

Medicare Savings Forgone Under the Proposed Restriction on Contracted Remote Monitoring Staff

An Economic Analysis:
CY 2027 Physician Fee Schedule Proposed Rule (CMS-1848-P)

91 FED. REG. 43842 - JULY 16, 2026

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

RE: Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program [CMS-1848-P] RIN 0938-AV82

Dear Administrator Oz,

On behalf of the Center for Telehealth and eHealth Law (CTeL), we are pleased to submit the enclosed economic impact analysis in response to proposed *CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies CMS-1848-P*, (“CMS 1848-P”) examining the potential Medicare spending implications of the proposed changes to remote patient monitoring (RPM) and remote therapeutic monitoring (RTM) in the CY 2027 Medicare Physician Fee Schedule.

The analysis was commissioned by CTeL and conducted by Charm Economics. Drawing on publicly available research covering more than 23,000 study participants—including randomized trials, a meta-analysis, and claims-based cohort studies—the analysis estimates that the proposed direct-employment requirement could result in approximately **\$684 million in forgone Medicare savings each year** if practices that rely on contracted clinical staff discontinue or materially scale back their RPM programs.

This finding is particularly important because the proposed policy would reverse the general supervision framework CMS established in the CY 2021 Physician Fee Schedule, which permits auxiliary personnel furnishing remote monitoring services to be employed by a third party under contract with the billing practitioner. That framework has enabled many practices—particularly small, independent, and rural practices that may lack sufficient internal staffing—to offer remote monitoring services to Medicare beneficiaries.

We recognize and share CMS’s interest in addressing improper billing and strengthening program integrity. However, the regulatory impact analysis accompanying the proposed rule does not estimate the potential increase in Medicare medical spending associated with reduced access to RPM. Remote monitoring can reduce hospitalizations, emergency department utilization, and other acute-care expenditures for beneficiaries with chronic conditions. When beneficiaries lose access to these services, Medicare may also lose the associated downstream savings.

Our analysis estimates that approximately 650,000 Medicare beneficiaries could be affected if 65% of current RPM utilization is tied to practices relying on partially or fully outsourced staffing models. Under that assumption, the resulting loss of medical spending reductions is approximately \$684 million annually. The model also tests more conservative scenarios: a 50% reduction in access produces approximately \$526 million in forgone annual savings, while a 35% reduction produces approximately \$368 million.

These findings suggest that the fiscal consequences of the proposed staffing restriction warrant consideration alongside CMS's program integrity concerns. We therefore respectfully urge CMS not to finalize the direct-employment requirement as proposed. Instead, we encourage the agency to retain the general supervision framework established in CY 2021 while pursuing targeted oversight and enforcement measures to address improper billing.

Such an approach would allow CMS to strengthen program integrity without unnecessarily disrupting established care models, reducing beneficiary access, or sacrificing potentially significant Medicare savings.

We appreciate CMS's consideration of this analysis and the opportunity to contribute additional evidence to the rulemaking record. CTeL would welcome the opportunity to discuss the findings and methodology with CMS and to provide any additional information that would be helpful as the agency considers the final rule.

Sincerely,

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EXECUTIVE SUMMARY

This document is an economic impact analysis submitted in response to CMS-1848-P. It draws on publicly available literature covering more than 23,000 study participants, including randomized trials, a meta-analysis, and claims-based cohort studies, and applies those findings to the population the proposed remote patient monitoring (RPM) and remote therapeutic monitoring (RTM) billing changes would displace. The estimate is \$684 million per year in forgone Medicare savings.

That displacement follows a proposed end to a contracting arrangement Medicare has permitted since the CY 2021 Physician Fee Schedule, under which the staff performing the monitoring may work for the billing practice or for a third party under contract with it, provided the practitioner exercises general supervision. It is what allowed practices without the staffing depth to monitor in house, particularly small, independent, and rural ones, to offer the service at all.

The Centers for Medicare & Medicaid Services (CMS) now proposes to pay only when the monitoring is performed by staff employed directly by the billing practitioner. The provision appears in the CY 2027 Physician Fee Schedule proposed rule, published July 16, 2026, and would take effect January 1, 2027. CMS has justified the change by the improper billing it would prevent, but the regulatory impact analysis offers no estimate of what it would cost in higher medical spending. Remote monitoring reduces Medicare spending on beneficiaries with chronic conditions by averting hospitalizations and acute care, and those savings are lost when practices exit.

