REMOTE MONITORING LEADERSHIP COUNCIL

August 26, 2026

Healthcare Advisory Committee
Centers for Medicare & Medicaid Services (CMS)
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Remote Monitoring Recommendations for Workgroup Consideration

Dear Members of the Healthcare Advisory Committee:

The Remote Monitoring Leadership Council (RMLC) shares the Committee's goals to promote initiatives focused on chronic disease prevention and management, accountability for patient health outcomes, improving the health of vulnerable populations, and multi-payer alignment. We urge the Committee to recognize the importance of remote monitoring in its recommendations to the agency on improving health outcomes for patients in federally administered healthcare insurance and payment programs.

We are therefore deeply concerned about CMS's calendar year (CY) 2027 remote monitoring proposals, which would reduce access to care for millions of Medicare beneficiaries, with particularly severe consequences for rural communities and patients served by small and independent practices.

The Remote Monitoring Leadership Council is a collaborative of companies operating across all 50 states and collectively offering a large percentage of all RPM and care management services delivered to Medicare beneficiaries. We have agreed to promote best practices and standards for the delivery of RPM services. We have offered CMS solutions to reduce inappropriate billing. Our shared objective is to ensure high-quality RPM services and address policy barriers to the evolution of this care. We support the creation of additional safeguards for remote monitoring.

Below, the RMLC offers specific recommendations for each of the workgroups to consider.

MAHA by Improving Wellness & Preventing Chronic Disease Working Group

RPM moves care from episodic counseling toward empowering Medicare beneficiaries to engage on their health. The highest-impact approaches to changing behavior combine personalized goals, accountability, and ongoing support. RPM reinforces these approaches by creating more appropriate touchpoints between beneficiaries and their care teams and providing objective data that can inform lifestyle changes.

Specifically, RPM paired with lifestyle coaching can help Medicare beneficiaries translate health data into achievable behavioral changes. Coaches, working alongside the clinical care team, can review trends, reinforce nutrition and physical activity goals, identify barriers to adherence, and escalate clinical concerns to the treating practitioner when appropriate. This combination of objective data and regular human engagement can make preventive recommendations more personalized, actionable, and effective than one-time counseling alone.

For the Medicare population, prevention must also extend beyond primary prevention. Many beneficiaries already have chronic conditions and therefore benefit from tertiary prevention, which focuses on preventing disease progression, reducing complications, and avoiding preventable emergency department visits and hospitalizations. For beneficiaries with hypertension, diabetes, heart failure, and other chronic conditions, remote monitoring can combine continuous measurement with lifestyle coaching, medication

management, and timely clinical intervention to help keep disease under control and preserve functional status.

As the Committee evaluates approaches to prevention, it should consider how RPM can create a more continuous model of care. RPM can help clinicians identify beneficiaries at elevated risk earlier, reinforce healthy behaviors over time, and provide more intensive support to beneficiaries with established disease who are at risk of costly complications.

Deploying Real-Time Data Working Group

The RMLC believes that delivering an effective RPM program today is far more complex, involves different costs, and has been subject to significant increases in device costs. Providing this care to seniors at home who are managing multiple chronic conditions involves software and technology costs, support staff costs, clinical interoperability costs, broadband costs, and other costs related to capabilities that drive the best patient outcomes.

The current fee-for-service 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 part of the infrastructure through which clinical value is created.

CMS should move away from payment policies that unnecessarily differentiate between clinically comparable in-person and virtual/remote services and instead place greater emphasis on outcomes, quality, and total cost of care. Giving accountable providers the flexibility to use RPM and other connected care tools can expand clinical capacity, improve access, and allow care teams to intervene earlier and more efficiently.

RPM gives providers timely, longitudinal health data between traditional encounters. Rather than waiting for a patient's condition to worsen enough to require an office visit, emergency department visit, or hospitalization, care teams can identify changes earlier, adjust treatment, reinforce medication and lifestyle goals, and target outreach to patients who need it most.

Fee-for-service payment misrepresents the value of health care because it rewards the volume of discrete services delivered rather than the long-term health outcomes and system-wide savings those services produce. An outcome-oriented approach would more accurately recognize the deflationary return on investment generated by technology-enabled care. Payment and quality measures should capture these downstream benefits rather than judging the technology, staffing arrangement, or care modality independently.

