



February 23, 2026

Steven Posnack
Assistant Secretary of Technology Policy
National Coordinator for Health IT
Department of Health and Human Services
7033A, 330 C Street SW
Washington, DC 20201

RE: Response to the AI in Clinical Care Request for Information

Assistant Secretary of Technology Policy Posnack,

Thank you for the opportunity to provide feedback on how HHS can encourage flexible, efficient, and clinically appropriate artificial intelligence (AI) adoption in care delivery. The agency's tech-enabled care agenda and consumer empowerment initiatives lend themselves readily to the already-emerging AI-enabled care delivery methods. As virtual care practitioners and advocates, the Alliance for Connected Care is pleased to provide our input on how HHS can drive the public and private sector toward a health care system that rewards outcomes, patient-centered care, and high-value services.

The [Alliance for Connected Care](#) ("The Alliance") is dedicated to improving access to care through the reduction of policy, legal, and regulatory barriers to the adoption of connected care capabilities, including telemedicine, remote patient monitoring (RPM), and AI-enabled care. Our members are leading health care and technology organizations from across the spectrum, representing health systems, health payers, technology innovators, and patient and provider groups, including many types of clinician specialty and patient advocacy groups who wish to better utilize opportunities enabled by virtual care.

As has long been true in health care, patients consistently seek easier navigation, timely and continuous support between visits, and simpler payment structures. Virtual care has made many strides in increasing access to services and empowering clinicians to create the best available care; however, the next generation of care is now upon us. Tens of millions of Americans have already turned to [non-medical AI chatbots](#) to help them diagnose conditions, determine treatment plans, evaluate medication conflicts and other functions. *The fact that patients are seeking this support outside of the medical community underscores a policy imperative. Our mission should be to further empower health care professionals and the capabilities they employ to meet the needs of their patients.*

Once we sort out the myriad of regulatory and payment issues, the ideal world is one in which a coordinated care team, consisting of both human and agentic AI capabilities, is able to provide a patient with both the expertise they require and the convenience of these consumer tools. Patients should have access to asynchronous care, aided by agentic AI and connected to their primary medical record, without worrying whether their data is secure or if they can trust the platform.



Through the below points, the Alliance argues that AI-enabled care is an evolution of existing tech-enabled care delivery and should be integrated into existing medical services. Federal policy should fully unlock digital health while remaining technology-neutral, modality-agnostic, and focused on clinical accountability and outcomes. Payment should reward value delivered to patients and drive increased efficacy and data-driven coordination across the patient’s clinical care team.

The Alliance recommends that HHS use its authority and work with Congress and states to advance the following objectives:

- **Strengthen virtual care foundations for AI-enabled care.**
 - Recognize AI-enabled care as a natural evolution of connected care, not a new kind of care in need of unique policy or regulatory solutions.
 - Clear the decks on longstanding barriers to telehealth and remote patient monitoring that will be equally burdensome to the expansion of AI-enabled care.
 - Avoid repeating the policymaking mistakes made in other digital health areas, where narrow allowances later hampered patient access.

- **Allow the integration of AI-enabled care into existing medical services, when clinically appropriate**
 - Pursue regulatory and reimbursement changes that allow for modality-agnostic care delivery to facilitate the expansion of AI-enabled care.
 - Circumvent barriers like time-based reimbursement to the expansion of AI-enabled care.
 - Further grow AI-enabled care delivery in models based on outcomes, where these changes can be made most easily.
 - Enable innovative “regulatory sandboxes” that create AI regulatory relief pathways that allow for temporary exemptions from regulation, subject to rigorous due diligence, safety constraints, and narrowly scoped use cases at the state and federal level.

STRENGTHEN VIRTUAL CARE FOUNDATIONS FOR AI-ENABLED CARE

AI-enabled care represents the natural next step in the evolution of connected and virtual care.

Just as telehealth expands access by expanding availability and bringing clinicians closer to patients regardless of geography, agentic AI continues that progress by enhancing clinical capacity, enabling continuous engagement between visits, and further customizing treatment plans and workflows around patient needs. Agentic AI can strengthen patient-centered services, improve outcomes, and increase system efficiency without disrupting the foundational principles of medical practice.

RPM improved care by making ongoing monitoring and clinical support available to patients when and where they were needed. AI-enabled care builds on this foundation, leveraging timely and actionable health information, strengthening clinical decision-making, supporting even more continuous engagement between visits, and enabling more meaningful asynchronous care capabilities. These capabilities represent



tangible improvements that patients value and that will measurably enhance outcomes without changing the underlying intent of the service.

It is our overarching position that federal policy should approach agentic AI capabilities not as a standalone treatment tool, but as an extension and modernization of modern digital health services. The majority of these patient-facing capabilities fall within the definitions of treatment already covered as medical services and should be viewed as the evolution of that care. To the extent that separate policy is required, AI-enabled care should be evaluated, regulated, and reimbursed based on the quality of care delivered and the health outcomes achieved. By aligning oversight and payment frameworks with this evolution, HHS can foster innovation while preserving trust, accountability, and access to high-quality care.