Quantifying those forgone savings proceeds in four steps. Approximately one million Medicare beneficiaries received RPM in 2024. Assuming 65% lose access, roughly 650,000 would be affected. Those beneficiaries are distributed across primary conditions using published claims data, at 57% hypertension, 13% diabetes, 3% heart failure, and 27% Other, which includes sleep-wake disorders, lipid metabolism disorders, and chronic obstructive pulmonary disease. Inflation-adjusted per-patient savings are applied to each group, and the total equals 4.5% of the estimated \$15.4 billion Medicare spends annually on beneficiaries with a comparable chronic disease burden.

While we believe 65% is the most defensible figure for access loss, it is a user-adjustable input, and total savings scale with it directly. A 50% loss yields approximately \$526 million and a 35% loss approximately \$368 million. The 4.5% savings rate holds at any level of access loss.

The proposed direct-employment requirement should therefore not be finalized as drafted. The record before CMS documents the program integrity risk the restriction addresses but contains no estimate of the medical spending reductions that would be forgone. Retaining the general supervision policy CMS established for CY 2021, paired with targeted enforcement against improper billing, meets the agency's stated concern while preserving those reductions.

1. BACKGROUND

RPM covers the collection and interpretation of physiologic data, most commonly blood pressure, weight, blood glucose, and pulse oximetry, transmitted from a patient's home to a clinician. Medicare has paid for these services under a family of CPT codes since 2018. In the CY 2021 PFS final rule, CMS confirmed that the auxiliary personnel furnishing remote monitoring could be employees of a third party under contract with the billing practitioner, working under that practitioner's general supervision.¹ Much of the delivery model that developed over the following years, particularly among small, independent, and rural practices, was built on that policy.

The CY 2027 proposed rule, released July 14, 2026 and published in the Federal Register on July 16, reverses it.² CMS proposes to allow payment for RPM and RTM only when the services are performed by clinical staff employed by the practice, and not when they are delivered by contractors. The rule also proposes an initiating visit requirement, extension of the established patient requirement to RTM, and revaluation of the underlying codes. CMS cites Office of Inspector General (OIG) findings on improper billing as the basis for the staffing provision, and requests comment on how the change would affect beneficiary access, particularly in rural areas where practices may not be able to replace outsourced services with internal staff.³

In soliciting that comment, the agency acknowledges that the provision would displace patients from RPM but does not carry the question through to its spending consequence. Doing so requires two quantities, the number of beneficiaries displaced and the effect of that displacement on Medicare spending. The first is a behavioral question the record does not currently answer, so this paper takes it as a stated assumption and estimates the second.

2. METHODS

2.1 AFFECTED POPULATION

OIG reported that nearly one million Medicare enrollees received remote patient monitoring in 2024, a 27% increase over 2023.⁴ The share losing access is set at 65%, based on industry surveys and market analyses cited by an American Telemedicine Association spokesperson estimating that 60% to 70% of hospitals and health systems using RPM rely on partially or fully outsourced vendor models.⁵ The midpoint of that range is used as a proxy for exposure to the proposed restriction.

¹ Centers for Medicare & Medicaid Services, "CY 2021 Revisions to Payment Policies Under the Physician Fee Schedule," final rule, *Federal Register* 85 (December 28, 2020).

² Centers for Medicare & Medicaid Services, "Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program," proposed rule, *Federal Register* 91, no. 135 (July 16, 2026): 43842.

³ CMS, "CY 2027 Payment Policies," 43842.

⁴ U.S. Department of Health and Human Services, Office of Inspector General, *Billing for Remote Patient Monitoring in Medicare* (Washington, DC: HHS OIG, 2025), <https://oig.hhs.gov/reports/all/2025/billing-for-remote-patient-monitoring/>.

⁵ "Health Systems, Trade Groups Oppose CMS Proposed Remote Patient Monitoring Ban," *Becker's Hospital Review*, 2026, <https://www.beckershospitalreview.com/healthcare-information-technology/telehealth/health-systems-trade-groups-oppose-cms-proposed-remote-patient-monitoring-ban/>.

The parameter is an input in the model and can be varied. At 65%, approximately 650,000 beneficiaries are treated as affected.

2.2 CONDITION DISTRIBUTION

The Peterson Health Technology Institute (PHTI) reports that among Medicare beneficiaries with an RPM episode in 2023, hypertension was the primary diagnosis for 57%, diabetes for 13%, and heart failure for 3%.⁶ The residual 27% is treated as a fourth category, Other, comprising conditions such as sleep-wake disorders, disorders of lipid metabolism, and chronic obstructive pulmonary disease, for which the literature on RPM cost effects is sparse. These shares are applied to the affected population.

