



Statement for the Record:
"Health at Your Fingertips: Harnessing the Power of Digital Health Data"

U.S. House of Representatives
Committee on Ways and Means, Subcommittee on Health

Remote Monitoring Leadership Council
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The [Remote Monitoring Leadership Council](#) appreciates the opportunity to submit testimony for this hearing on digital health data. We are a collaborative of seven innovative companies operating across all 50 states and collectively offering the majority of remote patient monitoring (RPM) services being delivered to Americans. In addition to advancing patient access to these important tools, we promote [best practices and standards](#) for the delivery of RPM services.

RPM involves the collection and analysis of patient physiologic data that are used to manage and adjust treatment plans, inside and outside the hospital or provider office. RPM is used to treat patients with chronic and acute health conditions in short or long-term episodes. The RPM process begins with an initial set up and patient education on the use of equipment. Next, data are collected from the repeated monitoring of the device. After the data collection period, physicians or other qualified health care professional analyze and interpret a patient's remotely collected physiologic data to inform the development of a treatment plan.

Background

RPM is a flagship example of "Harnessing the Power of Digital Health Data." By transmitting physiologic data from a patient's home to a care team in near real time, RPM gives clinicians the actionable insights they need to intervene early, adjust treatment plans promptly, and prevent avoidable hospitalizations. RPM supports both chronic and acute conditions across short- and long-term episodes of care, and is also used in inpatient settings to assist with caring for patients in the hospital. The workflow is straightforward:

1. Onboarding and education. Patients receive connected devices (e.g., blood-pressure cuffs, glucose meters, pulse oximeters) and training on their proper use.
2. Ongoing data capture. Devices automatically transmit readings, often multiple times per day, to a secure platform synced with the patient's electronic medical record.
3. Clinical review and action. Physicians or other qualified clinicians interpret the incoming data, identify trends, and modify therapy or outreach in real time, whether the patient is at home or recently discharged from the hospital.

RPM differs from a daily wearable device. The difference lies primarily in purpose, clinical integration and regulatory framework. Wearables generate data that may not be reviewed by a clinician or integrated into clinical workflows. RPM is designed for monitoring patients with chronic or acute conditions. Data from RPM is used so that providers can create proactive, tailored care plans for patients.

In short, RPM shifts care from sporadic, reactive visits to an always-on, technology-enabled model that lowers costs, improves outcomes and empowers patients.

RPM Achieves Dual Goals of Improved Patient Outcomes and Savings for Taxpayers

The first Trump Administration took decisive action to expand Medicare beneficiary access to RPM in 2019, laying the groundwork for technology-enabled chronic disease management and transforming how care is delivered to seniors. Since 2019, RPM has shown strong clinical outcomes, and prevented unnecessary and costly emergency department and hospitalization episodes.

Patients, practitioners, and health payers see the value in broad adoption of these services. RPM has produced unprecedented clinical outcomes, including sustained [blood pressure improvements](#) that increase in magnitude over time. A study on 79,672 fee-for-service beneficiaries (16,339 RPM vs 63,333 matched control) showed RPM use was associated with a 44% lower hazard of all-cause mortality. The impact of RPM extends beyond patient health, generating measurable cost savings while improving proactive, preventative care. RPM is [saving lives](#).

A peer-reviewed analysis of an RPM program for heart failure patients showed that 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](#). Meanwhile, a hospital-based study of patients in the [US Military Health System](#) found that when a remote care program including RPM is deployed, there is a significant decrease in the average length of stay and savings of \$2,047 per patient while maintaining clinical outcomes.

RPM Empowers Patient Access to Their Own Health Data

RPM, as defined by the Centers for Medicare and Medicaid Services (CMS), involves the collection and analysis of patient physiologic data that are used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition. Since 2020, 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. RPM has produced unprecedented clinical outcomes, including 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. RPM is [saving lives](#).

The biometric data collected through RPM requires clinical and technical expertise to make sense of for practitioners and the health system. 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, engage patients and encourage data submission, and provide other sorts of assistance. 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.

Typical patients utilizing RPM are usually either facing 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 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 different condition than the one we are explicitly monitoring for.

