February 23, 2026

VIA ELECTRONIC SUBMISSION

Steven Posnack
Principal Deputy Assistant Secretary for Technology Policy
Office of the National Coordinator for Health Information Technology
Office of the Deputy Secretary and Assistant Secretary for Technology Policy
U.S. Department of Health and Human Services
330 C Street SW
Washington, DC 20201

RE: HHS Health Sector AI RFI, **Request for Information: Accelerating the Adoption and Use of Artificial Intelligence as Part of Clinical Care**

Dear Mr. Posnack:

The National Alliance for Care at Home (the Alliance) appreciates the opportunity to comment on the U.S. Department of Health and Human Services' (HHS) Request for Information (RFI): Accelerating the Adoption and Use of Artificial Intelligence as Part of Clinical Care.

The Alliance is the unified voice for providers delivering high-quality, person-centered healthcare to individuals, wherever they call home. Our members are providers of different sizes and types—from small rural agencies to large national companies—including government-based providers, nonprofit organizations, systems-based entities, and public corporations. Our members, including over 1,500 providers representing 10,000 offices and locations, serve over 4 million patients nationwide through a dedicated workforce of over 1 million employees, staff, and volunteers. The Alliance is dedicated to advancing policies that support care in the home for millions of Americans at all stages of life, individuals with disabilities, those with chronic and serious illnesses, and Americans at the end of life who depend on those supports.

We thank the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC)'s efforts to identify barriers to private sector AI innovation and opportunities to improve regulations, policies, and programs that can promote appropriate and effective use of AI in care delivery for vulnerable patients.

At the same time, we offer comments to highlight the important role that care at home plays in our healthcare ecosystem, and important considerations relevant to AI use and innovation in this setting, informed through feedback from our members.

Discussion

The Home is a Distinct Care Setting

Home-based care is an essential part of our healthcare continuum, serving millions of patients at every stage of life in the setting they trust most. This care encompasses a broad continuum of services, including home health, hospice, palliative care, home care, Medicaid home and community-based services (HCBS), and pediatric care. The demand for these services continues to grow. By 2030, one in five Americans will be age 65 or older, and 87 percent of older adults express a strong preference to age in their own homes.[1] Care at home can support enhanced independence,[2] reduce mortality and hospital readmission rates and generate cost savings,[3] and improve quality of life.[4] As HHS considers how best to accelerate AI adoption in clinical care, it is important that home-based care be an important part of the Department's strategy.

The home is a fundamentally different care environment than hospitals, clinics, or inpatient facilities, and HHS should evaluate opportunities to promote AI with that distinction in mind. Clinicians delivering care in the home operate with a level of autonomy and variability that differs markedly from hospital or facility-based practice. It is important to note that in the home setting, there is no controlled environment or inpatient infrastructure, and often limited broadband connectivity, particularly in rural areas.

The Alliance recognizes that AI holds significant promise for clinical settings if developed and deployed appropriately. At the same time, there are important considerations for home-based care. For example, ambient listening tools, which can be used to support clinical documentation, raise particular concerns in the home, where visits frequently occur in the presence of family members, caregivers, neighbors, and other individuals who are not the patient. Concerns about who must provide consent for AI-enabled recording, what data is captured from non-patients nearby, and how that information is handled remain unresolved and raise risks for providers. Accordingly, we encourage HHS to

---

[1] *See* Geng F, McGarry BE, Rosenthal MB, Zubizarreta JR, Resch SC, Grabowski DC. Preferences for Postacute Care at Home vs Facilities. JAMA Health Forum. 2024;5(4):e240678. 10.1001/jamahealthforum.2024.0678

[2] *See*, *e.g.*, Boland L, Légaré F, Perez M, et al. Impact of home care versus alternative locations of care on elder health outcomes: an overview of systematic reviews. BMC Geriatrics, 2017;17

[3] *See*, *e.g.*, Xiao R, Miller JA, Zafirau WJ, Gorodeski EZ, Young JB. Impact of Home Health Care on Health Care Resource Utilization Following Hospital Discharge: A Cohort Study. Am J Med. 2018 Apr;131(4):395-407.e35. doi: 10.1016/j.amjmed.2017.11.010

[4] *See*, *e.g.*, Tay YL, Abu Bakar NS, Tumiran R. et al. Effects of home visits on quality of life among older adults: a systematic review protocol. Syst Rev, 2021; 10(307)

recognize these distinctions and account for the realities of care delivery in the home as the Department moves forward in its efforts to leverage AI in clinical care.

Individuals we serve also report concerns about the privacy of health information when it is provided to an AI model. Given the constant learning and recalibration inherent in much AI infrastructure, information provided for model interpretation and response is often added to the universe of data that the AI uses to formulate future responses. HHS must ensure that such functionality is disallowed when AI is used as a component of information systems with access to protected health information. Similarly, all AI systems in use should be HIPAA compliant and meet every standard for data integrity, encryption, storage, and transmission.

We also encourage HHS to support the development of benchmarking tools that would allow providers to evaluate AI performance in home-based care settings. AI models trained primarily on hospital or clinic data may not perform reliably when applied to home health, hospice, or HCBS populations. Tools that account for these unique populations and care delivery models would give providers greater confidence in AI tool selection, and help AI developers build more effective products for this setting.