2.3 PER-BENEFICIARY SAVINGS

Each condition is assigned a weighted per-patient-per-year (PPPY) savings estimate based on publicly available sources. Hypertension draws on a randomized trial of home blood pressure telemonitoring with pharmacist management, which reported net savings of roughly \$1,900 per patient over five years, annualized here to \$380,⁷ and on a vendor-reported estimate of \$2,467 PPPY for hypertension with complications.⁸ Diabetes draws on a randomized controlled trial reporting a six-month cost difference of \$881, doubled to annualize and converted from Australian dollars,⁹ and on a vendor-reported estimate of \$3,012 PPPY.¹⁰ Heart failure uses the midpoint of the EUR 300 to EUR 1,000 range reported in a meta-analysis of randomized trials, at full weight.¹¹ The Other category has no condition-specific source and is imputed from two mixed-cohort studies, one reporting a reduction in total cost of care of \$1,302 PPPY in a Medicare chronic disease cohort¹² and the other a reduction of \$108.50 per patient per month in an accountable care organization cohort.¹³

⁶ Peterson Health Technology Institute, *Evolving Remote Monitoring*, exhibit 6 (New York: Peterson Center on Healthcare, 2025), <https://www.phti.org/evolving-remote-monitoring/>.

⁷ Karen L. Margolis et al., “Cardiovascular Events and Costs with Home Blood Pressure Telemonitoring and Pharmacist Management for Uncontrolled Hypertension,” *Hypertension* 76, no. 4 (2020): 1097–1103, <https://doi.org/10.1161/HYPERTENSIONAHA.120.15492>.

⁸ Nsight Health, “Nsight Health Named No. 78 on the 2026 Inc. 5000 List,” press release, 2026, <https://nsightcare.com/press-release/inc-5000-fastest-growing-private-companies/>.

⁹ Robin Warren, Karen Carlisle, Gabor Mihala, and Paul A. Scuffham, “Effects of Telemonitoring on Glycaemic Control and Healthcare Costs in Type 2 Diabetes: A Randomised Controlled Trial,” *Journal of Telemedicine and Telecare* 24, no. 9 (2018): 586–95, <https://doi.org/10.1177/1357633X17723943>.

¹⁰ Nsight Health, “No. 78 on the 2026 Inc. 5000 List.”

¹¹ Catherine Klersy et al., “Economic Impact of Remote Patient Monitoring: An Integrated Economic Model Derived from a Meta-Analysis of Randomized Controlled Trials in Heart Failure,” *European Journal of Heart Failure* 13, no. 4 (2011): 450–59, <https://doi.org/10.1093/eurjhf/hfq232>.

¹² David I. Feldman et al., “The Impact of a Remote Patient Care Program on Health Care Costs and Utilization Among Medicare Patients with Chronic Disease,” *Mayo Clinic Proceedings: Innovations, Quality & Outcomes* 10, no. 1 (2026): 100679, <https://doi.org/10.1016/j.mayocpigo.2025.100679>.

¹³ W. Smith et al., “Abstract 4368970: Remote Patient Monitoring Lowers Healthcare Expenditures and Utilization in an ACO Cross-Sectional Cohort Study,” *Circulation* 152, suppl. 3 (2025), https://doi.org/10.1161/circ.152.suppl_3.4368970.

Three normalizations are applied. Non-US figures are converted at period average exchange rates of 1.39 USD per EUR for 2011 and 0.75 USD per AUD for 2018. All figures are inflated to 2026 dollars using the medical care component of the Consumer Price Index.¹⁴ The two vendor-reported estimates are stated before program costs, so a vendor program cost of \$720 PPPY, the midpoint of a reported \$40 to \$80 per patient per month for a full-service arrangement, is subtracted from each.¹⁵

Total annual savings for each condition is the product of affected beneficiaries with that condition and the condition's weighted PPPY savings. The four condition totals are summed.

3. RESULTS

Approximately 650,000 Medicare beneficiaries are treated as losing access to RPM, and the associated annual reduction in Medicare spending totals \$683,990,145, or approximately \$684 million.

