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Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1848-P
P.O. Box 8016
Baltimore, MD 21244-8016

**Re: CMS-1848-P - Request for Information: Technology and AI-Augmentation in Primary Care via the Medicare Annual Wellness Visit (91 FR 43842 at 43940-43941)**

Dear Administrator:

Caesar Health, Inc. is a U.S. clinical-AI company. We build software that supports clinical encounters in real time, reaches patients through SMS, voice, and portal channels, and integrates with electronic health records. We submit this comment in response to the request for information on technology and AI augmentation of the Medicare Annual Wellness Visit (AWV). The RFI's bulleted questions are unnumbered; we number them 1 through 8 in order of appearance.

This comment builds on a white paper that Caesar Health and PCP1st, LLC, a Medicare-enrolled primary-care practice in Florida, submitted jointly to the CMS Center for Clinical Standards and Quality QualTech 2026 showcase on September 3, 2026 (Opportunity Area #2, *AI-Enabled Annual Wellness Visits: Closing the Loop from Risk Detection to Delivered Care*).[5] That paper describes the workflow. This comment states the policy positions that follow from it. This is Caesar Health's comment; it does not purport to submit a comment on PCP1st's behalf.

## Summary of positions

1. The AWV's Health Risk Assessment detects risk. The response to what it detects is where the benefit breaks down. (Questions 1, 3, 4)

2. The highest-value role for clinical AI in the AWV is closing that detection-to-response loop, not increasing visit volume. (Questions 1, 2)

3. The requirement that a Medicare-enrolled clinician furnish the AWV should stand. Within it, CMS should recognize the pre-visit and post-visit work that determines whether the visit happens and whether its findings produce care, paid to the enrolled provider and conditioned on response-rate reporting, and test that pathway through a demonstration before any nationwide change. (Questions 5, 6)

4. CMS should hold technology accountable for response rates to positive HRA findings, not for completion counts. (Questions 4, 7)

5. The two information-sharing improvements with the largest payoff are eligibility verification through HETS and persistence of HRA findings as structured, actionable data. (Question 8)

## 1. Follow-through after risk identification (Questions 1, 3, 4)

The outcome evidence CMS cites in the RFI is mixed. Observational studies show that the Health Risk Assessment identifies concerns and that documented follow-up can be limited:

- Among 16,176 adults older than 65 with at least one AWV, 38% screened positive for falls risk, 23% for cognition concerns, and 32% for impairment in activities of daily living.[1]

- Among 1,411 patients newly reporting memory concerns on the AWV HRA, documented actions at the AWV included a cognitive assessment for 5.4%, a specialist referral for 2.1%, and both for 0.4%.[2]

- Among 13,776 older primary-care patients, 27.9% flagged hearing concerns on the HRA; a hearing-loss diagnosis was recorded for no more than 40% of them. In the reviewed sample of 474 AWV notes, 38 of 384 patients without a prior diagnosis (9.9%) received a hearing-care referral within one month.[3]

These studies identify opportunities to improve follow-through in the settings studied. They do not establish national rates, prove why overall AWV outcome findings are mixed, or demonstrate that AI improves outcomes. Our hypothesis is that better follow-through after clinically meaningful findings could improve the benefit of the AWV; it requires prospective evaluation.

CMS has articulated a related principle in Medicare Advantage rulemaking. In retiring the SNP Care Management measure (C07) from the 2029 Star Ratings, CMS wrote that it "is ultimately interested in whether enrollees receive needed care as indicated by this assessment and not only whether the assessment is completed" (91 FR 17384 at 17501-17502). Declining an AWV-based alternative for the depression-screening measure, CMS wrote that it "does not address a key component of DSF which is follow-up care for those who screen positive" (91 FR 17513). We agree with both statements. This comment applies them to the AWV itself.

## 2. The highest-value role for clinical AI: close the loop (Questions 1, 2)

CMS's understanding, stated in the RFI, is that clinical documentation and decision-support tools are the most common applications of AI in primary care today. That matches what we see. In the AWV specifically, technology concentrates on the visit: ambient documentation, pre-visit digital HRA collection, EHR-embedded templates. These are useful. They reduce clinician time per visit. Their efficiency benefits should be evaluated alongside what happens after the visit.