Barriers to AI Adoption in Home-based Care Settings
There are several significant barriers our members face in adopting and innovating with AI in home-based care settings. These barriers include, but are not limited to, cost and resource constraints, workforce readiness, technology integration, and regulatory and legal uncertainty.

The cost of AI adoption remains one of the most commonly cited barriers among our members. Providers delivering care in the home, including home health, hospice, Medicaid home and community-based services (HCBS), palliative care, and home care, face significant financial barriers in evaluating, customizing, and implementing AI tools. The costs extend beyond the technology itself and include staffing required to manage implementation, the clinical staff time needed for training and oversight, and the legal and compliance guidance and resources necessary to assess and manage risk.

In addition, our members report that a lack of staff with the necessary skillsets to manage AI implementation and ongoing oversight is a significant barrier to AI adoption. Adoption of AI tools requires not only technical expertise but additional training to ensure responsible and appropriate AI use in clinical care. Providers need resources and guidance to build capacity for training, monitoring, and auditing AI use. Accordingly, the Alliance urges HHS to identify and evaluate how it can support workforce development to promote AI use in clinical settings.

Significant concerns have also been raised about the legal risks associated with AI adoption. Providers face uncertainty regarding how they will be held accountable for errors generated by AI tools, including issues of algorithmic bias, ambient listening, inaccurate outputs, and data security. Smaller providers in particular lack the resources to independently evaluate vendor claims about data protection, the security of data flowing to large language models, and compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and data protection. Recent litigation underscores the legal risks our members face,[5] which contributes to this environment of uncertainty.

Further, the Alliance is concerned about the use of AI tools to deny or limit coverage for healthcare services, particularly in the home.[6] Even with human oversight, AI tools may have undue influence on reviewers in coverage decisions, as clinicians may face pressure to affirm recommendations made by AI. Accordingly, HHS should evaluate the need for guardrails around AI use in the insurance market to ensure that AI can be leveraged to improve efficiency in medical reviews—not as a blunt tool that can inhibit patient access to services in the home.

As noted above, consent to AI use is essential to its ethical use. Compounding this challenge is the current patchwork of laws governing AI use, data collection, and consent requirements. Members noted that this inconsistency across jurisdictions makes it difficult for providers, particularly those operating in multiple states, to use AI tools and develop policies with confidence and comply with all applicable requirements.

Accordingly, the Alliance encourages HHS to work in partnership with the states to work toward a standard for responsible AI use that would provide clarity for providers operating across state lines.

Opportunities for Regulatory and Payment Policy Refinements
HHS should prioritize payment policies that create direct financial pathways for AI adoption. One promising approach could be the development of new payment codes or enhanced payment rates for clinical services that demonstrably incorporate AI-assisted care, similar to how CMS has historically used add-on payments to encourage adoption of

---

[5] *See, e.g.*, *Saucedo v. Sharp HealthCare*, No. 25CU063632C (Cal. Super. Ct., San Diego Cnty. Nov. 26, 2025) (proposed class action alleging the use of ambient AI without obtaining patient consent); *Lisota v. Heartland Dental, LLC*, No. 25 CV 7518, 2026 WL _____, at *1–9 (N.D. Ill. Jan. 13, 2026) (granting defendants' motions to dismiss without prejudice a Federal Wiretap Act claim challenging an AI-powered telephone service's real-time transcription and analysis of patient calls).

[6] *See, e.g.*, Doe *v. Cigna Health & Life Ins. Co.*, No. 2:23-cv-01355 (E.D. Cal. July 24, 2023) (alleging that an insurer used an algorithm to automatically deny thousands of patient claims without individualized physician review as required by state law).

beneficial technologies and care models. Alternatively, CMS Innovation Center models could be designed to test value-based payment arrangements that reward providers who leverage AI to improve outcomes and reduce costs, creating a business case for adoption that does not rely solely on upfront grants or subsidies. These approaches would lower the barrier to entry for providers who recognize AI's clinical value but lack the capital to absorb upfront implementation expenses, and would be especially meaningful for smaller and community-based providers who operate on thin margins and cannot self-finance technology transformation.

Equally important is ensuring that home and community-based care settings are not left behind in these incentive structures. Unlike hospitals and physician groups that received financial incentives under the Health Information Technology for Economic and Clinical Health (HITECH) Act[7] to adopt electronic health records and build interoperable systems, home health and hospice providers were largely excluded from these incentives. As a result, these providers are continuing to play catch-up, at a time when making the leap to AI adoption will come with its own costs and resource constraints. HHS must be deliberate in designing AI incentive programs that explicitly include home-based care, personal care, and other non-institutional settings. Any new grant programs, payment adjustments, or adoption incentives should include provisions that extend to these providers, recognizing that a significant and growing portion of care, particularly for elderly and disabled populations, occurs in the home.

