REMOTE MONITORING LEADERSHIP COUNCIL

April 10, 2025

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

RE: 2025 Call to Action on the Future of Remote Physiologic Monitoring

Dear Administrator Oz;

The Trump Administration took decisive action to expand Medicare access to Remote Physiologic Monitoring (RPM) in 2019, laying the groundwork for technology-enabled chronic disease management and transforming how care is delivered to seniors. This action is delivering results – RPM is improving health outcomes while reducing costly hospitalizations, saving money for federal taxpayers. **We hope you will build on the first Administration's progress by ensuring accurate reimbursement for the technologies delivering meaningful results for both patients and taxpayers. At the same time, we urge you to raise the bar for RPM, and take steps to eliminate fraud, waste, and abuse.**

Access to real-time data and virtual visits empowers seniors – especially those in rural areas – to take accountability for their health and make lasting lifestyle changes in partnership with their clinicians. Patients appreciate building knowledge and self-management capability through the use of RPM tools.

The Remote Monitoring Leadership Council

We write you today as the newly-formed, Remote Monitoring Leadership Council. We are a collaborative of five innovative companies operating across all 50 states and collectively offering a significant percentage of all remote monitoring and care management services being delivered to Medicare beneficiaries. In addition to advancing patient access to these important tools, we have agreed to promote best practices and standards for the delivery of RPM services. We look forward to working with CMS to ensure the RPM services reimbursed by all payers deliver the strong patient outcomes and documented cost savings that our high-quality RPM services have consistently delivered.

The Data is in – RPM Works & Saves Money for Taxpayers

Since 2019, RPM has shown strong clinical outcomes for many Medicare beneficiaries in need of interventions to prevent unnecessary and costly emergency department and hospitalization episodes. Patients, practitioners, and health payers see the value in broad adoption of these services. For example, RPM has resulted in sustained blood pressure improvements that increase in magnitude over time. The impact of RPM extends beyond patient health, generating measurable cost savings while improving proactive, preventative care.

A published, peer-reviewed, analysis of a Medicare RPM program demonstrated significant improvement in clinical outcomes alongside substantial cost savings in the form of reduced hospital and post- hospital discharge spending. For heart failure patients, RPM plus medication optimization led to three times more

patients taking guideline-directed medical therapy and resulted in monthly savings on average of over $1,000 per patient.

Similarly, The cost savings of high-quality RPM extend well beyond the heart failure population. One of our members recently completed a cost and utilization analysis, which included 5,872 patients enrolled in an RPM program compared against 11,449 patients in propensity-score matched control group, demonstrating annual total savings of $1,308 per patient across three chronic disease programs (heart failure, hypertension, and type 2 diabetes). Cost savings were primarily driven by a 27% reduction in hospital admissions – specifically, reductions in hospitalizations for heart failure and stroke.

Moreover, longitudinal, consistent monitoring of patients may help identify novel risk factors—such as daily blood pressure variability, medication interactions, or subtle patterns in symptom reporting—that can be used to predict health deterioration before it occurs. This adds an important predictive dimension to RPM's role in early intervention and care optimization. One study found that greater adherence to self-measurement led to greater reductions in blood pressure.

A RPM program at Geisinger health system demonstrated, hypertension control and reduced hospitalizations through RPM, as well as greater access to pharmacists and blood pressure medication management leading to $216 per member per month savings.

A study of patients in the US Military Health System found that when a remote care program including RPM is present, there are facility-level cost savings and also benefits to the inpatient cohort not enrolled in the program. The analysis showed that, with the program, there was a 12% lower length of stay averaged across all patients, saving the U.S. $2,047 per patient without affecting clinical outcomes.

Realities of Providing RPM

The biometric data collected through RPM must be appropriately filtered so that practitioners and the health system can make sense of it. Data systems must be built to capture and interpret data, generate reports, send alerts, and transmit data to appropriate electronic health records (EHR) and partners – which can be an expensive and challenging task. Support staff must be available to troubleshoot device and software issues for patients, as well as engage patients and encourage data submission.

Challenges also result from the inherent complexity of the patients themselves, emerging from complex conditions in the post-acute space or a senior at home managing multiple chronic conditions concurrently. A remote monitoring provider who has taken responsibility for a patient's chronic condition becomes the de facto manager of all of that patient's urgent and chronic conditions, as we have a responsibility to track and respond to any material change in vital readings that we see. This means that we often go above and beyond in serving patients who are experiencing symptoms of a condition that is different from than the one we are explicitly monitoring.

