



March 6, 2026

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: Driving Innovation and Outcomes through RPM

Dear Administrator Oz:

We applaud the Administration for its policies to empower patient access through technology-enabled care, such as remote physiologic monitoring (RPM). The Trump Administration continues to lay the groundwork for technology-enabled chronic disease management and transforming how care is delivered to seniors. We hope you build on the last rulemaking cycle's progress by ensuring accurate reimbursement for technologies that deliver real and meaningful results for both patients and taxpayers. At the same time, we urge you to work with us to raise the bar for RPM, and take steps to eliminate fraud, waste, and abuse.

The Remote Monitoring Leadership Council ("the Council") is a collaborative of innovative companies operating across all 50 states and collectively offering a large percentage of all RPM and care management services 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 Trump Administration took decisive action to expand Medicare access to RPM in 2019, laying the groundwork for technology-enabled chronic disease management and transforming how care is delivered to seniors. The Council generally applauds the Administration for its commitment to modernizing the current fee-for-service structure to better reflect the fast pace of digital health technologies, such as RPM.

As reflected in the comments below, the Council:

- Applauds CMS for its RPM policies in the 2026 rulemaking cycle and urges CMS to build on this momentum to create a vision for a stable, longer-term modernized valuation methodology for device codes.
- Urges CMS to work with stakeholders on a path to reflect the complexity of patients with multiple comorbidities using RPM.
- Calls on CMS to continue shaping quality RPM services a by issuing best practices and further guidance on billing to ensure the best use of taxpayer dollars.
- Encourages CMS to ensure that 1) coverage of RPM is consistent across both fee-for-service and Medicare Advantage (MA) and 2) reflects the best outcome beneficiaries and taxpayers. Accordingly, we call on CMS to incentivize MA plans to invest in care (like RPM) that yields multi-year financial benefits to the Medicare program.

RPM Improves Seniors' Care Management and Saves Money for Taxpayers

As you know, 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. 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. 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.

Patients, practitioners, and health payers see the value in broad adoption of these services to revolutionize chronic care management. RPM programs are accessible to a wide swath of Americans, creating access for rural seniors with devices that do not require patients to have or use personal technology, such as home computers or telephones.

The Council also notes that our patient population is generally very ill and requires intense clinical care. While we are enthusiastic about the growth of wearable devices for Americans, these wellness tools are very different from the services we provide. RPM uses a highly accurate FDA-approved device to monitor patients with chronic or acute conditions while providing ongoing clinical support. Data from RPM is used so that providers can create proactive, tailored care plans for patients. At this time, wearables generate data that may not be reviewed by a clinician or integrated into clinical workflows and may not appropriately serve patients with life-threatening conditions that require FDA-approved, clinician connected devices.

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:

RPM has resulted in sustained [blood pressure improvements](#) that increase in magnitude over time. [Analyses](#) of RPM programs for blood pressure management found a 49% reduction in inpatient admissions over 12 months compared to a cohort receiving usual care. A study of patients in the [US Military Health System](#) also found that, through its RPM 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. Another study similarly [showed](#) that RPM use in hypertension and diabetes patients led to a \$12,036 annual cost reduction per patient (30.6%), primarily due to fewer inpatient and ED visits. The impact of RPM results from beyond patient health, generating measurable cost savings while improving proactive and preventive care for chronic conditions.

A [systematic review](#) of economic evaluations of monitoring techniques found that, for 60% of studies "at-home blood pressure monitoring was found to be more cost-effective than monitoring in a clinical setting," further supporting the net-positive health economics of the technology. An [economic evaluation of NYU Landgone's cardiology RPM program](#) showed a 22% positive return on investment (ROI), even using Medicare rates, further demonstrating that these tools are indispensable to modern, comprehensive hypertension management for a health system. 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, demonstrated [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 for heart failure and stroke.

Most importantly, the true value of RPM comes from patient engagement, recentring care around the patient. A 2025 retrospective clinical outcomes analysis showed that RPM hypertension programs can help rural seniors [reduce their blood pressure levels](#), empowering them to focus on their health goals. One [study](#) found that greater adherence to self-measurement led to greater reductions in blood pressure. Another [study](#) showed that participation in RPM programs was correlated with greater improvements in the patient's mean arterial pressure. Another [showed](#) a correlation between higher RPM engagement and increased blood pressure reduction across over 20,000 hypertensive adults.

Sustained patient engagement can lead to better health outcomes for patients with chronic diseases, necessitating sustainable ways to pay for this technology. 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, a [RPM program at Geisinger health system](#) found its program created greater access to pharmacists and blood pressure medication management leading to \$216 per member per month savings.