We recommend prioritizing what happens after a positive finding. We offer no quantified claim about changes in AWV-specific AI adoption over the past year. Over the next several years, CMS should test whether better synthesis and follow-through improve care beyond documentation efficiency.

- **Before the visit:** collect the HRA through the channels patients actually answer - SMS, voice, portal - adapted to the patient's language and health literacy, so the clinician starts the visit with findings rather than forms.

- **During the visit:** present each positive finding to the clinician with the chart evidence behind it, so accepting or overriding it is a decision, not a search.

- **After the visit:** convert each clinician-accepted finding into a tracked order or referral, follow up until the action is completed, the beneficiary declines, or the clinician records an appropriate disposition, and surface the open items at every subsequent touchpoint.

The third function supports execution of the personalized prevention plan. CMS states that much of this technology support can occur under current billing guidance. That does not establish separate payment for every activity; section 3 proposes testing a bounded payment pathway.

On the activities that require direct clinician involvement (question 2): interpretation of findings, the decision to assess, order, or refer, personalized health advice, and final validation of the HRA and prevention plan. When separately furnished, advance care planning remains voluntary and subject to its own requirements. AI should prepare and track; the responsible health professional should decide. Beneficiaries should retain telephone, staff-assisted, caregiver-supported and accessible language pathways; an AI interaction should not substitute for required beneficiary participation or an IPPE examination.

### 3. Keep the clinician accountable. Open a bounded pathway. (Questions 5, 6)

CMS asks what barriers current requirements create for delivery models in which an AI technology company affiliates with a Medicare-enrolled provider, and when it should consider payment or policy changes.

We support preserving the existing furnishing, enrollment and supervision requirements. As CMS explains, the AWV must be performed by a physician or other health professional, or a team of medical professionals directly supervised by a physician currently enrolled as a Medicare provider. Much technology support can occur under current billing guidance. CMS should clarify how those requirements apply to distributed workflows without transferring clinical accountability to software.

The barriers are operational:

- **Unrecognized work.** Eligibility verification, pre-visit HRA collection, and post-visit follow-through determine whether an AWV happens and whether its findings produce care. Existing AWV and care-management payments may not adequately support this work for all practices. CMS should examine the incremental resources required and prevent payment for activities already included in another billed service.

- **Fragmented eligibility and visit-history data.** Whether a beneficiary is due, and which visit type applies, often lives outside the practice's own EHR. HETS returns the essentials, but how practices reach it and how EHRs expose it vary widely.

- **EHR integration access.** The interfaces required for pre-visit preparation and follow-through tracking are frequently absent or priced as bespoke projects. When integration cost, not capability, decides which practices can adopt AWV support, their beneficiaries bear the gap.

- **Documentation conventions.** CMS should clarify how documentation should identify AI-drafted content, beneficiary-reported information, staff-entered data, and clinician-validated findings. Source traceability, role-based access, audit logs and recorded clinician approval should make review auditable. Affiliations must also comply with applicable state licensure and professional-practice requirements, privacy duties and beneficiary consent requirements.

On when CMS should consider payment or policy changes: when the technology organization participates through a defined relationship with a Medicare-enrolled provider that retains clinical validation, the beneficiary interaction, the personalized prevention plan, documentation, and billing. Within that structure, CMS could recognize the pre-visit and post-visit work as an add-on to the AWV, on the model of remote monitoring and treatment-management services, billed by the enrolled provider and conditioned on reporting the response-rate measures in section 4. A demonstration or Innovation Center model is the right first vehicle. A nationwide pathway should follow evidence, not precede it.

What CMS should not do is create a pathway for technology organizations to bill AWV-related services directly. The program-integrity record is specific: MedPAC found that diagnostic coding associated only with health risk assessments accounted for $15 billion in payments to Medicare Advantage plans in

2023, with about 80 percent of those payments from HRAs conducted as part of an AWV or IPPE.[4] This Medicare Advantage evidence is not evidence of fraud by AI vendors or a direct estimate of fee-for-service risk; it supports testing safeguards against coding-driven payment detached from delivered care.

