



January 26, 2026

*Submitted via regulations.gov*

The Honorable Mehmet Oz  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244

***Re: Request for Information on Future Directions in Medicare Advantage (CMS-4212-P)***

Dear Administrator Oz,

The [Remote Monitoring Leadership Council](#) (the Council) welcomes the opportunity to provide feedback on the Centers for Medicare & Medicaid Services (CMS) request for information on the future directions of Medicare Advantage program. Remote physiologic monitoring (RPM) is improving health outcomes while reducing costly hospitalizations, saving money for federal taxpayers by detecting deterioration early and enabling timely clinical intervention. RPM has been shown to improve patient outcomes and contain the cost of care, two priorities of the MA program.

The Council is a collaborative of seven innovative companies operating across all 50 states and collectively offering a large percentage of all remote physiological monitoring (RPM) 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.

Since 2019, RPM has shown strong clinical outcomes for many Medicare beneficiaries in need of interventions to prevent unnecessary and costly emergency department (ED) and hospitalization episodes. Patients, practitioners, and health payers see the value in broad adoption of these services to revolutionize chronic care management. These services work best when closely integrated with the patients' existing provider and coordinated care team.

We are encouraged by CMS' [commitment](#) to embracing high-quality, evidence-based, patient-focused technology in the health care system. We believe that policies that facilitate RPM services have the potential to bring the MA program into the modern era of health care delivery and reimbursement.

In advance of our detailed response, the Council recommend the following to CMS, which would modernize the MA program to meet the technology-enabled care movement:

- CMS should clarify that provider-ordered RPM is a covered medical service in Medicare and issue guidance clarifying that MA plans must cover; and
- CMS should incentivize RPM utilization through the Stars program by:
  - o Updating data collection technical specifications to include RPM data collection
  - o Allow RPM-enabled care to qualify as follow-up
  - o Ensure monitoring counts towards coordinated care metrics.
- Design incentives to encourage MA plans to invest in care that yields multi-year financial benefits to the Medicare program.

**RPM in Medicare Advantage**



Patients use RPM technology to manage multiple chronic conditions or high-risk post-acute conditions without travelling to a health care provider. Already, older adults spend an [average of three weeks](#) every year on health care outside their homes. Additionally, many patients who utilize RPM live in areas with clinician shortages, lack a caregiver or transportation, are homebound due to their medical condition, or experience other barriers. RPM allows providers to monitor patients' conditions to proactively respond to a patient's status, leading to better health outcomes and better quality of life.

Federal law requires MA plans to provide all benefits available under Traditional Medicare. As such, an MA plan may not limit coverage that differentiates from Traditional Medicare coverage standards and service definitions. CMS' CY 2024 MA and Part D Final Rule amended federal law to ensure MA plans could not deny coverage for services covered by Part B, further binding MA plans to Traditional Medicare criteria. More specifically, RPM is codified in law as a Part B benefit for acute and chronic conditions; MA plans must cover it comparably to Traditional Medicare.

Though basic covered service parity between MA and Traditional Medicare is required in statute, the Council recommends that CMS reiterate its requirement for parity in RPM access between MA and traditional Medicare beneficiaries. Our members have anecdotally experienced MA plans attempting to restrict patient access to RPM services. This guidance will help ensure access to RPM services for tens of thousands of seniors and ensure services remain a robust offering in the MA program for beneficiaries that rely on market-driven innovation and supplemental benefits.

Similarly, CMS should prohibit MA plans from denying or redirecting clinician-ordered RPM solely to steer beneficiaries into a plan-preferred vendor arrangement. These changes can be disruptive to patient care and undermine the medical decision-making of the patient's clinical team. The Council believes that there is a need for appropriate guardrails to ensure patients are receiving high-quality RPM connected services, however policy guardrails should not be at the expense of a patient's health care status. These guardrails should also be aligned across MA and fee-for-service (FFS). We look forward to working with CMS on developing guardrails that uphold standards of excellence and bridge care gaps.

### **RPM in Stars Ratings**

The Council recommends CMS accelerate the adoption of effective provider-integrated RPM in MA using Star Ratings by recognizing remote data and workflows within current HEDIS, CAHPS, and care-coordination constructs.

*Update Technical Specifications* - CMS should work with NCQA and other measure stewards to modernize technical specifications so validated home-based physiologic data (captured via RPM) can satisfy measure requirements when clinically appropriate. For example, home blood pressure readings (when captured using validated devices, with minimum frequency requirements, timestamp rules, and [guardrails](#) against outliers) should be permitted to count toward blood pressure control measures when in-office readings are unavailable or insufficient. CMS has already recognized remote monitoring devices in the reporting of [MIPS measures](#). This change would reflect how care is increasingly delivered in practice, particularly for beneficiaries with mobility limitations, transportation barriers, or limited access to in-person visits. Allowing high-quality home data would improve completeness, reduce reliance on episodic office visits as the sole source of clinical information, and encourage plans and providers to adopt modern, patient-centered care models without sacrificing rigor or accountability.

*RPM as Follow-Up Care* - CMS should consider allowing RPM interactions to qualify as acceptable follow-up or care-gap closure activities for existing preventive and chronic care measures in the Star Rating program. Remote check-ins supported by continuous monitoring and defined clinician escalation pathways can trigger timely medication adjustments, prompt lab ordering and completion, and ensure post-discharge



follow-up occurs within clinically appropriate timeframes. These activities are already embedded in existing Stars measures; RPM allows them to occur earlier, more reliably, and with greater clinical context. Recognizing RPM-enabled follow-up would modernize the MA program by aligning quality measurement with proactive, longitudinal care rather than episodic, visit-based encounters, while still holding plans accountable for documented clinical action and outcomes.

*Care Coordination Enablement* - CMS should ensure that remote monitoring and timely tech-enabled response capabilities such as RPM, are fully captured in the raw score for CAHPS. RPM can improve MA beneficiaries' care experience by enabling faster responses to symptoms, reducing unanswered outreach, and providing clearer communication about next steps when clinical issues arise. Because CAHPS measures carry Star Ratings weight, improvements in perceived access, responsiveness, and coordination driven by RPM translate into stronger plan performance, reinforcing investments in care models that beneficiaries experience as more connected and reliable.

### **Advancing Technology-Enabled Care**

Facilitating and incentivizing the appropriate use of RPM equally in both FFS and MA directly advances CMS' modernization of care delivery via technology-enabled, person-centered models. RPM enables a shift from episodic, visit-based care to continuous, home-based monitoring that reflects how chronic disease is managed in real-world settings. By supporting longitudinal data collection and earlier clinical intervention, RPM allows plans and providers to identify deterioration sooner and respond before conditions escalate into avoidable emergency department visits or hospitalizations.

*We encourage CMS to work on incentives to encourage MA plans to invest in care that yields multi-year financial benefits to the Medicare program.* These incentives are needed because cost-savings from RPM do not always materialize in the same calendar year but do materialize for the Medicare program and taxpayers more broadly. By enabling earlier intervention, improved follow-up, and better chronic disease control, RPM helps plans manage total cost of care and reduce preventable utilization, aligning with the objectives of the MA program.

We look forward to continuing discussion on how the MA program can fully embrace technology-enabled care like RPM services to ensure patients, providers, and plans have access to the most effective care management tools possible. Please reach out to Rikki Cheung ([rcheung@rpmleadershipcouncil.org](mailto:rcheung@rpmleadershipcouncil.org)) with any additional questions.

Respectfully,

Remote Monitoring Leadership Council