AGS Geriatrics Healthcare Professionals
Leading Change. Improving Care for Older Adults.

THE AMERICAN GERIATRICS SOCIETY
40 FULTON STREET, SUITE 809
NEW YORK, NEW YORK 10038
212.308.1414 TEL
www.americangeriatrics.org

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Robert F. Kennedy Jr.
Secretary
Department of Health and Human Services
Assistant Secretary for Technology Policy
Office of the National Coordinator for Health Information Technology
Attention: HHS Health Sector AI RFI, Mary E. Switzer Building
Mail Stop: 7033A
330 C Street SW
Washington, DC 20201

Re: Request for Information: Accelerating the Adoption and Use of Artificial Intelligence as Part of Clinical Care (RIN 0955-AA13)

Dear Secretary Kennedy:

The American Geriatrics Society (AGS) greatly appreciates the opportunity to submit our comments to the Department of Health and Human Services (HHS) on its request for information (RFI) regarding the acceleration of the adoption and use of artificial intelligence (AI) as part of clinical care.

AGS is a nationwide, not-for-profit society of geriatrics healthcare professionals dedicated to improving the health, independence, and quality of life of older people. Our 6,000+ physician and non-physician practitioners (NPPs) are pioneers in serious illness care for older individuals, with a focus on championing interprofessional teams, eliciting personal care goals, and treating older people as whole persons. AGS is an anti-discriminatory organization. We believe in a society where we all are supported by and able to contribute to our communities. The Society leads efforts to incorporate attention to older adults living with multiple chronic conditions into research[1,2] and clinical care[3,4] and is a champion for improving attention to the unique health care needs of older adults in workforce training.[5,6] We believe that understanding disease across the lifespan[7] is important to extending healthspan—the time someone lives in generally good health—for all of us as we age.

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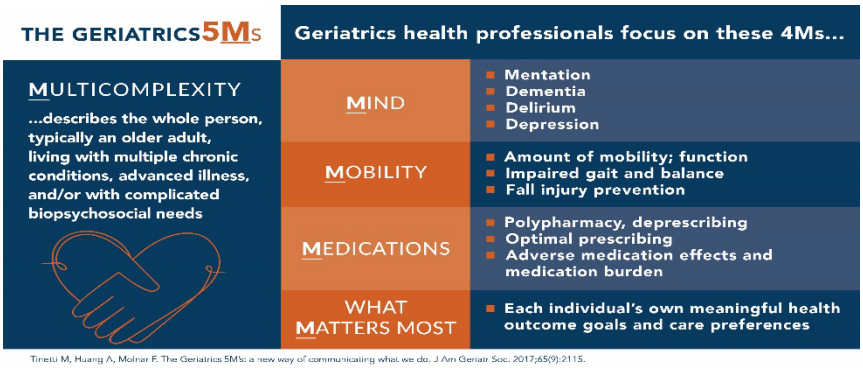
[1] Advancing Geriatrics Research: AGS/NIA Conference Series. American Geriatrics Society. Accessed February 17, 2026. https://www.americangeriatrics.org/programs/advancing-geriatrics-research-agsnia-conference-series
[2] The AGS/AGING LEARNING Collaborative. AGS CoCare. Accessed February 17, 2026. https://mccresearch.agscocare.org/what_is_the_ags_aging_learning_collaborative
[3] American Geriatrics Society Expert Panel on the Care of Older Adults with Multimorbidity. Guiding principles for the care of older adults with multimorbidity: an approach for clinicians. *J Am Geriatr Soc*. 2012;60(10):e1-e25. doi:10.1111/j.1532-5415.2012.04188.x
[4] McNabney MK, Green AR, Burke M, et al. Complexities of care: common components of models of care in geriatrics. *J Am Geriatr Soc*. 2022;70(7):1960–1972. doi:10.1111/jgs.17811
[5] American Geriatrics Society. Letters to House and Senate Appropriations Leadership on FY 2026 Funding for Geriatrics Workforce Training Programs. July 14, 2025. Accessed February 17, 2026. https://www.americangeriatrics.org/sites/default/files/Letters%20to%20House%20and%20Senate%20Appropriations%20Leadership%20on%20FY%202026%20Funding%20for%20Geriatrics%20Workforce%20Training%20Programs%20%287%2014%2025%29.pdf
[6] AGS Advancing Geriatrics in Surgical & Medical Specialties. Special Collection. *J Am Geriatr Soc*. Accessed February 17, 2026. https://agsjournals.onlinelibrary.wiley.com/hub/journal/15325415/agsadvancinggeriatrics
[7] Inclusion Across the Lifespan in Human Subjects Research. National Institutes of Health. Updated February 27, 2025. Accessed February 17, 2026. https://grants.nih.gov/policy-and-compliance/policy-topics/inclusion/lifespan

