidated Appropriations Act, 2026, a requirement governing how a service is reported is a substantive standard, so CMS should propose such a policy change and take comment before implementation, not leave it to later guidance.
- AI and the Redesign of Primary Care: we commend CMS for recognizing that the fee schedule's resource inputs were defined before generative and agentic AI existed. We oppose a two-track structure separating technology-enabled from traditional care management. Technology enablement is now a property of how care management is delivered, not a category of it, and a bifurcated code set would penalize the practices least able to document it.
- Ambulatory Specialty Model and Medicare Shared Savings Program: we support the Ambulatory Specialty Model as a useful vehicle for embedding remote monitoring, wearables, and PGHD in specialty care. We oppose mandatory participation and a payment methodology under which most participants lose. In the Shared Savings Program, we strongly support the simplified certified electronic health record technology (CEHRT) requirement and the FHIR attestation pathway. CMS should keep every proposed pathway, carry the MIPS small practice exclusion into it, and treat a new ACO as compliant in its first year. We support the proposed growth adjustment, and urge CMS to lift telehealth restrictions for all ACOs.

Further, we offer the following input on the proposed CY 2027 QPP rule for CMS' consideration:

- MIPS Value Pathways, Digital Quality Measurement, and Promoting Interoperability: we support the transition to MIPS Value Pathways provided CMS preserves a reporting path for specialties that still lack a relevant option. We support the direction of FHIR-based digital quality measurement, but the sector is not ready for the proposed timeline. CMS should not limit data sources to certified health IT, should bring PGHD within scope from the start, and should account for vendor readiness and small-practice burden. We support the proposed Improvement Activity for responsible clinician use of AI, and CMS should weight it highly and align it with established health AI frameworks. Safe and effective AI is a shared responsibility, with obligations attaching to whoever is best positioned to identify a risk and reasonably mitigate it. CMS should not concentrate that burden on any single actor, whether clinician or developer. We support removing the Security Risk Analysis measure and the surveillance attestations. CMS should also reduce Promoting Interoperability to its statutory floor as digital quality measurement becomes operational. We also support making the electronic prior authorization measure optional in 2027, with ten bonus points available and no penalty for declining to report, before it is required in 2028.
- Alternative Payment Models: we share CMS' goal of developing a vibrant Alternative Payment Model (APM) ecosystem that will drive value for all beneficiaries, and call on CMS to embrace digital medical technologies in APMs, including wearables and AI drawing on PGHD.

We appreciate CMS' attention to the extraordinary potential of digital health technologies, encourage its thoughtful consideration of our input on the proposed CY 2027 PFS and QPP rule, and stand ready to assist further in any way we can.

Sincerely,

Alliance Tele-Med

Connect America

Connected Health Initiative (CHI)

Dogtown Media LLC

GenieMD, Inc.

Global Ultrasound Institute

Health Recovery Solutions

Health Tech Strategies

Medical Society of Northern Virginia

MiCare Path

Nova Insights Corp

Patient Premier Corp.

Rubix LS

Smart Measures, LLC

The Authentic Consortium

The Omega Concern, LLC

UnaliWear, Inc.