Congress of the United States

Washington, DC 20515

October 2, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Oz:

We write regarding the proposed changes to remote monitoring in the Calendar Year 2027 Medicare Physician Fee Schedule proposed rule.

We share CMS's commitment to strengthening program integrity and saving taxpayer dollars. However, we are concerned the proposed policies 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 and hospitals.

We urge CMS to work with remote monitoring stakeholders to develop targeted safeguards that address fraud, waste, and abuse without disrupting clinically appropriate care.

According to HHS, nearly 1 million Medicare enrollees utilized remote monitoring services to manage their conditions in 2024.[1] Remote monitoring is especially important in rural communities – where 58 percent of beneficiaries live[2] -- to bridge care access. Beneficiaries often face long travel distances, transportation barriers, clinician shortages, and limited access to timely follow-up care. Remote monitoring allows clinicians to engage patients directly in their health, monitor health metrics in real time between visits, identify worsening conditions earlier, and intervene before a patient requires an emergency department visit or hospitalization.

Many rural, small, and independent practices, as well as both urban and rural health systems, rely on partners for remote monitoring. According to a National Association of Rural Health Clinics survey, nearly seventy percent of RHCs who reported offering RPM relied on specialized clinical and technology partners to make remote monitoring services available to their patients.[3] These arrangements help practices manage patient onboarding, device support, data review, alert management, documentation, and clinical escalation with full visibility and integration with the treating practitioner. Nearly all rural hospitals (98%) are already short staffed,[4] and rely on partners to bridge these care gaps through remote monitoring.

We deeply share CMS's interest in rooting out waste, fraud, and abuse in all forms. It is imperative to distinguish fraudulent arrangements and inappropriate behavior from legitimate, clinically necessary care. Indeed, CMS's source for greater oversight of remote monitoring services observed concerning patterns in less than 1 percent (0.68%) of practices that routinely bill for remote monitoring.[5] This indicates a need for sensible and targeted attention to the issue, not sweeping changes that will fundamentally disrupt care for one million seniors that currently receive remote monitoring.

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[1] https://oig.hhs.gov/documents/evaluation/10901/OEI-02-23-00261.pdf
[2] https://www.kff.org/medicare/key-facts-about-medicare-beneficiaries-in-rural-areas/
[3] https://www.narhc.org/images/narhc/NARHC-2027-MPFS-Comments.pdf
[4] https://csgsouth.org/policies/regional-resource-more-than-a-bandage-long-term-efforts-to-solve-the-rural-nursing-crisis/
[5] https://oig.hhs.gov/documents/evaluation/10901/OEI-02-23-00261.pdf

We recognize the benefit remote monitoring has on both improved patient health and health system savings. The Rural Patient Monitoring Access Act (H.R.3108) recently advanced from the Ways and Means Committee with unanimous support. Congress, states, and providers are working to expand technology-enabled care, strengthen the rural health workforce, modernize health information infrastructure, and support care in the home through the Rural Health Transformation Program. Remote monitoring is central to these rural health transformation efforts, and we are concerned that a blanket prohibition on partnering clinical staff could inadvertently disrupt the care delivery models that CMS and the states are working to build, and both small and rural practices and hospitals often lack the internal workforce to manage these programs entirely in-house. Only about half of the patients who need a check-up after leaving the hospital see a doctor within 30 days, despite the fact that a clinical interaction greatly lowers the risk of rehospitalization.[6] Restricting clinically integrated partnerships, which help to fill this gap through a remote monitoring and care team, would leave rural providers with fewer tools to serve their patients and could push care back toward more costly emergency departments and institutional settings. Removing access to a high-quality remote monitoring program could increase hospitalizations among that patient population by 27% and increase total cost of care by more than $1,300 per patient per year.[7]

We respectfully urge CMS to reconsider the proposal's limits on remote monitoring staffing and partner with providers, patient advocates, and remote monitoring stakeholders on program-integrity standards that reach bad actors while preserving access for the beneficiaries these services were designed to serve.

Thank you for your attention. We look forward to your prompt reply.

Sincerely,

David Kustoff
Member of Congress

Troy Balderson
Member of Congress

Donald G. Davis
Member of Congress

Carol D. Miller
Member of Congress

Jack Bergman
Member of Congress

Gregory F. Murphy, M.D.
Member of Congress

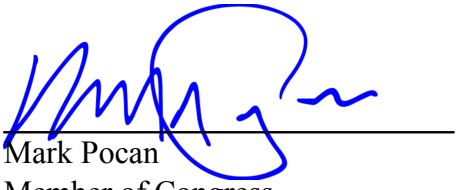
[6] https://pubmed.ncbi.nlm.nih.gov/24038901/
[7] https://www.sciencedirect.com/science/article/pii/S2542454825000906



Adrian Smith
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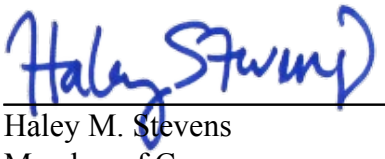
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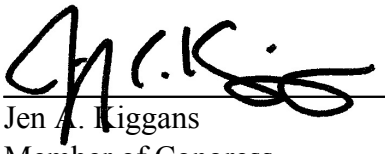
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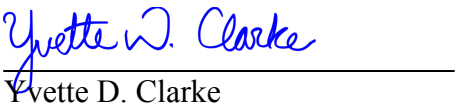
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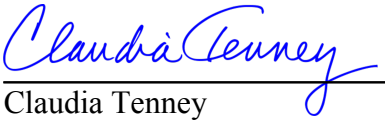
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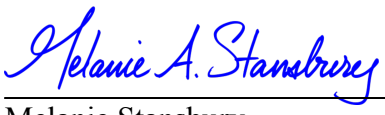
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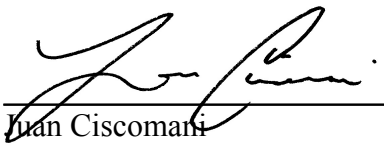
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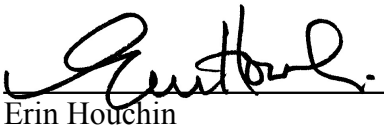
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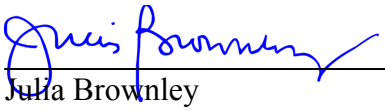
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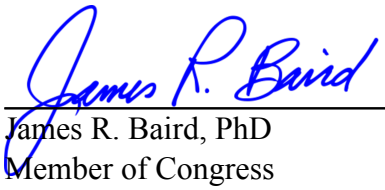
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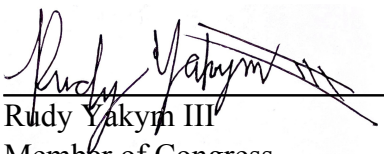
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