Federation of American Hospitals

Charles N. Kahn III
President and CEO

November 18, 2025

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: CMS Regulations and UnitedHealthcare's Medicare Advantage Coverage Policy

Dear Dr. Oz:

On behalf of the Federation of American Hospitals (FAH), we are writing to make you aware of a new and inappropriate coverage policy that UnitedHealthcare (United) has announced for its Medicare Advantage (MA) plans across the country. The FAH is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

We commend the Centers for Medicare & Medicaid Services (CMS) for its ongoing commitment to protecting the quality and integrity of the coverage and care provided to the millions of seniors who choose to access their Medicare benefits through private MA plans. FAH members increasingly care for more seniors enrolled in MA as compared to those in Traditional Medicare fee-for-service, and both the FAH and our members strongly support the program's ability to offer greater flexibility beyond the structure of Traditional Medicare. Despite this support, we remain deeply concerned about the troubling and harmful practices by some MA plans that undermine patient access to medically necessary care. These plans too often inappropriately deny, restrict, or delay services, forcing providers to divert critical time and resources toward navigating denials and delays—rather than focusing on their core mission of delivering high-quality patient care.

Recently, United announced a new policy that will sharply reduce its MA members' access to remote physiologic monitoring (RPM) for hypertension, type 2 diabetes, and other conditions when it takes effect on January 1, 2026.[1] Under this policy, tens of thousands of seniors with chronic diseases will lose access to RPM tools for the effective management of their conditions based on restrictive internal coverage criteria

[1] UnitedHealthcare Medicare Advantage Medical Policy No. MMP395.01, Remote Physiologic Monitoring (RPM) (eff. Jan. 1, 2026), https://www.uhcprovider.com/content/dam/provider/docs/public/policies/index/mamp/remote-physiologic-monitoring-mamp-01012026.pdf.

that are not supported by current evidence on January 1, 2026, unless action is taken. We urge CMS to investigate this issue and take additional steps to ensure that United properly provides all medically necessary RPM coverage to its MA enrollees by withdrawing this policy.

CMS has long recognized that RPM is appropriate for a wide range of acute and/or chronic conditions, but the United policy would limit coverage to two specific conditions—heart failure and hypertensive disorders of pregnancy—and uniformly deny coverage for "all other indications," including but not limited to diabetes, chronic obstructive pulmonary disease, hypertension (other than hypertensive disorders of pregnancy), anxiety, bipolar disorder, depression, and schizoaffective disorder. This policy leaves no room for professional judgment by treating physicians or the MA organization physician reviewing the coverage determination and will eliminate access to RPM among most of its MA members. The Office of Inspector General's analysis of Medicare claims and Medicare Advantage encounter data for 2024 (OEI-02-23-00260, Appendix A) found that essential hypertension (55%) and diabetes (16%) were the most common conditions for which enrollees received remote patient monitoring, but United's policy will not cover RPM for these conditions at all. Only a small number of MA beneficiaries received RPM for conditions that would be covered by United's policy—just 4% of RPM claims involved heart failure. Moreover, this significant limitation of coverage does not conform to any Medicare coverage criteria and is unsupported by current evidence in widely used treatment guidelines or clinical literature. CMS has expressly recognized the wide range of appropriate uses of RPM, noting that typical uses include monitoring for "high blood pressure, diabetes, [and] COPD," and that RPM could also be used to monitor a patient with an acute respiratory virus or a post-surgical patient recovering at home.[2] Under United's policy, however, RPM would not be covered for any of these conditions despite CMS's express acknowledgement of coverage.

Pursuant to section 1852(a)(1) of the Social Security Act, MA plans must provide to enrollees "benefits under the original Medicare fee-for-service program" for all Medicare Part B services. CMS's implementing regulation at 42 C.F.R. § 422.101(a), directs MA organizations to provide coverage of "all services that are covered by . . . Part B of Medicare," and § 422.101(b) mandates that MA plans comply with "[g]eneral coverage and benefit conditions included in Traditional Medicare laws." Together, these requirements ensure that MA members receive their Part B benefits and prohibit MA plans from limiting or conditioning coverage in a manner that conflicts with the coverage standards or benefit definitions established under Traditional Medicare.

Here, CMS has in fact set out Medicare Part B coverage and benefit conditions for RPM in notice-and-comment rulemaking. In particular, CMS clarified in rulemaking that "practitioners may furnish RPM services to patients with acute conditions as well as chronic conditions."[3] CMS has further interpreted and summarized its coverage criteria in a Medicare Learning Network (MLN) booklet,[4] a Program Transmittal,[5] and web-based guidance.[6] Together, CMS rulemakings and guidance confirms the required components of RPM and the coverage and billing requirements for RPM, which expressly exclude any condition-based limitations on the coverage of RPM. United's policy, however, erroneously disregards these CMS

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[2] 85 Fed. Reg. 19,230, 19,264 (Apr. 6, 2020); 85 FR 84,472, 84,545 (Dec. 28, 2020).