RPM is a low margin service and increasingly difficult to deploy as the reimbursement environment has become more challenging. The investment required to provide these services is the same across geographic areas even though RPM reimbursement is discounted in rural areas because it theoretically (though not in reality) costs less to deliver care in rural areas.

In addition, Medicare cuts unrelated to the performance or value of RPM services have continued – ranging from 7% up to a staggering 33% since 2019 despite the increasing costs of devices and labor required to deliver RPM. Further decreases in reimbursement will hamper access for patients, especially those living in rural communities whose distant care providers benefit the most from technology-enhanced care and who already are disadvantaged by the geographic adjustment factor.

RPM Council Ask of CMS

As you look at modernizing Medicare, by leveraging technology, we request that you consider our recommendations for how to ensure RPM continues to serve Medicare beneficiaries.

We believe CMS should modernize the way it reimburses to:

- Include the necessary capabilities of a top-tier RPM program – such as capturing costs related to the software and technology required to delivery these services at scale.
- Account for average patient complexity, including presence of co-morbid conditions that are better managed when a patient receives RPM.
- Adopt reasonable guardrails to ensure patients are receiving a high-quality RPM services and the Medicare program sees the cost-savings that we know they generate.

Specific Opportunities to Modernize RPM Reimbursement

CMS should modernize 99454 inputs to better reflect the real-world usage of RPM technologies

There are a several reasons why reimbursement for 99454 does not accurately capture the costs of providing high-quality RPM services. While some may have envisioned RPM as requiring no more than a simple device that captures data, the delivery of an effective RPM program today is far more complex and has different costs (and has been subject to significant increases in device costs). We urge CMS to update its valuation process to more accurately incorporate costs associated with modern-day technologies used to deliver high-quality RPM under 99454.

- CMS needs to account for software costs related to RPM. Given how crucial data integrations are to enabling effective care management through RPM, CMS should recognize and capture the significant software costs and resources expended on platform interoperability and maintenance by software engineers and data experts.
- CMS needs to include the full costs of cellular-enabled medical devices in its calculations, including per-patient cellular fees per device; per-device SIM cards; and replacement parts and/or devices.
- CMS should capture clinical staff time required to transform and deliver patient vitals, including non-clinical data review, report generation, and ongoing patient support related to devices.

CMS should adopt payment for 10-19 minutes of RPM treatment management services

CMS should adopt payment for 10-19 minutes of treatment management services, better reflecting the true costs of delivering these services. Greater flexibility in the time-based reimbursement window better reflects the reality that the practitioner time required for effective treatment management services varies significantly based on acuity, number of conditions, and other patient needs. Allowing shorter increments of time helps to better manage and reimburse RPM when it is working most effectively. There are many situations in which a well-managed patient speaks to a practitioner about their care plan, but does not require a longer care management visit. These situations still require clinical time and attention, and the costs to deliver this care is not zero.

CMS should increase the valuation of the RPM treatment management codes (99457 & 99458) to reflect patient complexity

We urge CMS to make an upward valuation and payment adjustment for RPM treatment management services that mirrors the adjustment previously made for chronic care management services in 2022. The AMA noted several years prior to the increase in valuation for chronic care management services that RPM "services required the same physician work and similar time to perform [as chronic care management services], and are appropriately valued the same." This change would reflect the highly complex nature of the average RPM patient and the impossibility of managing one condition without also managing concurrent conditions. It is very common for patients who need RPM to have co-morbidities. As noted above, an RPM provider who has taken responsibility for monitoring a patient's chronic condition becomes the de facto manager of all of that patient's urgent and chronic conditions. This creates additional

complexity and burden on the clinical staff supporting RPM and justifies our recommendation that RPM services receive the same upward valuation change as chronic care management services.

CMS should adopt a payment pathway for less than 16 days of data collection via RPM, where it is supported by the clinical literature

While we recognize that more patient data is typically better, there are some conditions and situations for which fewer than 16 data points can be clinically significant, as demonstrated by the clinical literature. Evidence demonstrates that patients can still achieve highly statistically significant and clinically meaningful improvements even when transmitting data fewer than 16 days per 30-day period. **P**atients who submit more frequent data saw greater improvements in their health due to higher engagement. Patient engagement through regular check-ins from the clinical team ensures that they remain committed to their care plans. We urge CMS to adopt new coding to capture situations in which less than 16 days of data is appropriately captured for patient care.