Data integrations are crucial to enabling effective care management through RPM. Rather than relying on periodic, arbitrary check-ins, RPM creates continuity of care through an ongoing line of communication that enables timely discussions and proactive outreach. Clinical staff providing high-quality RPM don't wait to find out about a sudden blood sugar spike or weight gain—they see it and reach out to the patient and, as appropriate, the qualified health care practitioner. RPM also helps identify inconsistent medication adherence, driving timely, data-informed decisions that improve outcomes. Patients often report a greater sense of security and a stronger bond with their clinical care team, who has a stronger connection to their well-being, as a result of this remote connection.

Data captured by RPM should create opportunities for both care teams and patients to monitor vitals and use this information to support the care plan. Patients often report increased self-efficacy as they gain metacognitive feedback from seeing their data trends over time and understanding how medication adherence and lifestyle choices impact their health – an embodiment of the Make America Healthy Again goals. All RPM should include appropriate use of clinical staff to support continuity of care and ensure ongoing patient engagement. These clinicians serve as health care liaisons to build patient knowledge and self-management capability, which has been consistently shown to improve clinical outcomes.

Raising the Bar for High-Quality RPM

As leaders in the world of remote monitoring, the Remote Monitoring Leadership Council is committed to the integrity of patient care using remote monitoring capabilities. We support ongoing and expanded efforts to ensure that the Medicare program (and the RPM industry as a whole) is not harmed by occasional practitioners providing suboptimal care.

We follow all CMS and American Medical Association guidance for appropriate billing, we only offer RPM where it is appropriate for specific patient conditions, we are highly responsive to patient and qualified healthcare practitioner needs, and we enact strong protocols to protect patient data.

On top of adhering to [principles](#), we recommend the following best practices to ensuring patients receive only high-quality RPM.

- 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 health care practitioner.
- RPM programs should ensure all data is available to the clinical care team by sending 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 it 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.

Ensuring a Future Where Patients Are Able to Access High-Quality RPM

The current Medicare fee-for-service payment structure does not accurately capture the costs of providing high-quality RPM services with robust data capabilities. 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.

RPM is a low margin service and increasingly difficult to deploy as the reimbursement environment has become more challenges. 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 (not in reality) costs less to deliver care in rural areas.

In addition, Medicare cuts unrelated to the performance of the RPM codes have continued -- ranging from 7% up to a staggering 33% since the 2020 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.

For small providers, this has an even larger impact. Small practices, especially those in rural or underserved areas, often operate on tight budgets. It becomes challenging to absorb the costs associated with providing high-quality RPM. Effective RPM today requires advanced data capabilities, dedicated clinical staff, ongoing patient engagement, and substantial infrastructure—all of which demand considerable investment. As a result, patients served by smaller practices may miss out on access to RPM services because smaller providers may scale back or even eliminate the use of RPM services.

Additionally, leaders in the RPM space are moving toward models that leverage AI to fully realize the potential of the detailed patient data captured through RPM. AI is helping to detect conditions sooner, to lessen the paperwork/documentation burden on clinicians, and streamline the delivery of care. Actions from CMS to specifically support data and technology costs are crucial to unlocking the potential of advanced data capabilities like artificial intelligence alongside RPM.

The RMLC has encouraged CMS to modernize RPM coding to enable this digital health data revolution and we would welcome your support for this as it aligns with the committees' priorities. We appreciate the leadership of Representative David Kustoff in introducing the [Rural Patient Monitoring \(RPM\) Access Act \(H.R. 3108\)](#), which takes an important step to ensure rural seniors are not left out of this life-saving health data innovation. Additionally, we appreciate Chairman Jason Smith's support, who has [emphasized](#) that RPM helps providers coordinate quality care across different health settings.

As Medicare leverages technology-enabled care, its payment structure should modernize the way it reimburses to:



- Include the necessary capabilities of a top-tier 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 service and the Medicare program sees the cost-savings that we know RPM generates.

Thank you for considering our comments. We look forward to working with the Committee and welcome the opportunity to provide further feedback on how patients are empowered to their own health care through digital health data collected by RPM. Please reach out to Krista Drobac (kdrobac@sironastrategies.com) with any additional questions.

Respectfully,

Remote Monitoring Leadership Council