Our members are on the frontlines of caring for older Americans, many of whom are living with multiple chronic conditions, advanced illness, and/or with complicated biopsychosocial issues. An important framework for how geriatrics health professionals care for older adults is the Geriatrics 5Ms (see table on the right).[8] The Geriatrics 5Ms informed the development of the 4Ms of age-friendly care (What **M**atters, **M**edications, **M**entation, and **M**obility) of the Age-Friendly Health Systems (AFHS) movement which seeks to reimagine the 21st century health system so as to provide care that is age-friendly, respects the goals and preferences of older persons, and meaningfully and substantially includes family caregivers in the plan of care.[9]



AGS appreciates that HHS is seeking feedback to inform HHS-wide use of regulation, reimbursement, and research & development in the application of AI for the ultimate benefit of patients, caregivers, and communities. Geriatricians and other geriatrics clinicians who care for older adults with complicated medical issues and social challenges support a holistic life stage approach. This is vital to fully understand the diverse effects of aging on the older adult population and effectively address the multifaceted issues related to aging. Accordingly, AGS respectfully submits the following recommendations that reflect the most relevant and appropriate considerations for older adults.

TOPIC	RECOMMENDATION
Barriers to private sector innovation in AI for health care and its adoption and use in clinical care	<u>Addressing Time Constraints; Lack of Knowledge, Readily Available Information, and Evidence; and Insufficient Implementation Support</u> • Promote hybrid AI-human systems where decision-making is transparent and guided by clinician and patient values and preferences. • Increase transparency about how AI models and tools are built, used, and updated. • Support participatory design methods that align AI tools with users' goals, abilities, and values, as well as studies that address barriers to uptake, including workflow integration, clinician burden, and reimbursement models. • Focus on clinician-in-the-loop AI for geriatrics decision support, involving both computer scientists and geriatrics health professionals. • Invest in continual learning algorithms that adapt to population shifts (e.g., post-COVID aging care patterns, new medications) while maintaining clinical safety.
Regulatory, payment policy, or programmatic design changes HHS	<u>Ensuring Data Readiness, Interoperability, and Integration</u> • Facilitate linkage and harmonization across electronic health records (EHRs), sensors, imaging, genomics, claims, and social determinants data.

[8] Tinetti M, Huang A, Molnar F. The Geriatrics 5M's: a new way of communicating what we do. *J Am Geriatr Soc*. 2017;65(9):2115. doi:10.1111/jgs.14979

[9] Mate KS, Berman A, Laderman M, Kabcenell A, Fulmer T. Creating age-friendly health systems - a vision for better care of older adults. *Healthc*. 2018;6(1):4-6. doi:10.1016/j.hjdsi.2017.05.005

should prioritize to incentivize effective use of AI and augment ability to develop or use AI in clinical care	• Promote common data models and standards (e.g., Fast Healthcare Interoperability Resources, Observational Medical Outcomes Partnership) to support scalable and reusable AI tools. • Develop standardized frameworks for Intellectual Property (IP)-sharing, privacy-preserving analytics, and responsible model stewardship (e.g., model cards, usage audits) that would further support innovation without compromising trust or transparency. • Evaluate Centers for Medicare and Medicaid Services (CMS) payment models for AI-assisted care interventions. <u>Ethical and Equity Considerations</u> • Create aging-specific ethical frameworks addressing consent capacity, data sharing preferences, surveillance, and autonomy in AI-assisted decision-making, while considering the critical importance of delivery of person-centered care[10] that facilitates cross-study research and evaluation of best practices in clinical care. • Build regulatory frameworks for age-related bias and equity to establish standards that identify and mitigate age-related algorithmic bias and promote equitable AI performance across diverse older populations.
For non-medical devices, novel legal and implementation issues that challenge existing governance and accountability structures and HHS' role to help address them	<u>Legal Implications and Safeguards</u> • Facilitate educational activities to raise awareness that helps all stakeholders ensure appropriate steps are taken for the implementation and evaluation of legal frameworks and safeguards that define liability boundaries and support safe and ethical use of non-medical devices across populations. • Ensure safeguarding of data privacy and confidentiality, advancement of health equity and addressing bias, and protecting patients and care partners. • Establish guardrails for passive monitoring (e.g., smart home devices, wearables) and algorithm-driven recommendations for vulnerable populations. <u>Governance and Accountability</u> • Create aging-specific governance models that guide data access, model approval, and clinical integration. • Develop and pilot institutional governance toolkits for AI in aging. • Require governance plans for all AI research, including use cases, data flows, and accountability mechanisms.
For non-medical devices, promising AI evaluation methods (pre- and post-deployment), metrics, robustness testing, and other evaluation methods for clinical care and HHS'	<u>Evaluation Methods</u> • Human-centered and accessible design that requires geriatrics-informed user experience standards to ensure devices are usable by older adults and avoid misapplication and safety risks. • Geriatrics-specific testbeds, "living labs" for aging AI, and real-world environments (e.g., older adult housing, Program of All-Inclusive Care for the Elderly (PACE) programs, home health agencies) where models can be safely deployed and iteratively refined.