CMMI should explore models that remove cost-sharing barriers to RPM to enable chronic disease management

Cost-sharing requirements can be a significant barrier to patient participation in care management programs like RPM. Even when relatively low, a monthly cost adds up to create a significant disincentive for a senior with complex medical conditions, on a fixed budget, to participate in a remote monitoring program. As demonstrated above, these programs are generally a good investment for the federal government – particularly for highly vulnerable populations with multiple chronic conditions and a risk of hospitalization/readmission. We encourage CMS and the Centers for Medicare and Medicaid Innovation to explore the development of models that encourage the adoption of high-value remote monitoring services through the waiver of Medicare Part B cost-sharing requirements.

Raise the Bar for RPM and Eliminate Fraud, Waste, and Abuse

As leaders in the world of remote monitoring, are working to elevate our industry. Below, we outline several concrete policy steps that we believe could be advanced alongside policy changes that expand access to RPM.

OIG Report

The HHS Office of the Inspector General (OIG) issued a report last year with several recommendations on RPM. We respect the role of the OIG, but there are some aspects of the report that belie a fundamental misunderstanding of how RPM is delivered. We believe industry expertise is needed prior to the implementation of any of these recommendations to ensure that real-world experience is incorporated into policy development. For any new service, such as RPM, there are contextual guardrails that need to be added. We have provided below a list of best practices we believe addresses realities on the ground, and further matures the RPM industry.

The OIG raised a concern about whether RPM services are being used properly based on the observation that some RPM enrollees did not receive certain component services, such as education and setup on the device and treatment management. There are specific scenarios where it is entirely appropriate and consistent with CMS guidance to bill one component service without the others. For example, there are several situations where a patient may not appear to receive treatment management services as part of their RPM service. One scenario is where a patient who is responding well to treatment does not require a full 20 minutes of treatment management each month, such that reimbursement cannot be sought. CMS action to ensure treatment management services can be billed for less than 20 minutes would help to differentiate these legitimate treatment management situations from those where a provider is not offering appropriate patient care. A second scenario is one where the patient is utilizing RPM but is also participating in another care management program where a different code is billed for the care provided to avoid double billing,

consistent with CMS requirements. Scenarios like these must be taken into account as part of any oversight effort

Therefore, given our collective experience, we recommend a set of best practices that we encourage CMS to adopt to ensure high-quality delivery. We request the opportunity to work with you to further develop best practices that better address concerns and promote high quality RPM services.

Recommendations for Best Practices:

- RPM programs should strengthen continuity of care through a capability for timely and proactive outreach to the patient in response to reported biometrics and, as appropriate, alerts to the qualified healthcare practitioner.
- RPM programs should ensure all data is available to the clinical care team by sending it to the EHR of the qualified healthcare provider in a timely manner.
- RPM programs should create opportunities for patient empowerment and greater patient ownership of the care plan through knowledge of their vitals data.
- RPM services should only be provided with purposeful patient inclusion and exclusion criteria to ensure the program is appropriate for that patient's condition(s).
- RPM programs should take appropriate steps to protect patient data, without creating barriers to patient access.
- In addition to device setup, RPM programs should provide ongoing technical support for patients to ensure devices continued to be used appropriately.

Conclusion

Thank you for your consideration of these requests. We believe this proposal fits within the Trump Administration's laudable focus on addressing the ever-growing challenge of chronic disease across the United States. Beyond improving patient health, RPM drives measurable cost savings by enabling proactive, preventative care that reduces hospitalizations and enhances chronic disease management. It keeps older Americans out of hospitals, reducing the burden on the system. RPM also helps close equity gaps in care by supporting patients who face barriers related to geography, socioeconomic status, mobility limitations, disability, or a lack of reliable transportation – ensuring more Americans can access consistent, high-quality care regardless of circumstance. Importantly, we risk losing progress from the first Trump Administration in this space. **If decreasing RPM reimbursement causes providers to stop offering this care, total healthcare costs will go up, not down, and sick patients will remain sick.**

We appreciate your time and consideration and respectfully request a joint meeting to discuss these critical issues with CMS leadership. Please contact Chris Adamec at cadamec@sironastrategies.com with any questions about this letter or to schedule a meeting with the members of the Remote Monitoring Leadership Council.

Respectfully,

Remote Monitoring Leadership Council