Table 1. Estimated annual Medicare savings forgone, by primary condition

Condition	Affected RPM users	Share with condition	RPM users with condition	Weighted savings (PPPY)	Total net savings (\$/yr)
Hypertension	650,000	57%	370,500	\$766	\$283,871,094
Diabetes	650,000	13%	84,500	\$1,793	\$151,501,698
Heart failure	650,000	3%	19,500	\$1,337	\$26,075,260
Other*	650,000	27%	175,500	\$1,268	\$222,542,094
Total		100%	650,000		\$683,990,145

*Note: Weighted savings are per patient per year in 2026 dollars. Components may not sum exactly because of rounding. Condition shares are drawn from PHTI; see section 2.2 for their derivation and section 2.3 for the sources and weights underlying each savings estimate. *The Other category comprises conditions such as sleep-wake disorders, disorders of lipid metabolism, and chronic obstructive pulmonary disease.*

Hypertension accounts for the largest share of the total at \$283.9 million, driven by population size rather than by per-patient savings, which are the lowest of the four categories at \$766 PPPY. Diabetes contributes \$151.5 million on 13% of the population, reflecting the highest per-patient

¹⁴ U.S. Bureau of Labor Statistics, *Consumer Price Index*, medical care component, as compiled at <https://www.usinflationcalculator.com/inflation/health-care-inflation-in-the-united-states/>.

¹⁵ J. Whittaker, "How Much Does Remote Patient Monitoring Cost in 2026?," HealthArc, 2026, <https://www.healtharc.io/blogs/remote-patient-monitoring-pricing-structure-and-models-for-healthcare-providers/>.

estimate at \$1,793 PPPY. Heart failure contributes \$26.1 million. The Other category, at 27% of the affected population, contributes \$222.5 million.

The total is divided by estimated Medicare spending on the affected population, using annual Medicare payments of \$14,931 for a beneficiary with two chronic conditions,¹⁶ inflated to \$23,626 in 2026 dollars. Across 650,000 affected beneficiaries, that implies total annual Medicare spending of \$15.4 billion, against which the estimated savings represent a 4.5% reduction.

4. DISCUSSION

CMS has assessed the staffing restriction against its program integrity benefits alone, without estimating the medical spending reductions it would eliminate. Those reductions are on the order of \$684 million per year for the displaced population. The figure captures avoided medical spending, principally inpatient and cardiovascular event costs, associated with remote monitoring of beneficiaries with chronic conditions, rather than a net budgetary effect.

The size of that omission depends on how many practices would discontinue RPM rather than bring the work in house, which the record does not establish. That uncertainty bounds the total but does not move the savings rate. For example, at a 40% loss of access the forgone savings fall to roughly \$421 million, and at 80% they rise to roughly \$842 million. Across that range the rate still holds at 4.5%, because the affected population enters both the savings estimate and the spending base against which it is measured, and so cancels out. CMS need not accept any particular figure for how many beneficiaries would lose access in order to accept that remote monitoring of this population is associated with measurable reductions in other Medicare spending, and that its impact analysis assigns those reductions no value.

5. LIMITATIONS

The 65% access loss is an assumption about how many practices would discontinue RPM rather than bring the work in house. No published estimate exists of how practices would respond to the requirement. While we believe 65% is the most defensible figure, it is a user-adjustable input in the model, and total savings scale with it directly. A 50% loss of access yields approximately \$526 million and a 35% loss yields approximately \$368 million. The 4.5% savings rate holds across all inputs.

The condition-level savings estimates draw on sources that vary in design, setting, and follow-up period. Where more than one source was available for a condition, estimates were combined using fixed weights that give greater weight to peer-reviewed evidence than to vendor-reported figures. Those weights reflect a judgment about relative reliability and are inputs in the model.

¹⁶ Kathleen M. Schneider, Brian E. O'Donnell, and Debra Dean, "Prevalence of Multiple Chronic Conditions in the United States' Medicare Population," *Health and Quality of Life Outcomes* 7 (2009): 82, <https://doi.org/10.1186/1477-7525-7-82>.

Several modeling conventions are worth noting. The model treats each affected beneficiary as enrolled for a full year, so the estimate may be lower if mean episode duration is shorter. Condition shares reflect the primary diagnosis for a single RPM episode and do not capture beneficiaries monitored for more than one condition. The Other category is assigned an estimate imputed from mixed chronic disease cohorts, which serves as a reasonable average across a heterogeneous group.

6. CONCLUSION

CMS has a legitimate interest in the program integrity findings that motivated the proposal. Restricting RPM payment to directly employed clinical staff would, however, remove the service from an estimated 650,000 Medicare beneficiaries and forgo approximately \$684 million in annual reductions to Medicare medical spending, equal to 4.5% of spending on that population.

Instead, that concern is addressable through enforcement against improper billing and through the initiating visit and documentation requirements the rule already proposes, none of which requires eliminating the contracted staffing model CMS authorized for CY 2021 and on which a substantial share of small and rural practices now depend. Because narrower remedies are available, CMS should decline to finalize the direct employment requirement and should incorporate an estimate of forgone medical spending reductions into its impact analysis before proceeding.

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