June 15, 2025

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

The Honorable Thomas Keane, MD
Assistant Secretary for Technology Policy
National Coordinator for Health Information Technology
Office of the National Coordinator for Health Information Technology
Department of Health and Human Services
330 C St. SW, 7th Floor
Washington, D.C. 20024

Re: Comment on CMS-0042-NC: Health Technology Ecosystem RFI

Submitted electronically by Drive Health, https://drivehealth.ai/ .

To the Centers for Medicare & Medicaid Services:

Introduction

Drive Health appreciates the opportunity to comment on the Health Technology Ecosystem RFI (CMS-0042-NC). We are a digital health organization focused on scalable patient engagement solutions, best exemplified by Avery, our agentic AI nurse. Avery is an *agentic* AI health assistant designed to complement clinical care by bridging communication between patients and providers and prompting timely interventions. In light of an aging Medicare population and widespread provider shortages straining healthcare capacity, we urge CMS to support policies that enable scalable digital outreach and education technologies. Such support will help reach **all** Medicare beneficiaries with preventive screenings and guidance, close care gaps, and optimize limited human resources while enhancing patient outcomes.

Our comments cover a wide range of questions in the Request, largely targeted towards:

- E. Technology Vendors, Data Providers, and Networks
    - 1. Ecosystems
    - 4. Data Exchange
    - 5. Compliance

- F. Value-Based Care Organizations
    - 1. Digital Health Adoption

AI-Enabled Outreach to Reach All Medicare Members with Preventive Screenings

Advances in artificial intelligence and digital communication now make it feasible to engage virtually 100% of Medicare members in preventive health screenings and surveys. Multi-channel AI tools (e.g. automated calls, SMS, patient portals) can administer standardized assessments like the PHQ-9 depression screen and annual health risk assessments (HRA's) across the entire beneficiary population. This is crucial because traditional in-person outreach leaves many gaps – for example, only 18% of Fee-for-Service Medicare beneficiaries (and 25% of Medicare Advantage members) received their Annual Wellness Visit in 2019, meaning the vast majority missed out on comprehensive risk evaluation. Likewise, an estimated 25% of Medicare beneficiaries aged 65+ have undiagnosed or undertreated depression or dysthymia, indicating a "considerable unmet need" for screening and treatment. Proactive digital outreach can fill these gaps by delivering assessments directly to patients at home, without waiting for an office visit.

Importantly, the infrastructure exists to support broad digital engagement. In 2023, 77.1% of Medicare beneficiaries reported using the internet at home (up from 68.6% in 2019). Even those without broadband can often be reached via telephone or text messaging. By leveraging certified AI-enabled outreach on multiple platforms, health plans and providers can ensure virtually all members complete key health questionnaires (such as PHQ-9 for depression, fall risk surveys, or health risk appraisals). This not only identifies issues early but also stratifies members by risk level for follow-up. High-risk findings (e.g. a positive PHQ-9 indicating possible major depression) can trigger care managers to contact the patient and arrange timely clinical interventions. In short, scalable digital outreach initiates the engagement and risk stratification needed to drive timely care for every beneficiary, including those who might otherwise "fall through the cracks."

Addressing Care Gaps and Workforce Shortages through Digital Engagement

Digital outreach technologies are a force multiplier for our strained healthcare workforce. The U.S. faces a growing provider shortfall – for example, projections show a shortage of up to 139,000 physicians by 2033 in the United States. Nursing and mental health practitioner gaps are similarly daunting, especially in rural and underserved areas. As one recent analysis noted, an aging population with increasing needs is colliding with a limited supply of providers, creating capacity challenges that demand innovative solutions. Scalable AI tools, that have been clinically verified, can help bridge this gap by handling routine yet crucial tasks (screenings, education, check-ins) that would otherwise require significant staff time.

By automating initial outreach and data collection, digital tools allow clinicians to *efficiently* extend their reach. For example, instead of a nurse calling each patient to administer a PHQ-9

or falls-risk questionnaire, an AI system can deliver the survey to thousands of members simultaneously and flag the subset who need follow-up. This not only expands preventive screening to everyone, but also frees up healthcare professionals to focus on those patients with acute or complex needs. In areas with provider shortages, such digital engagement is essential to cover the population. (For instance, in one state pilot addressing maternal health, over 90% of hospitals faced mental health staffing shortages – a gap that an AI "nurse" assistant helped to mitigate by providing support to patients between clinic visits.) Digital engagement can similarly augment Medicare services, ensuring beneficiaries get guidance on preventive care, medication adherence, and chronic condition monitoring even when clinics are understaffed or far away. Those who do not need immediate follow up can benefit from validated and curated health education to improve health literacy and engagement in healthy behaviors. In sum, CMS support for digital outreach is support for *efficiency* and *equity* – using technology to extend care to more people amid workforce constraints.