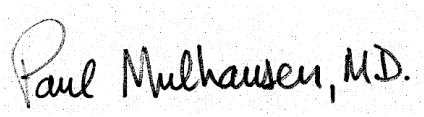
[10] The American Geriatrics Society Expert Panel on Person-Centered Care. Person-centered care: a definition and essential elements. *J Am Geriatr Soc*. 2016;64(1):15-18. doi:10.1111/jgs.13866

support of these processes	• Engage older populations, including those with complex needs (e.g., multimorbidity, frailty, cognitive impairment) and care partners as co-creators, testers, and evaluators of AI tools. • Create regulatory quality parameters for developers to apply when marketing a device to ensure transparency, trust, and awareness about the benefits and risks of the device. <u>Metrics for Evaluation</u> • Error rate reduction • User satisfaction • Match accuracy • Scheduling efficiency • Reach and usability
Where AI tools deployed in clinical care met, exceeded, or fell short of performance and cost expectations	<u>Areas for Improvement</u> • Accessibility and usability • Accuracy without omissions or hallucinations • Supporting prevention of clinician burnout • Enhancing patient-clinician communications
Administrative hurdles for health care organizations in the adoption of AI in clinical care	<u>Administrative Hurdles</u> • Determination of the most appropriate AI tools to implement in a transparent manner involving frontline clinicians and the community in decision-making processes. • Regular and frequent access to clinical informatics teams or users who are familiar with AI use in clinical settings.
Where enhanced interoperability would widen market opportunities, fuel research, and accelerate the development of AI for clinical care	<u>Widen Market Opportunities</u> • Pilot dual-licensing strategies for AI tools and datasets that are open for non-commercial and academic use to support reproducibility. • Provisions for commercial use to support public benefit, such as reinvestment into communities or low-resource settings. ○ Support open science by default while allowing more restrictive licensing or data use when justified by privacy, national security, or competitiveness concerns. • Create partnerships and data- and model-sharing consortia via interagency initiatives or collaborations with the Department of Veterans Affairs (VA), the Food and Drug Administration (FDA), and other aging-related agencies as well as philanthropic organizations and state-level aging agencies to pilot AI on regulatory science, reimbursement pathways, and care delivery pilots across settings (e.g., home-based care, PACE, skilled nursing facilities) where older adults receive the bulk of their care. <u>Fuel Research</u> • Develop model repositories (akin to the National Institutes of Health (NIH) Bridge2AI) that include metadata on population characteristics, social determinants variables, bias assessments, and intended use.

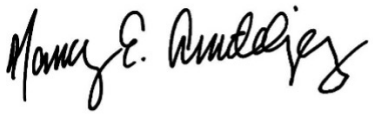
	• Support cross-institution human factors research in AI that emphasizes interface usability for aging clinicians and patients, shared decision-making integration, explanation clarity, and communication of uncertainty. • Encourage use of data sheets for datasets and model cards for all AI tools proposed for aging research with emphasis on generalizability, limitations, and ethical considerations. • Advance lifelong learning agents that adapt to evolving patient data and generate aging-specific insights across datasets.
Challenges and concerns of patients and caregivers related to the adoption and use of AI in clinical care	<u>Concerns of Privacy, Safety, and Use of Data Without Clear Consent</u> • Implement safeguards for vulnerable frail older adults, especially those with cognitive impairment and whose first language is not English. • Address historical mistrust, especially among underrepresented populations. • Encourage support of AI for care coordination and caregiver engagement. ○ Development and evaluation of tools that assist with transitions of care, caregiver support, and advance care planning in older adults.
Specific areas of AI research that HHS should prioritize to accelerate the adoption of AI as part of clinical care	<u>Research Areas to Prioritize</u> • Curated, longitudinal aging studies with linked clinical and functional outcomes to enable training and validation of generalizable models. • Preclinical-to-clinical pipelines specific to aging interventions, including tools for assessing functional outcomes, quality of life, and caregiver burden as core AI endpoints. • Whole-person-focused studies of age-related chronic diseases, such as diabetes, heart disease, and cancer that continue to afflict 80 percent of people who are 65 and older.[11] • Replication studies that independently validate AI models in different health systems and among diverse aging subpopulations such as those living in rural areas, who are cognitively impaired, or with limited function. • Benchmark studies for aging-related conditions (e.g., frailty, dementia, falls) with pre-defined tasks and metrics for fair comparison across models.

Thank you for your consideration of our recommendations. If you have comments or questions, please contact Anna Kim, Senior Manager of Public Affairs & Advocacy, at 212-308-1414 or akim@americangeriatrics.org.

Sincerely,



Paul Mulhausen, MD
President



Nancy E. Lundebjerg, MPA
Chief Executive Officer

[11] National Prevention Council. Healthy Aging in Action: Advancing the National Prevention Strategy. November 2016. Accessed February 17, 2026. https://www.hhs.gov/sites/default/files/healthy-aging-in-action-final.pdf