The goal should be a more flexible and accountable system in which RPM and other connected care tools are fully integrated into care delivery and providers are rewarded for outcomes rather than modality.

Improving Care for Vulnerable Populations Working Group

For rural communities, the value of remote monitoring infrastructure is the ability to identify deterioration earlier, manage chronic and high-risk conditions between visits, and reduce avoidable emergency department visits and hospitalizations. This technology helps improve outcomes while managing utilization and demonstrating the cost-effectiveness needed to sustain these models within broader Medicaid and federal financing constraints.

Forty-seven states have prioritized investments for remote monitoring in the Rural Health Transformation Program (RHTP). Of the first year funding, 22 states have announced or awarded about $240 million in RPM-specific funding. Similarly, 35 states have announced specific dollar figures for opportunities that may fund RPM, totaling over $2.4 billion. It is difficult to reconcile a historic federal investment encouraging states to build technology-enabled rural care infrastructure with a Medicare payment policy that would prohibit many of the partnerships needed to operate that infrastructure.

Most states plan to enable providers to use RPM for chronic disease management (hypertension, diabetes, heart failure, COPD) and/or maternal health, with many relying on vendor partnerships since most rural providers lack the capacity to build in-house programs. Specialized clinical and technology partners are often what make remote monitoring feasible for a rural hospital in the first place, providing devices, connectivity, data infrastructure, clinical staffing, escalation support, and technical expertise that a small rural provider could not economically reproduce on its own.

RHTP's long-term viability depends on integration into Medicare and Medicaid coverage, not solely reliance on grant or demonstration funding. States are using RHTP investments to build remote monitoring capacity because it allows scarce rural clinicians to manage patients between visits and reach patients who face geographic and transportation barriers. However, the value of those investments will ultimately depend on whether the broader payment environment supports their continued use.

In the Calendar Year (CY) 2027 Medicare physician fee schedule, CMS proposed changes to RPM that would significantly restrict the use of contracted clinical partners and make it harder for rural hospitals and physician practices to operate RPM programs. Those effects would be particularly acute in rural communities, where providers often do not have the workforce, capital, technology infrastructure, or patient volume necessary to bring these capabilities entirely in-house. If Medicare policy makes those partnerships financially or operationally unworkable, states could be investing RHTP dollars in building programs that providers are unable to sustain.

The implications extend beyond Medicare. Recent activity in the commercial and Medicare Advantage (MA) markets has raised concerns about the long-term stability of funding for these services. States are investing federal transformation dollars to build RPM infrastructure, but inconsistent and restrictive coverage policies across payers leave providers without a sustainable reimbursement pathway once that funding ends.

CMS should therefore create a stronger policy-alignment process across RHTP, Medicare, Medicaid, and the Innovation Center. Before finalizing major payment or delivery-system changes, CMS should assess whether those policies conflict with state transformation priorities or make federally supported investments less sustainable. This is particularly important for RHTP, where states are using time-limited federal funding to build infrastructure and delivery models that will ultimately need a viable reimbursement pathway to be sustained once program funding ends.

Strengthening Medicare Advantage Working Group

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 polices clearly stated on the Medicare.gov website.

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

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 for these services difficult for MA plans, which have inadequate incentives to bend the cost curve across multiple plan years. As articulated in our MA comments earlier this year, *we call on the Committee to recommend that CMS to work on incentives that 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 also for broader access to these services across the entire Medicare program.

Without action to drive additional consideration of 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 been shown to lead to positive clinical outcomes and reductions in the cost of care for many patients. However, long-term ROI is often not acted upon by MA payers because of the incongruent timelines over which they measure the 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 forward to ensure Medicare covers high-quality, clinically effective RPM that improves cost outcomes for taxpayers. We believe that conversation should be held with CMS leadership, as a Medicare-wide policy discussion, not at the individual plan level. We look forward to working with Committee to improve program integrity within the FFS program, improve alignment and quality consistency across payers, and drive savings for American taxpayers.

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Thank you for your consideration of these requests. Please feel free to reach out to cadamec@rpmleadershipcouncil.org for additional information and context.

Sincerely,

Remote Monitoring Leadership Council