Reimbursing Digital Engagement and Survey-Based Assessments (CPT/HCPCS Coding)

To realize the full potential of scalable outreach, CMS's payment policies must evolve to directly reimburse digital engagement activities. We recommend the creation of new CPT/HCPCS codes (or expansion of existing ones) to cover digital preventive services – for example, an AI-guided health risk survey completed by a beneficiary, or a series of automated educational check-ins for chronic disease management. Currently, billing for such digital interactions is limited. Medicare does have codes for preventive screenings (e.g. HCPCS G0444 for annual depression screening, CPT 96127 for brief behavioral assessments), but these are typically only reimbursed when performed as part of an office visit and often are not paid separately for remote or stand-alone use. In practice, providers report that CPT 96127 (for a PHQ-9 or similar screening) is "often not a payable service" unless appended to a traditional visit. This creates a disincentive to perform preventative outreach outside of visits.

CMS should address this by explicitly covering digital-administered assessments. For example, if a beneficiary completes a PHQ-9 or falls-risk questionnaire at home via an approved digital platform, a modest reimbursement could be made to the managing provider or plan for that service. This would encourage health systems to invest in outreach tools knowing they can recoup some costs. It would also recognize the clinical value of these interactions. Notably, CMS has begun to acknowledge digital health modalities in coding – for instance, establishing HCPCS code A9291 for FDA-authorized digital behavioral therapy tools. Similarly, CMS could create codes for "AI-supported preventive health outreach" or remote survey completion. By doing so, Medicare can mainstream the practice of engaging patients outside the clinic. We also suggest CMS consider incorporating digital engagement metrics into quality programs (e.g., Medicare Advantage Star Ratings or MSSP ACO quality measures) to further incentivize adoption – for example, a quality measure tracking depression screening rates or social needs

assessments achieved through digital outreach.

Aligning Incentives: Counting Digital Outreach as a Medical Expense (MLR and MA Plan Policy)

Beyond coding and reimbursement, we urge CMS to support flexible financing models for digital health outreach. In Traditional Medicare Fee for Service (FFS) and Medicare Advantage (MA), this means allowing plan expenditures on digital member engagement to count toward the Medical Loss Ratio (MLR) as a quality-improvement or care activity rather than administrative overhead. CMS already permits certain quality initiatives to be MLR-eligible: for instance, wellness assessments, chronic disease education, and lifestyle coaching are recognized as allowable quality expenditures under CMS guidelines. A member outreach campaign conducted via an AI platform should likewise qualify as a quality-improvement expense. Treating these costs as part of "medical care" in the MLR calculation will encourage investments in robust outreach programs without fear of penalizing their MLR.

We note that analogous flexibility exists in Medicaid managed care through "In Lieu of Services" (ILOS) options. Under recently expanded CMS guidance, state Medicaid programs can allow plans to cover non-traditional but health-related services as substitutes for standard benefits, counting them as medical costs. For example, providing housing support or nutritious meals can be considered an ILOS if it prevents a worse health outcome – *e.g.*, stable housing might be covered in lieu of repeated emergency visits, given evidence that housing support can avert the need for emergency care. This shows CMS's willingness to let plans fund innovative interventions that improve health outside the clinic. We encourage a similar mindset for Medicare Advantage: investments in digital engagement (from AI virtual nurses to remote monitoring devices) should be recognized as contributing to better health outcomes, and thus be counted toward care spending. Below is an example of how we have implemented code concession with a Medicaid state.

Example – *Drive Health's "Healthy Baby" Digital Outreach Pilot in Illinois*

Drive Health's *Healthy Baby* initiative—developed with Illinois Medicaid and Google—shows how AI-enabled outreach can close maternal-health gaps at scale. Expectant and new mothers receive smartphones and wearables pre-loaded with *Avery,* our agentic AI nurse, which conducts remote screenings, delivers personalized coaching, and routes high-risk cases to human clinicians. Importantly, the program secured a state-approved code concession that reimburses these digital outreach activities, demonstrating the kind of policy flexibility we urge CMS to adopt. Early results indicate improved engagement and faster clinical follow-up, underscoring how reimbursable digital outreach can strengthen care delivery across large, underserved populations—insights directly applicable to Medicare beneficiaries.

Conclusion

In closing, Drive Health strongly supports CMS policies that promote scalable digital engagement tools across Medicare. By adopting forward-looking reimbursement codes,

encouraging flexible use of funds (e.g. counting digital outreach in MLR), and generally viewing technology-driven outreach as an integral part of care delivery, CMS can unlock innovations that improve outcomes and reduce costs. The “last mile” of healthcare – engaging patients where they are – can be efficiently managed by AI and digital platforms, as our experience with Avery shows. We urge CMS to craft the Health Technology Ecosystem policies with a scalable, preventive, and patient-centered lens, empowering health plans and providers to reach every member with the right intervention at the right time.

Thank you for considering our comments and for your commitment to building a more accessible, tech-enabled healthcare system for all Medicare beneficiaries. We look forward to future collaborations with CMS to advance these concepts.

Sincerely,

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https://drivehealth.ai/