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. When the University of Michigan enrolled patients with a [high risk of rehospitalization](#) due to COVID-19, congestive heart failure and uncontrolled hypertension hospitalization among these patients dropped by 59% due to early detection. Today, the program enrolls patients with other cardiac conditions, liver cirrhosis, sepsis, diabetes, chronic lung disease and some cancers.

Please find below specific comments in response to proposals in the CY 2027 PFS. We look forward to meeting with you to discuss these items more in detail, as needed.

Consider Longer-Term Reforms to Medicare Fee-for-Service Structure to Reflect Modern Technology

The Council applauds CMS for its short-term path on 99454 practice expense calculation, which ensures continued access to RPM. As mentioned in our previous comments, RPM is a low margin service and has become 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 is based on assumption (though not in reality) that it costs less to deliver care in rural areas.

As we have written in depth previously, there are several reasons why reimbursement for RPM device codes do not accurately capture the costs of providing these services. 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). Providing this care for seniors at home managing multiple chronic conditions has software and technology costs, support staff costs, clinical interoperability costs, broadband costs and other costs related to capabilities that drive the highest patient outcomes.

Critically, the current reimbursement structure does not adequately account for the clinical software infrastructure that underlies high-quality RPM delivery. Unlike traditional physician services, RPM involves substantial ongoing investment in platforms that capture, transmit, analyze, and present physiologic data to care teams and patients. These software costs are the mechanism through which clinical value is created. We urge CMS to develop a formal methodology for classifying modern clinical software resource costs as a distinct practice expense category for technology-enabled services. Without this foundational step, neither today's RPM services nor tomorrow's AI-enabled care will be adequately reimbursed for the true cost of delivery.

While we appreciate CMS for its attempt to update its valuation process to more accurately incorporate costs associated with modern-day technologies used to deliver high-quality RPM, we urge CMS not to lose sight of a more permanent rate setting methodology that truly reflects the value of technology-enabled care. As the health technology ecosystem develops, CMS, in collaboration with stakeholders, may need to develop a rate setting methodology that truly reflects the value of technology-enabled care. The Council offers what a modernized long-term approach could include:

- Shifting payment emphasis away from device-only components and toward clinical decision-making, care coordination, and longitudinal management.
- Reassessing time thresholds to reflect asynchronous review and team-based workflows (create a pathway for emerging AI triage tools, focusing attention of medical experts).
- Exploring bundled or episode-based RPM payment options in value-based arrangements.

We therefore call on CMS to create stability by maintaining the CY2026 OPPS payment rate for an additional period while it continues to engage with stakeholders and evaluates more accurate approaches to determining RPM device payment.

Finally, we appreciate CMS recognizing that RPM services did not belong within the new efficiency adjustment policy last year. The efficiency adjustment relies on visit-based, time-reduction models of physician work and is not a good fit for RPM's continuous, preventive, and data-drive care realities. We encourage you to maintain this important separation.

Offering RPM in Medically Complex Patient Care Teams

The Council urges CMS to consider an add-on code, and work with stakeholders, to reflect the complexity of patients with multiple comorbidities using RPM. RPM is a sustainable way to improve chronic care management. Sustained use of RPM has proven to continuously improve patient outcomes. Patients with multiple chronic conditions need to manage, not just one condition, but multiple concurrent conditions. It is very common for patients who need RPM to have comorbidities. 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.

We encourage CMS to view RPM not merely as a discrete service but as an extension of an episode of care. For some patients, it is clinically appropriate for two episodes of care requiring RPM to coexist. Currently, CMS prohibits multiple clinicians from billing RPM, which in practice means that the first clinician to initiate RPM effectively blocks other practitioners from utilizing these tools, regardless of clinical appropriateness. For example, under current practice, an endocrinologist may be unable to bill for RPM if the patient's cardiologist has already prescribed it. This approach does not reflect the realities of patient care, particularly as RPM becomes the standard of care for a growing number of conditions.

The Council kindly requests that CMS engage with stakeholders to develop policies that facilitate cross-specialty communication and documentation regarding when RPM has been initiated. Further, we encourage CMS to consider long-term solutions that better account for patients who may require multiple episodes of RPM concurrently, thereby ensuring access to high-quality, cost-saving care.

Build a Glide-Path for RPM to Outcomes-Based Payment

The Council shares CMS' goals for greater adoption of outcome-based payment and recognizes that the future of RPM as a service that drives downstream cost savings is closely linked to broader alternative

payment model (APM) adoption. This being said, we believe there are interim steps CMS could take to encourage adoption of APM while maintaining stability for existing RPM services.

Specifically, we suggest that CMS engage with stakeholders on the possibility of an add-on payment for RPM that is specifically tied to a clinical outcome. An outcome-based payment would begin RPM down the path towards paying for value without fully disrupting care for seniors currently receiving these services.

We believe strongly in the clinical efficacy of our care and welcome some initial steps to begin to tie reimbursement to clinical performance.

