

119TH CONGRESS
1ST SESSION

H. R. 3032

To ensure appropriate access to remote monitoring services furnished under the Medicare program.

IN THE HOUSE OF REPRESENTATIVES

APRIL 28, 2025

Mr. BALDERSON (for himself, Mr. DUNN of Florida, and Mr. MURPHY) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To ensure appropriate access to remote monitoring services furnished under the Medicare program.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Expanding Remote
5 Monitoring Access Act”.

6 **SEC. 2. FINDINGS.**

7 The Congress finds the following:

1 (1) Remote monitoring is an option that can
2 help patients manage their health conditions from
3 their homes with oversight from their health care
4 providers, which can improve patient health out-
5 comes, reduce long-term health costs, and increase
6 care options for patients.

7 (2) The Department of Veterans Affairs (VA)
8 saw such results in a 2019 report. Veterans enrolled
9 in remote patient monitoring had a 53 percent de-
10 crease in VA bed days of care and a 33 percent de-
11 crease in VA hospital admissions.

12 (3) Providers are currently required by Medi-
13 care to collect 16 days of patient data over a 30-day
14 period in order to bill Medicare for remote moni-
15 toring services, even in cases where this full duration
16 is not medically necessary to ensure the health and
17 safety of the patient. This can limit the use of re-
18 mote monitoring in instances where it can promote
19 patient health and safety and where it can reduce
20 the overall cost on the health system.

21 (4) In the 2021 Physician Fee Schedule, the
22 Centers for Medicare and Medicaid Services (CMS)
23 issued an interim policy to lower the duration re-
24 quired by Medicare to bill for remote monitoring
25 services from 16 days to 2 days within a 30-day pe-

1 riod, but only for individuals who had been diag-
2 nosed with, or were suspected of having, COVID–19.
3 This short-term flexibility called attention to the
4 long-term need to reassess the minimum duration
5 required for providers to bill for remote monitoring.

6 (5) As part of issuing the 2021 Physician Fee
7 Schedule, CMS studied comments in support of per-
8 manently lowering the minimum required duration
9 of remote monitoring for all patients, not just those
10 with COVID–19.

11 (6) CMS concluded that “we agree that a full
12 16 days of monitoring may not always be reasonable
13 and necessary” but did not revise the 16 day per 30-
14 day period minimum duration for all patients be-
15 cause CMS did not believe they had received “spe-
16 cific clinical examples” to allow for “understanding
17 under what clinical circumstances fewer days of
18 monitoring would be medically reasonable and nec-
19 essary and allow a practitioner to establish clinically
20 meaningful care”.

21 (7) Clinical evidence shows numerous instances
22 in which fewer than sixteen days of monitoring with-
23 in a 30-day period establishes clinically meaningful
24 care. These include:

1 (A) Sixteen days of monitoring per 30-day
2 period may not be required to establish that a
3 patient has sleep apnea.

4 (B) A patient prescribed a narcotic for
5 pain may require their breathing to be mon-
6 itored only while on the medication.

7 (C) A patient with a chronic condition like
8 diabetes, congestive heart failure, or obesity
9 may have their weight monitored over a longer
10 period of time, but it is not clinically appro-
11 priate to have such patient step on a scale 16
12 or more times in each 30-day period.

13 (D) A patient whose blood pressure or oxy-
14 gen levels are monitored during physical ther-
15 apy may not necessitate 16 days of monitoring
16 in each 30-day period given physical therapy is
17 often ordered twice weekly.

18 (E) A patient who wears a heart monitor
19 to measure palpitations may wear the monitor
20 continuously, but the data only needs to be col-
21 lected when the individual is experiencing symp-
22 toms.

23 (F) A patient with hypertension is often
24 monitored for long-term management of this
25 condition on more of a weekly basis, only need-

1 ing more frequent data collection for active
2 monitoring with changes in medication or dos-
3 ages.

4 (G) A patient who suffers from Muscular
5 Sclerosis or Muscular Dystrophy may benefit
6 from a provider tracking the patient's exercise
7 between visits to monitor certain physiologic pa-
8 rameters such as muscle movement but may not
9 produce 16 days of data in a 30-day period.