We also recommend that existing regulatory approaches at both the state and federal level be leveraged wherever possible. Policymakers should only act where genuine gaps exist, rather than taking steps that could either 1) create duplicative requirements on the same care or 2) create unnecessary parallel regulatory structures that dramatically complicate coverage and treatment using these AI-enabled capabilities.

Clear the decks on longstanding restrictions on telehealth and RPM that will be equally burdensome to the expansion of AI-enabled care.

The Alliance has led on issues related to connected care regulation and reimbursement for many years. Throughout that period, we have seen short-sighted regulatory and reimbursement approaches allow for the care delivery model of the moment, without considering the continuing evolution of that care. Nearly all of the policy challenges faced in the expansion of telehealth and RPM apply to the further transformation of care with the addition of agentic AI capabilities.

Despite rapid technological advancement, existing regulatory structures continue to pose significant barriers to responsible AI integration. HHS should eliminate outdated telehealth-era restrictions such as rigid interaction rules and geographic limitations, ensuring regulatory frameworks reflect that clinical value is determined by outcomes, not modality. Outdated interaction and location-based care delivery requirements, designed for a pre-digital health environment, limit clinicians' ability to leverage AI-enabled tools in remote and distributed care settings. These barriers also impede models that rely on continuous monitoring, asynchronous communication, and/or digitally supported decision-making.

With this in mind, we call on policymakers to seek broad solutions to care delivery that remove traditional payment and access barriers for all connected care capabilities, including telehealth, RPM, and agentic AI capabilities. We call on HHS to lead efforts (along with Congress/states) to:

- End short-term extension-to-extension policymaking that hampers the ability of innovators to invest in tech-enabled care for seniors. Examples include recent lapses of Medicare telehealth and hospital at home, and near lapses of telehealth prescribing allowances. The ongoing and very real risk to these foundational elements of a modern health care system undermines the promise of

healthcare transformation and stifles innovation and expansion (including investments in AI-enabled care).

- Eliminate Medicare geographic and originating site limitations, allowing patients to communicate remotely with care, regardless of location. Not only do these restrictions limit telehealth, but this outdated regulatory structure is entirely unsuited for a future in which on-demand agentic support is a crucial part of the care delivery ecosystem.
- Remove archaic distant site practitioner-type limitations on connected care. Any provider who can deliver clinically appropriate care should be able to do so. This language can be modernized to focus on clinical appropriateness, with the understanding that care may not always include a human practitioner.
- Permanently remove the concept of an in-person visit as a “guardrail” on connected care access. These restrictions serve to limit access to care, particularly for those with transportation, mobility, frailty, or stigma-related barriers. This concept is fundamentally incompatible with the promise of AI-enabled care, which will help to resolve in-person access constraints.
- Address duplicative state licensing regulations that limit health care competition and stifle care delivery innovation. While there is robust debate currently about state-based AI regulation, barriers to the ability to practice across state lines remain a significant drag on the opportunity to scale national care-delivery networks that leverage both human and agentic capabilities.
- Modernize health plan network adequacy requirements to reflect real-world access measures, such as beneficiary access and satisfaction, rather than outdated time and distance standards. The realization of outcome-based measurements for network adequacy is equally important for a world in which a portion of patient care is provided by agentic AI capabilities.

Avoid repeating the policymaking mistakes made in other digital health areas, where specific allowances later hampered patient access.

Our experience with telehealth, through which policymakers created statutory and regulatory permissibility designed for one moment, without anticipation of the evolution of that care should be a lesson for policymaking in the age of AI. Policymaking barriers, such as Congressional Budget Office scoring, have caused major telehealth wins to age poorly and ultimately become major impediments to patient access. Federal policymakers should avoid repeating this cycle by regulating AI to the point of stagnation or focusing primarily on guardrails when incentive-aligned policy frameworks more effectively promote safe, scalable innovation. These guardrails (such as location requirements for telehealth) ultimately become barriers to care long after the concern they were designed to address has passed.

We believe HHS should avoid tool-specific regulatory regimes that delay deployment of clinically effective AI-enabled services. Lessons from telehealth demonstrate that technology-specific rules create fragmentation, limit scalability, and distort care delivery. HHS should focus on payment for services and outcomes, with flexibility for agentic AI capabilities to be deployed as clinically proven and validated over time. A risk-based, technology-neutral approach focused on clinical function, safety, and outcomes will better support responsible innovation.



Similarly, workforce regulations should be modernized to enable clinicians to safely extend their reach using agentic AI tools. HHS can support team-based, technology-supported care while preserving oversight and accountability. As a result, providers would feel empowered to use the best tools available to provide the highest quality care possible, without being concerned about jumping through hoops required for the billing of that service.