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

As leaders in the world of remote monitoring, we are working to elevate our industry. The Council promotes adoption of RMLC best practices to distinguish clinically robust RPM programs from low-touch or non-clinical offerings. We urge CMS to partner with stakeholders to establish clear guardrails and billing standards for RPM, providing certainty to compliant providers and vendors. 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 health care practitioner.
- RPM programs should ensure all data is available to the clinical care team by sending it to the electronic health record of the qualified health care 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). Similarly, the care plan documentation should articulate the goal of this monitoring, such as a post-acute period or longer-term chronic disease engagement. These treatment goals should be reflected by the services actually billed.
- 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 continue to be used appropriately.

Recommendations for Additional CMS Guidance

In addition to best practices, we believe specific CMS guidance is needed to 1) clarify the permissibility of certain actions that do not align with high-quality RPM services and 2) strengthen the foundations of RPM billing. Please find attached RMLC recommendations outlining specific practices we think CMS should clarify as nonperishable. More broadly, we recommend that CMS:

- Clarify ordering provider documentation requirements. CMS should direct the ordering provider to document the condition(s) monitored with appropriate ICD-10 codes and verify that the monitoring is appropriate for the documented condition(s) as part of the demonstration of medical necessity. This is a critical step to ensure RPM is used only when clinically indicated and to stop the enrollment of patients without an established clinical relationship or a condition appropriate for RPM.

- Reaffirm the interactive communication standard for 99457 and 99458. CMS should reaffirm that these codes require "interactive communication," which CMS has defined as a real-time synchronous, two-way audio interaction that is capable of being enhanced with video or other kinds of data transmission. Clarify that providers must separate and distinguish time to prevent double counting of time spent performing RPM versus other care management services such as chronic care management and reinforce existing guidance on the use of appropriate clinical staff for RPM. Clear reaffirmation of these standards will prevent dilution of the care management services these codes are intended to support.
- Strengthen device codes by clarifying that only a transmission of physiologic data captured by an FDA-cleared or approved medical device meets requirements for billing 99454. Clarify that providers must use auditable, accurate electronic time-tracking methodologies and should bill based on actual time spent delivering services.
- Work with stakeholders on a process to drive appropriate RPM duration rather than considering a blanket limit. Blanket duration limits on RPM services are insufficiently nuanced to account for variation in patient progress, outcomes, and comorbid conditions. Many patients with complex chronic conditions derive sustained clinical and cost-saving benefit from RPM well beyond an arbitrary cutoff. At the same time, we recognize that RPM should not continue indefinitely without clinical justification. We therefore recommend that CMS require providers not enrolled in risk-based models to re-evaluate and document medical necessity for a patient's continued use of RPM on an annual basis. This approach preserves the clinical judgment of the ordering provider while creating a meaningful accountability mechanism.

The Council recommends CMS deploy targeted oversight capabilities rather than blunt coverage restrictions. The Council has [identified common characteristics](#) associated with fraudulent or low-quality RPM billing. CMS could incorporate these indicators into program integrity monitoring tools to proactively identify aberrant billing before it generates unnecessary spending or harms beneficiaries, including flagging anomalous utilization patterns in near real-time, differentiating high-quality RPM programs from those lacking clinician involvement, intervening earlier, before inappropriate billing results in unnecessary spending or beneficiary harm.

Ensure Equal Access for Medicare Beneficiaries Across MA and Traditional FFS

We commend the Administration's comment to enable technology-enabled care to support Medicare beneficiaries and provide them more options for achieving their health goals. Despite this support, we continue to remain concerned about seniors' continued access to RPM services in the MA program, given recent development threatening that access. Ensuring parity in RPM coverage is both a legal imperative and a patient care imperative. Any attempts to eliminate coverage will reverse measurable gains in chronic disease control and increase costs for both beneficiaries and the Medicare program writ large. Variation between FFS and MA coverage will also create significant challenges for CMS, as Medicare patients will not understand why their health plan deviates from policies clearly stated on the Medicare.gov website.

As outlined in our [shared commitment](#), the Council commits to providing RPM services that delivers measurable value and clinical excellence. Additionally, we ensure that we are providing the level of RPM services [consistent](#) with both the [2020](#) hypertension policy statement and [2025](#) guidelines from the American College of Cardiology/American Medical Association (ACC/AHA) Joint Committee, which recommended self-measured blood pressure monitoring supported by telehealth and team-based workflows as routine care.



As demonstrated above, RPM services drive significant savings for the American taxpayer. Unfortunately, these savings are not always realized within a single plan year. This makes the justification of these services difficult for MA plans, who have inadequate incentives to bend the cost curve across multiple plan years. As articulated in our MA comments earlier this year, *we call on 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 important not only for MA, but for broader access to these services across the entire Medicare program.