[3] 85 FR 84,472, 84,546 (Dec. 28, 2020); *see also* 85 Fed. Reg. 19,230, 19,264 (Apr. 6, 2020).
[4] CMS, MLN901705, Telehealth & Remote Patient Monitoring, pp.9–10 (April 2025)
[5] CMS, Summary of Policies in the Calendar Year (CY) 2020 Medicare Physician Fee Schedule (MPFS) Public Health Emergency (PHE) Interim Final Rules, Pub. 100-20, Transmittal 10160, https://www.cms.gov/files/document/r10160otn.pdf (Change Request 11805) (May 22, 2020). *See also* CMS, MLN Matters MM11805, Summary of Policies in the Calendar Year (CY) 2020 Medicare Physician Fee Schedule (MPFS) Public Health Emergency (PHE) Interim Final Rules, https://www.cms.gov/files/document/mm11805.pdf (May 22, 2020).
[6] CMS, Remote Patient Monitoring, https://www.cms.gov/medicare/coverage/telehealth/remote-patient-monitoring (last modified May 5, 2025).

regulations (and supporting guidance materials) with respect to RPM benefits and coverage and instead asserts that the clinical coverage criteria for RPM "have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria." Because the Traditional Medicare laws—adopted through notice-and-comment rulemaking—establish general coverage and benefit conditions for RPM, United must comply with those Traditional Medicare coverage and benefit conditions and "may not deny coverage or basic benefits based on coverage criteria not specified in [42 C.F.R. § 422.101](b) or (c)."[7]

Even if CMS had not established Medicare regulations applicable to RPM such that the coverage criteria were not fully established under 42 C.F.R. § 422.101(b)(6)(i)(C), United could not lawfully implement its condition-based exclusion of coverage for RPM because it is unsupported by current evidence. MA organizations cannot adopt internal coverage criteria unless those criteria are "based on current evidence in widely used treatment guidelines or clinical literature." 42 C.F.R. § 422.101(b)(6). In the absence of such supporting clinical evidence, an MA organization is precluded from adopting internal coverage criteria and must make medical necessity determinations based on other factors, including the enrollee's medical history, physician recommendations, and clinical notes.[8] United's policy, however, does not find a basis in widely used treatment guidelines or acceptable clinical literature and in fact runs against the weight of current evidence on RPM.

The evidence clearly shows strong clinical outcomes for many more conditions beyond heart failure and hypertensive disorders of pregnancy. Multiple randomized controlled trials, systematic reviews and meta-analyses, and observational studies demonstrate the clinical efficacy of RPM when it is performed alongside provider-led, team-based care, for patients with hypertension and type 2 diabetes. By combining consistent, real-time tracking of patients' blood pressure and other vital signs outside of the clinical setting and support from a responsive provider, patients are able to receive the high-quality and easily accessible care CMS envisioned when creating these services and offering them to all Medicare beneficiaries. The Remote Monitoring Leadership Council has compiled the peer-reviewed and published literature[9] that clearly demonstrates how RPM can enhance patient adherence, provide early detection of hypertensive or diabetic crises, and facilitate timely intervention by health care providers, which has led to its definitive adoption and recommendation by national societies and guidelines for use cases including hypertension and diabetes.

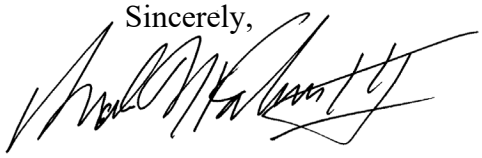
Against this evidence, however, United has adopted a profoundly restrictive policy that eliminates coverage of RPM for hypertension (outside of pregnancy), diabetes, and all conditions other than heart failure and hypertensive disorders of pregnancy without any discussion of the significant harms that may result from delayed or decreased access to RPM. The evidence cited by United does not support the bar on coverage implemented under the policy. In fact, some of the studies indicate that RPM is beneficial. For example, United cites a randomized clinical trial by Mehta et al. (2024), which found that blood pressure was controlled in 49% of patients receiving RPM compared to 40% in the usual care group. At best, the studies identified by United indicate the need for further study but do not support any diagnosis-based limitation on RPM coverage. And many of the studies cited by United likewise are not acceptable under 42 C.F.R. § 422.101(b)(6). By regulation, acceptable clinical literature includes large, randomized controlled trials or prospective cohort studies with clear results, published in a peer-reviewed journal, and specifically designed to answer the relevant clinical question, or large systematic reviews or meta-analyses summarizing the literature of the specific clinical question. Yet United bases its policy on studies conducted on small groups,

[7] 42 C.F.R. § 422.101(b)(2), (c)(1)(i)(A).
[8] 42 C.F.R. § 422.101(c)(i).
[9] A summary of clinical evidence on RPM for treating hypertension and type-2 diabetes is available here: https://rpmleadershipcouncil.org/wp-content/uploads/2025/10/UHC-RPM-Policy_Clinical-Evidence-Response_10.14.2025.pdf.

unmasked studies, and other studies that are insufficient to form the basis for internal coverage criteria. As CMS has confirmed, 42 C.F.R. § 422.101(b)(6) prohibits MA plans from applying internal coverage criteria in the absence of appropriate supporting evidence.[10] Because the clinical literature simply does not support a diagnosis-based limitation on RPM coverage, the United policy is impermissible and should be withdrawn.

Thank you for your leadership on this important priority. We request that you work with United to remove diagnostic restrictions inconsistent with Medicare's established RPM coverage and ensure full parity in RPM access between MA and Traditional Medicare beneficiaries. These actions will help to protect tens of thousands of seniors while ensuring the MA program remains a robust offering for beneficiaries that relies upon market-driven innovation and supplemental benefits to differentiate itself from the traditional Medicare experience.

Sincerely,



[10] CMS, Frequently Asked Questions Related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule (CMS-4201-F), p.2 (Feb. 6, 2024).