ALLOW THE INTEGRATION OF AI-ENABLED CARE INTO EXISTING MEDICAL SERVICES, WHEN CLINICALLY APPROPRIATE

Pursue regulatory and reimbursement changes that allow for modality-agnostic care delivery to facilitate the expansion of AI-enabled care.

Agentic AI has the potential to significantly expand clinical capacity and improve care delivery. This promise will only be realized at scale if HHS adopts regulatory and reimbursement changes that allow for modality-agnostic care delivery, evaluated on outcomes. AI-enabled clinical services should not be evaluated and reimbursed based on the specific tools, algorithms, or modalities used to deliver those services. In the near-term, payers should take steps toward the reimbursement of clinicians for clinically meaningful outputs delivered through validated, guideline-based workflows—whether those workflows are executed by human team members or AI-enabled agents. Federal policies that are organized around care delivery and outcomes, not the specific technologies used to achieve them will create the necessary flexibility for future evolution as these capabilities mature.

AI-enabled care holds promise for expanding patient access to timely, continuous, and clinically meaningful services, especially through RPM, chronic disease management, and patient engagement. These capabilities enable earlier intervention, reduce avoidable hospitalizations, and lower total cost of care while ensuring patients—particularly those in rural, underserved, mobility-limited, or clinician-shortage settings—can receive appropriate care without relying solely on in-person encounters. Virtual behavioral health and primary care further illustrate agentic AI’s clinician-extending potential, supporting on-demand asynchronous care and regular patient engagements.

AI-enabled virtual and hybrid care should be integrated into existing delivery and payment systems, rather than siloed into technology-specific reimbursement structures. This integration will promote continuity, efficiency, and equitable access to virtual care. Importantly, by retaining the same reimbursement structures for services, with flexibility for modality, we empower clinicians and patients to fully control the choice for how care is delivered rather than creating payment incentives for one modality over another.

Circumvent barriers like time-based reimbursement to the expansion of AI-enabled care.

One of the most significant reimbursement barriers to AI-enabled clinical care is the continued reliance on time-based payment. Rewarding clinician minutes rather than outcomes, efficiency, or productivity gains discourages adoption of models that extend clinician capacity and improve care delivery.

CMS’s recent Advanced Primary Care Management (APCM) codes signal movement away from rigid time tracking; these demonstrate a pathway that could continue to be expanded to better accommodate AI-



enabled workflows. Unfortunately, current asynchronous billing codes—including Chronic Care Management (CCM), Principal Care Management (PCM), Remote Therapeutic Monitoring (RTM), RPM, and Online Digital Evaluation and Management (Digital E/M)—remain heavily tied to time-based inputs. This structure paradoxically penalizes clinicians who deploy AI tools that improve efficiency.

Payment policy should not penalize AI-driven efficiency, such as faster diagnoses, fewer unnecessary visits, or reduced clinician time per episode, when outcomes improve. HHS must work with stakeholders to continue progress in efforts to move beyond time-based reimbursement to reward efficient, outcome-driven services, allowing AI-enabled care to evolve naturally within the market. A practical near-term policy option, included in a recent [NEJM Catalyst](#) article, proposed that HHS consider a dual billing pathway similar to synchronous Evaluation and Management services—permitting reimbursement based on medical decision-making (MDM) complexity rather than time alone. This modification would allow clinicians to retain accountability for care delivered under their supervision while capturing the clinical value, liability, and oversight associated with AI-enabled workflows.

Agentic AI meaningfully expands clinical capacity (far beyond the requisite minutes that a clinician might otherwise bill), enabling proactive outreach, behavioral coaching, medication adherence support, and early intervention at a scale not possible under traditional time-bound models. Payment frameworks should recognize this expanded capacity as an opportunity to reduce downstream utilization and total cost of care.

Further grow AI-enabled care delivery in models based on outcomes, where these changes can be made most easily.

Continued transition toward outcomes-based, value-aligned payment is essential for the expansion of care with flexibility for AI-enabled capabilities. Evaluation and payment for these services must be tied to clinical outcomes, rather than process-driven payments and measures in order to unlock the capabilities of AI-enabled care. Greater opportunities to align payment incentives around outcomes, and with appropriate flexibility, will allow the market to determine the most effective methods of delivery including AI-enabled capabilities as a natural evolution of care.

As a first step, HHS should establish reimbursement pathways for AI-enabled care within existing covered service lines. These services include remote, asynchronous, and longitudinal models where there are clear, low-hanging opportunities for AI to augment existing services, such as RPM which could more clearly depend on continuous, technology-supported engagement rather than discrete care management encounters.