Without action to drive additional consideration for multi-year cost savings, there will remain a strong disincentive to cover many forms of RPM; specifically, those that change the trajectory of a chronic condition and demonstrate financial returns over time, rather than within a single plan year. RPM services have proven to lead to positive clinical outcomes and reduced cost of care for many patients. However, long-term ROI is often not acted upon by MA payers because of the incongruent timelines on which they measure cost of care and cost savings. RPM allows patients to monitor and manage chronic disease and prevent hospitalizations, which leads to a positive ROI for CMS and taxpayers.

We believe there is a path to work together to ensure Medicare covers high-quality, clinically effective RPM that drives cost outcomes for taxpayers. We believe that conversation should be had with CMS leadership, as a Medicare-wide policy discussion, not at the individual plan level. We look forward to working with CMS to improve program integrity within the FFS program and alignment in quality consistency across payers and drive savings for American taxpayers.

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 hospitalization 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.

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@rpmleadershipcouncil.org 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

Attachment 1

Remote Physiologic Monitoring (RPM)

Opportunities to reduce inappropriate billing in Medicare and ensure high-quality care delivery

As national leaders in remote patient monitoring (RPM), we have committed to a [shared set of principles](#) to ensure the delivery of high-quality, patient-centered care and to shape the future of our industry. Recognizing the critical role RPM plays in the future of health care, we endorsed these shared principles to define and uphold standards of excellence.

Building upon our efforts to uphold standards of excellence in RPM, we have collected a list of specific practices that we do not believe reflect the spirit or intent of the RPM CPT codes, or appropriate patient care.

99454 Data- Within billing for CPT 99454, we are aware of organizations that have misinterpreted what constitutes a data transmission by counting:

- a device status indication as a data reading.
- a ping to a cell tower.
- SMS interactions with a patient as a reading under 99454, even if no patient data is transmitted.
- a “null data point” as a reading (e.g., counting the absence of data as a data point - even if the patient did not transmit anything).

Recommendation: CMS should clarify that only a transmission of physiologic data captured by an FDA-cleared or approved medical device meets requirements for billing 99454.

99454 Relevance – Within billing for CPT 99454, we are aware of situations in which the monitoring is not clinically indicated or sufficiently directed by the provider. Such situations include:

- organizations tracking physiologic data unrelated to or not clinically indicated for the patient’s diagnosed medical condition. (e.g., a device does not support requirements for condition and there is no clear clinical indication for RPM).

Recommendation: CMS should direct the ordering provider to document the condition(s) being monitored with appropriate ICD-10 codes and the device that is relevant and appropriate for monitoring the condition(s) as part of the demonstration of medical necessity.

CPT 99457/8- Within billing for CPT 99457/8, we are aware of organizations that have adopted an inadequately rigorous tracking of time spent on care, such as:

- intentionally rounding the time (e.g., a provider meets 18 minutes for CPT 99457 but rounds up to 20 minutes).
- operationalizing potentially inflated assumptions for how long a service/condition may take to perform/treat and billing that time rather than documenting actual time spent (e.g., assuming review of vitals readings for a heart failure patient takes 3 minutes and billing as such rather tracking and billing actual time spent).

- double counting time spent providing RPM services alongside time spent providing chronic care management services.
- exploiting unclear definitions/understanding of roles that constitute clinical staff. This includes the inappropriate use of staff outside of the United States.
- tracking time that does not result in the occurrence of any clinically meaningful activity (e.g., staff counts time during which they were not documenting the patient's visit or counts time attempting to contact a patient they never spoke with).

Recommendations:

- *CMS should clarify that providers must use auditable, accurate electronic time tracking methodologies and should bill based on actual time spent delivering services.*
- *CMS should clarify that providers must separate and distinguish time to prevent double counting of time spent performing RPM versus other care management services such as chronic care management.*
- *CMS should reinforce existing guidance on the use of appropriate clinical staff for RPM.*
- *CMS should reaffirm that 99457 and 99458 require "interactive communication", which CMS has [defined as](#) "a real-time synchronous, two-way audio interaction that is capable of being enhanced with video or other kinds of data transmission."*

RPM plan of care – As the RMLC has previously communicated to CMS, we are aware of concerns around the appropriate clinical selection and duration for RPM services, including situations such as:

- organizations in which a vendor organization drives patient selection without appropriate provider direction and oversight.
- the delivery of RPM outside of a care plan that is regularly re-evaluated by the supervising clinician and patient based on progress. We believe RPM should exist as part of a plan of care with goals or benchmarks for the conditions upon which medical necessity should be re-evaluated.

Recommendation: CMS should require providers not enrolled in risk-based models to re-evaluate medical necessity for patients continued use of remote monitoring on an annual basis.