### 4. Measure response, not completion (Questions 4, 7)

CMS asks how to evaluate whether AI-enabled AWVs improve outcomes rather than visit volume, documentation completeness, coding intensity, or low-value cascades. Completion counts alone cannot answer that question. We recommend the following process measures alongside clinical outcomes:

- Of beneficiaries with a positive HRA finding (falls, cognition, hearing, depression, functional impairment), the share with an appropriate clinician-reviewed assessment, order, referral or documented disposition within a prespecified, risk-appropriate interval. Ninety days could be tested for nonurgent findings; urgent concerns require faster action.

- Of those orders and referrals, the share actually completed within a defined window. Report beneficiary declinations and clinically justified closure separately, with reasons; administrative closure must not count as delivered care.

- Beneficiary-reported outcomes tied to the flagged domain, not global satisfaction.

EHR data, supplemented by claims where appropriate, could support audit of these measures. A positive-finding denominator alone does not prevent unnecessary testing. Evaluation should also track guideline-concordant preventive services, avoidable emergency visits and admissions, total spending, low-value testing and referrals, duplicate AWVs, unsupported diagnosis capture and AI error rates. Stratify access and outcomes by disability, rurality, dual eligibility and other relevant factors. Use a prospective comparison population, prespecified endpoints and adequate statistical power. The 5.4% and 9.9% observations concern different actions, populations and time windows; they are not interchangeable national benchmarks.

CMS could test response-rate reporting through a demonstration while assessing alignment with existing improvement activities such as IA_AHW_1, Chronic Care and Preventative Care Management for Empaneled Patients. This is a recommendation for future testing, not a claim that existing attestation requirements already include these measures.

AWV uptake, HRA completion and documentation quality remain useful access and operational measures, including separate reporting for initial and subsequent AWVs. They should not be the sole basis for payment or evidence of clinical benefit. Technology organizations should report workflow reliability, errors and completion of their assigned tasks; participating providers and technology partners should jointly evaluate patient outcomes without obscuring clinical responsibility.

### 5. Eligibility verification and persistent findings (Question 8)

Two specific supports for information sharing across the primary-care relationship:

- **HETS.** The HIPAA Eligibility Transaction System can return next-eligible dates for G0438/G0439 when available; missing data must trigger further verification. Its current-date response should not be treated as a complete historical visit record. CMS should support authorized eligibility verification while retaining HETS enrollment, provider/vendor authorization and permitted-use safeguards. HETS access should not become a tool for indiscriminate beneficiary prospecting.

- **Persistent findings.** A positive HRA finding should live in the record as structured data with a state - recommended, approved, ordered, scheduled, completed, beneficiary-declined, or clinically closed - not

as narrative in a visit note. That is the substrate for follow-through across the year: every subsequent encounter, and every tool a practice uses, can see what was detected and what remains unanswered. This - not retrospective summarization - is where AI-enabled tools most improve information sharing from the AWV throughout the primary-care relationship.

## Conclusion

CMS should improve both equitable access to AWVs and appropriate follow-through on their findings. Clinician-supervised AI could support that work. A bounded demonstration should test clinical benefit, resource needs and program integrity before broader payment changes. We would welcome the opportunity to provide further technical detail.

Respectfully submitted,

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## References

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3. Powell DS, et al. The Medicare annual wellness visit: An opportunity to improve health system identification of hearing loss? *J Am Geriatr Soc.* 2024;72(10):3089-3097. doi:10.1111/jgs.19111.

4. Medicare Payment Advisory Commission. *Report to the Congress: Medicare Payment Policy.* March 2026, Chapter 12, p. 400.

5. PCP1st, LLC and Caesar Health, Inc. *AI-Enabled Annual Wellness Visits: Closing the Loop from Risk Detection to Delivered Care.* White paper submitted to the CMS CCSQ QualTech 2026 showcase, Opportunity Area #2, September 3, 2026.

6. CMS. CY 2027 Physician Fee Schedule proposed rule, CMS-1848-P. 91 FR 43842, 43940-43941. July 16, 2026.

7. CMS. Contract Year 2027 Medicare Advantage and Part D final rule, document 2026-06600. 91 FR 17384, 17501-17502 and 17513.

8. CMS. HETS 270/271 5010 Companion Guide, version 15.0, section 7.28; HETS EDI: How to Enroll (May 28, 2026).

9. CMS Quality Payment Program. 2026 improvement activity IA_AHW_1, Chronic Care and Preventative Care Management for Empaneled Patients.