

September 11, 2026

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Calendar Year 2027 Medicare Physician Fee Schedule Proposed Rule

Dear Administrator Oz,

The [Digital Medicine Society \(DiMe\)](#) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed Calendar Year (CY) 2027 Medicare Physician Fee Schedule. DiMe is a global nonprofit organization dedicated to advancing the safe, effective, and ethical use of digital technologies to optimize health. We work with patients, clinicians, health systems, payers, technology developers, life sciences companies, researchers, and regulators to develop the evidence, resources, and implementation approaches needed to integrate digital technologies into healthcare and medical product development.

Given the breadth of the proposed rule, our comments focus specifically on policies that will influence the adoption and use of digital technologies in care delivery. This is where DiMe and our community bring particular expertise, including in digitally enabled care, digital measurement, patient-generated health data (PGHD), and the evolving role of clinicians as digital technologies and AI become increasingly integrated into care.

We strongly support CMS's ambition to accelerate the transition toward more preventive, longitudinal, and accountable care and welcome the Agency's request for input on the payment implications of technology-enabled primary care. Digital technologies can help clinicians identify risk earlier, extend care beyond traditional settings, better manage chronic disease, expand clinical capacity, and measure outcomes in patients' daily lives. Realizing those benefits, however, requires alignment across the policies that determine how technology-enabled care is delivered, paid for, and measured.

The CY 2027 proposed rule comes at an important moment as CMS simultaneously advances new models, including ACCESS, intended to accelerate technology-supported chronic care. Providers making decisions today about the capabilities, technologies, workforce, and partnerships required to deliver digitally enabled care need coherent signals from Medicare. Payment policies that reward technology-enabled models in one context while discouraging the same capabilities or partnerships in another risk slowing investment and adoption, particularly among providers with fewer resources to build these capabilities themselves.

We therefore encourage CMS to consider its technology-enabled care policies as a connected strategy. Medicare payment should enable productivity gains created by technology without

rewarding technology adoption absent demonstrated value; providers should have flexibility to assemble the capabilities and partnerships necessary to deliver high-quality digitally enabled care; and CMS must continue building the measurement infrastructure needed to determine whether these models are improving outcomes. Our comments offer three recommendations toward these goals.

1. Establish a coherent payment framework for technology-enabled care

DiMe strongly supports CMS's efforts to consider how Medicare payment should evolve as technology becomes increasingly embedded in care delivery. Digital technologies and AI are already changing the tasks required to deliver care, the resources associated with those tasks, and where and when care can be delivered. As these models mature, Medicare needs a coherent approach to payment that recognizes the value of technology-enabled care without requiring a new payment mechanism for every technology that enters clinical practice.

This transition creates an important payment paradox. Technologies that automate or augment clinical tasks can reduce the time required to deliver aspects of care, improve quality, expand clinical capacity, or enable earlier intervention. If reductions in clinician time or other inputs automatically translate into lower reimbursement, Medicare risks penalizing the productivity gains it seeks to encourage. At the same time, maintaining payment irrespective of whether technologies improve care risks rewarding adoption without value. CMS should therefore increasingly evaluate technology-enabled care by the outcomes and value it produces, rather than relying primarily on the individual inputs required to deliver it.

In response to CMS's question about how technology-enabled care may affect clinical workflows and how clinicians use the capacity created by greater efficiency, we encourage CMS to recognize that AI is changing the distribution of work across the care team. Recent multi-stakeholder work led by the American Medical Association's Center for Digital Health and AI, with support from DiMe, underscores that the [physician's role remains essential](#) even as the tasks associated with delivering care evolve. Technology can increasingly support information gathering, monitoring, synthesis, documentation, and other activities, allowing physicians and other clinicians to direct more of their capacity toward clinical judgment, complex decision-making, communication, and patient relationships. Medicare payment should enable these productivity gains and the redeployment of clinical capacity toward higher-value care.

Ongoing conversations with DiMe partner organizations to [operationalize AI governance](#) reinforce that the effort associated with implementing technology is increasing and the distribution of work is changing. For instance, translating high-level AI governance principles into practical workflows, establishing clear ownership and accountability, and maintaining appropriate monitoring once AI is deployed, all require careful coordination across teams and provide an opportunity for redeploying clinical capacity.

In response to CMS's questions regarding the evidence that should inform payment for technology-enabled care, we encourage the Agency to develop a consistent, technology-agnostic framework for evaluating impact across clinical outcomes, patient

experience and access, clinician capacity, safety, equity, downstream utilization, and total cost of care. Such a framework could support payment approaches that appropriately recognize technologies that improve care while avoiding fragmented reimbursement policies tied to individual tools or technology categories.

CMS should also use prospective payment approaches, Innovation Center models, and other demonstrations to test models that give clinicians greater flexibility to determine the appropriate combination of people and technologies used to deliver care while maintaining clear accountability for quality, outcomes, beneficiary experience, and total cost of care. These efforts can provide the evidence needed to build a Medicare payment system that rewards better and more efficient care as technology continues to reshape clinical practice.

2. Preserve access to scalable remote monitoring models

DiMe has significant concerns about CMS's proposed changes to payment for remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM), particularly the proposal to limit payment to services performed by clinical staff employed by the billing practice rather than contractors. Combined with proposed changes to valuation and additional requirements for initiating these services, these policies risk reducing access to remote monitoring at precisely the moment CMS is seeking to expand technology-enabled chronic care.