On the question of standards and oversight, establishing formal AI accreditation or certification requirements at this stage of the technology's development may be premature, but some foundational framework is nonetheless needed. HHS should prioritize developing standards that allow providers, payers, and regulators to evaluate AI tools against consistent, transparent criteria. This intermediate step would help establish accountability without stifling innovation. These standards could address clinical accuracy, bias, data integrity, and outcomes impact, giving the health care sector clearer signals about what constitutes responsible AI deployment.

Guidance and Oversight
HHS can best support private sector activities by providing clear guidance on permissible uses and by establishing clear accountability for potential harms that may result from the use of this technology. HHS can provide minimum standards for AI implementation as well as certification of accreditation agencies to establish minimum standards. Providers and patients need guardrails to assure safety, efficacy, and risk mitigation with clear assignment of liability. Providers and provider organizations will almost always be consumers of AI applications, and there is a great desire to make better use of the

---

[7] Pub. L. 111-5

mountains of data captured in medical coding. Further, use of AI embedded into EHRs and other technologies already in use may not be a choice by providers.

HHS can also support providers by having well-funded, minimally burdensome, and meaningful oversight. AI adoption in the medical industry is in a "wild west" and the technology has progressed in use and utility beyond the current regulatory paradigm. To adequately provide regulatory oversight, HHS would need to have regulators that are able to determine whether AI models are designed and behaving safely, and there must be enough regulators to address a large and growing industry, at least inasmuch as AI becomes embedded in many other IT tools.

Providers need specific, clear guidance to fully account for the risks they may be taking when they use AI products, particularly as it may affect or intersect with CMS regulatory and subregulatory guidance. These products may affect billing, coding, notetaking, route planning, and so on – any given product may affect a variety of different concerns, whether it is data security of medical records or consent of everyone who may be in the room when an ambient notetaking AI is working. Each different AI product – or product embedded in an existing app – carries a potential set of liabilities that are not yet tested in the courts. Consistent with the Department's goal of reducing uncertainty in the wake of AI innovation, the Alliance urges HHS to pursue clear, prospective regulatory guidance that promotes the use of AI in ways that benefit patients, improve efficiencies, and are minimally burdensome on providers.

Interoperability and Technology Infrastructure
Interoperability remains a foundational prerequisite for effective AI use, and HHS should revisit existing interoperability regulations and programs to strengthen incentives for data sharing and integration. Grant programs under HRSA, CMS Innovation Center models, and other HHS programmatic levers should be designed to fund not just AI tools themselves, but the interoperability infrastructure that makes them viable and with particular attention to ensuring home health, home care, and hospice providers are eligible recipients.

Indeed, AI tools are only as effective as the data they can access, and fragmented, siloed health data undermines their clinical utility.
Enhanced interoperability is essential to realizing the potential of AI in home-based clinical care. There are opportunities for care coordination with real-time data, real communication between provider IT systems to reduce duplicate tests, referral systems improvements, and more but none of them are possible without real cross-sector and intra-sector interoperability.

Without meaningful progress on interoperability, innovative AI applications will remain out of reach for much of the care-at-home sector. The Alliance urges HHS to prioritize

interoperability investments and standards that include home health and hospice providers.

As noted above, home health and hospice providers were largely excluded from the EHR adoption incentives made available to hospitals and eligible professionals under the HITECH Act and subsequent programs. This exclusion has left our members at a significant technological disadvantage. The Alliance urges HHS to ensure that any interoperability initiatives or incentive programs related to AI adoption include home health and hospice in the mix of participants. Without inclusion, these providers risk being left out of an emerging AI ecosystem altogether, further widening the digital divide in home-based care settings.

Indeed, our members have emphasized that a common barrier to AI deployment is the inability of many AI products to integrate effectively with their EMR platforms. Accordingly, we recommend HHS partner with AI and EMR vendors to consider solutions to ease seamless integration, and promote uptake instead of adopting costly, resource-intensive custom builds.

Opportunities for Research
Opportunities for AI in home care could benefit from significant research funding which focuses on understanding, among other ideas, the uniqueness of providing care in the home. As noted previously, the home as a site of care differs significantly from institutional settings and provides both opportunities and significant barriers to AI implementation. Studies which specifically address the nature of providing care outside of an institutional setting can accelerate that adoption by spurring investment in technologies specifically designed for patients receiving care at home.

Patient safety is another top area which should be prioritized for research funding. Providers and patients continue to express concerns about privacy and patient information within the confines of AI usage. Further study on the safest ways to implement AI is critical before widescale adoption.

Additional areas of research which should be prioritized include potential efficiencies for the home care workforce in clinical care, with a focus on not creating additional burden. This may include AI applications for remote patient monitoring, documentation assistance for clinicians, and more.

Currently, limited research on AI implementation in care in the home exists, and few studies have been published within the past year. The Alliance encourages HHS to invest more funding for research into AI in home health, home care, and hospice. This will help drive adoption and level the playing field for home care with evidence-based technologies.

Conclusion

We appreciate your consideration of our comments. The Alliance stands ready to partner with HHS to promote the appropriate use of AI to improve patient lives in the home. If you have any questions, your staff should feel free to contact Patrick Harrison, vice president, public policy, at pharrison@allianceforcareathome.org.

Sincerely,

Scott Levy
Chief Government Affairs Officer
National Alliance for Care at Home