HHS can lay the foundation for linking payment more directly to long-term health outcomes while preserving near-term compatibility with existing billing infrastructure by treating high-value clinical outputs as measurable and reimbursable units of care. Paying for validated outputs of care also creates a pathway toward broader outcome-based reimbursement. AI-enabled workflows can document patient follow-through on care plans, such as completion of ordered diagnostics, medication initiation, adherence, and symptom improvement. These measurable clinical actions serve as proximal indicators of improved



health outcomes and can be standardized, audited, and ultimately tied to value-based payment arrangements when a fully outcome-based model is not possible.

As CMS has recently engaged in through the ACCESS model, federal demonstrations through CMMI offer another important opportunity to scale access-expanding AI-enabled care models, align payment with measurable outcomes, and support regulatory sandboxes that enable innovation with appropriate risk-based safeguards. Through these combined actions, HHS can take steps to expand options for AI-enabled care as an integrated extension of modern care delivery thus expanding access and strengthening the workforce.

Enable innovative “regulatory sandboxes” that allow for temporary exemptions from regulation, subject to rigorous due diligence, safety constraints, and narrowly scoped use cases.

HHS should more broadly seek to encourage experimentation with AI-enabled care, while continuing to ensure risk-based oversight as needed. This should include partnerships with states to test novel AI capabilities within their regulatory jurisdictions.

As mentioned above, there is significant opportunity to continue to build on CMMI payment model exploration to create regulatory flexibility in the testing of AI services at scale in real-time. Flexibility on both the existing virtual care restrictions mentioned previously as well as additional AI-specific flexibilities should accompany outcome-based payment models testing the ability of AI-enabled care.

There is robust interest in AI-focused activity at the state level. It may be possible to divert some of that energy into productive testing and evaluation of AI-enabled health care services through state or regional sandboxes in which AI-enabled health care is tested within a regionally constrained, and narrowly scoped situation with risk-based oversight.

Regulatory flexibility should be paired with structural safeguards that preserve program integrity. AI-enabled clinical workflows can be configured to follow evidence-based pathways, blocking inappropriate actions and ensuring all interventions are clinically justified. Additionally, AI-enabled systems will offer enhanced auditability compared to traditional models as each action can be logged, traceable, and evaluated against predefined criteria. HHS should incorporate auditability and pathway-based safeguards into sandbox and demonstration models, enabling innovation while strengthening fraud prevention and oversight.

INITIAL OPPORTUNITIES FOR AI-ENABLED CARE

The Alliance believes that there are specific areas in digital health that are most ripe for AI-enabled care innovation. This evolution builds directly on telehealth’s success in bringing clinicians closer to patients and reflects what individuals increasingly expect from a modern, responsive health system. These opportunities include –

- Expand chronic disease management support between visits, including medication adherence, symptom tracking, and behavioral coaching. Asynchronous care strengthened by agentic AI



represents a critical access pathway, enabling patients to receive guidance, monitoring, and timely clinical intervention between traditional encounters. This should include options to move beyond time-based reimbursement – including MDM or outcome-based reimbursement.

- RPM, as previously noted, is a particularly strong opportunity as the combination of agentic AI and RPM strengthens patient engagement and self-management through personalized feedback, education, and adherence support without increasing workforce strain. HHS should work to remove outdated payment and program design barriers that discourage the appropriate use of automation and AI to deliver higher-value care.
- Remove barriers to agentic AI-enabled triage, intake, screening, and follow-up, including autonomous or semi-autonomous patient interactions that are part of a reimbursable interaction. While barrier removal is the first step, clinical efficacy of specific interventions will still need to be evaluated and risk related to this care will need to be evaluated.
 - While we have largely discouraged “AI codes” one specific opportunity is the reimagining of virtual check-ins as a payment pathway for agentic AI. These Medicare codes are a classic example of telehealth payment restrictions making an otherwise promising service unworkable, all for a relatively low-value code. However, the objective for this care—in which a patient is contacted between other services to manage their condition—is an ideal structure for agentic AI.
- Convene experts and stakeholders to reimagine what core virtual interactions, including remote supervision and interprofessional consultations should look like in a world where clinicians have AI capabilities assisting them.
- Recognize the trajectory of care and begin to create flexibility within many other services for agentic AI tools to be deployed as they become clinically proven.

HHS has a critical opportunity to ensure that AI strengthens—not fragments—the clinician-patient relationship. By aligning payment with clinically meaningful outputs and modernizing outdated modality restrictions, the Department can ensure patient AI adoption happens in alignment with the patient care team, rather than outside of it.

Thank you for your consideration of these recommendations. We look forward to continuing to work with you on this important next step in America’s tech-enabled care journey. Please do not hesitate to contact Rikki Cheung at rikki.cheung@connectwithcare.org with any questions or to schedule a meeting.

Sincerely,

A handwritten signature in cursive script that reads "Christopher Adamec".

Chris Adamec
Executive Director