The proposal also creates an important inconsistency across CMS's technology-enabled care strategy. Through the ACCESS Model, CMS explicitly recognizes that traditional providers can benefit from partnerships with organizations that bring specialized technology, infrastructure, and capabilities to support patients with chronic conditions. CMS has created a co-management payment to support collaboration between ACCESS organizations and patients' existing clinicians. Yet under the proposed PFS, practices seeking to offer RPM or RTM would face a strong incentive to build the clinical capabilities required to deliver these services internally rather than partner with organizations that already possess them.

Providers need coherent signals about the capabilities CMS expects them to build, buy, or access through partnerships. This is particularly important for smaller, rural, safety-net, and other resource-constrained practices. Requiring practices to employ the clinical staff needed to support remote monitoring may be feasible for large organizations with sufficient scale and capital. Other practices may be unable to make the same investment, leaving the patients they serve with less access to technology-enabled care. Payment policy should enable those providers to access high-quality capabilities through appropriate partnerships rather than make organizational scale a prerequisite for offering them.

In response to CMS's questions regarding the resources required to deliver technology-enabled care, we also urge CMS to take a broader view when valuing RPM and RTM. The value and resources associated with remote monitoring extend beyond the acquisition price of the device. Effective programs require patient onboarding and engagement, data infrastructure and integration, clinical review, escalation pathways, and the ability to translate longitudinal patient-generated data into appropriate clinical action. Reductions in

device prices alone therefore provide an incomplete basis for assessing the resources required to deliver high-quality remote monitoring.

DiMe encourages CMS to reconsider the proposed restriction on contracted clinical staff and ensure that any changes to RPM and RTM payment preserve multiple pathways for practices to deliver high-quality remote monitoring. Requirements should focus on clinical accountability, quality, appropriate oversight, and patient outcomes rather than employment structure. We also encourage CMS to evaluate changes to RPM and RTM alongside ACCESS and its broader technology-enabled care strategy to ensure that Medicare payment policies provide coherent incentives for providers investing in the capabilities required to deliver modern, digitally enabled care.

3. Make patient-generated health data and digital measurement part of the infrastructure for outcomes-based payment

DiMe strongly supports CMS's continued transition toward digital quality measurement, including its proposed pathway toward FHIR-based quality reporting. As CMS simultaneously seeks to accelerate accountable care and develop payment approaches that reward outcomes rather than volume, we encourage the Agency to consider digital quality measurement as more than a more efficient way to report measures that exist today. Digital technologies create an opportunity to expand what Medicare can measure and, ultimately, what it can reward.

Much of what matters to patients happens between clinical encounters. Patient-generated health data (PGHD), including data generated through connected technologies, sensors, apps, patient-reported tools, and other digital technologies, can provide longitudinal insight into symptoms, function, treatment response, disease progression, and other aspects of health that are difficult to capture through claims or episodic clinical data alone. DiMe's work on [the use of PGHD and real-world data and evidence](#) has demonstrated the opportunity to use these data to better understand patient experience and outcomes in real-world settings. When appropriately validated and fit for purpose, PGHD can provide a richer understanding of whether care is improving outcomes in patients' daily lives.

In response to CMS's questions about how technology-enabled care can support improved quality and outcomes, and as CMS advances accountable and prospective payment models, we encourage the Agency to recognize that a payment system that rewards outcomes requires measurement infrastructure capable of reliably assessing those outcomes. CMS should establish a deliberate pathway for incorporating fit-for-purpose PGHD and digitally derived measures into quality measurement and value-based payment, including clear expectations for data quality, validation, interoperability, clinical meaningfulness, and appropriate contexts of use. As CMS develops these approaches, we also encourage alignment with FDA and other federal partners so that, where appropriate, common standards and evidence can support PGHD across regulatory, quality, and reimbursement decision-making rather than requiring duplicative evidence generation for each use case.

As CMS advances its transition to digital quality measurement, we encourage the Agency to pursue two complementary goals: modernize the infrastructure through which existing quality measures are calculated and exchanged, and create pathways for new measures enabled by digital technologies and PGHD. This evolution will require an interoperable data infrastructure capable of incorporating fit-for-purpose PGHD and other emerging data sources in standardized, computable formats so they can be used across care delivery, quality measurement, and payment. Together, these capabilities would allow Medicare to measure health more continuously and in the settings where people live their daily lives, providing critical infrastructure for the transition from encounter-based reimbursement toward payment for better health outcomes.

Conclusion

CMS has an important opportunity through the CY 2027 Physician Fee Schedule and its broader payment innovation agenda to create a more coherent foundation for technology-enabled care. The policies governing payment, care delivery, and measurement will be most effective when they reinforce one another and provide clear signals to clinicians and healthcare organizations investing in new care models.

DiMe encourages CMS to establish a payment framework that rewards the value and productivity gains enabled by technology; preserve flexible, scalable pathways for delivering remote monitoring; and build PGHD and digital measurement into the infrastructure needed for outcomes-based payment. Together, these actions can help ensure that Medicare payments keep pace with the increasingly high-quality care being delivered while maintaining appropriate accountability for safety, quality, outcomes, and beneficiary experience.

DiMe and our community welcome the opportunity to continue working with CMS to advance these goals.

Sincerely,

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