10 (H) A patient who needs a total joint re-
11 placement may simply need pre-testing for sur-
12 gery baselines, including to establish gait, force,
13 activity, heart rate and other factors and then
14 compare pre-surgery and post-surgery function.

15 (I) For a patient with urologic dysfunction,
16 male urine flow data obtained from the patient
17 can be collected in two to four consecutive days.

18 (J) Remote monitoring may allow a pro-
19 vider to assess a patient's adherence, range of
20 motion, and response to physical therapy and
21 occupational therapy regimens even though
22 many such regimens are less than 16 days per
23 month.

24 (K) Monitoring cognitive behavioral ther-
25 apy for less than 16 days in a 30-day period

1 may provide clinically meaningful care while
2 moderating a patient’s anxiety and other symp-
3 toms.

4 (L) A patient with respiratory issues may
5 not require a full 16 days of monitoring of in-
6 haler usage to get clinical benefits from remote
7 monitoring.

8 (8) A two-day minimum duration would permit
9 Medicare coverage of the full range of remote moni-
10 toring services that can be beneficial to a patient
11 without precluding the differential reimbursement of
12 individual remote monitoring services based on pa-
13 tient acuity and cost.

14 **SEC. 3. ENSURING APPROPRIATE ACCESS TO REMOTE**
15 **MONITORING SERVICES FURNISHED UNDER**
16 **THE MEDICARE PROGRAM.**

17 (a) IN GENERAL.—Notwithstanding any other provi-
18 sion of law, the Secretary of Health and Human Services
19 (in this section referred to as the “Secretary”) shall en-
20 sure that remote monitoring services furnished under title
21 XVIII of the Social Security Act (42 U.S.C. 1395 et seq.)
22 during the period beginning on the date of the enactment
23 of this Act and ending on the date that is 2 years after
24 such date of enactment are payable for a minimum of 2
25 days of data collection over a 30-day period, regardless

1 of whether the individual receiving such services has been
2 diagnosed with, or is suspected of having, COVID–19.

3 (b) REPORT.—

4 (1) IN GENERAL.—Not later than 1 year after
5 the date of the enactment of this Act, the Secretary
6 shall, after consulting with entities specified in para-
7 graph (2), submit to Congress a report that includes
8 the following:

9 (A) A summary and analysis of previous
10 experience with such remote monitoring services
11 being payable under such title for a minimum
12 of 2 days of data collection over a 30-day pe-
13 riod.

14 (B) Recommendations for implementing a
15 reimbursement model that takes into account
16 patient acuity and cost of providing remote
17 monitoring services, including potentially cre-
18 ating differential reimbursements for periods
19 with different durations, such as fewer than
20 and more than 16 days.

21 (C) An analysis and justification for the
22 appropriate place of service and supervision re-
23 quirements for non-clinical staff reviewing and
24 escalating patient data and provide rec-
25 ommendations.

1 (D) An analysis of the estimated savings
2 resulting from earlier interventions and fewer
3 days of hospitalizations among patients fur-
4 nished remote monitoring services.

5 (2) SPECIFIED ENTITIES.—For purposes of
6 paragraph (1), the entities specified in this para-
7 graph are the following:

8 (A) Relevant agencies within the Depart-
9 ment of Health and Human Services (including,
10 with respect to issues relating to waste, fraud,
11 or abuse, the Inspector General of such Depart-
12 ment).

13 (B) The Department of Veterans Affairs
14 (including the Office of Connected Care of such
15 Department).

16 (C) Licensed and practicing osteopathic
17 and allopathic physicians, anesthesiologists,
18 physician assistants, and nurse practitioners.

19 (D) Hospitals, health systems, academic
20 medical centers, and other medical facilities,
21 such as acute care hospitals, cancer hospitals,
22 psychiatric hospitals, hospital emergency de-
23 partments, facilities furnishing urgent care
24 services, ambulatory surgical centers, Federally
25 qualified health centers, rural health clinics,

1 and post-acute care and long-term care facili-
2 ties.

3 (E) Medical professional organizations and
4 medical specialty organizations.

5 (F) Organizations with expertise in the de-
6 velopment of or operation of innovative remote
7 physiologic monitoring services technologies.

8 (G) Beneficiary advocacy organizations.

9 (H) The American Medical Association
10 Current Procedural Terminology Editorial
11 Panel.

12 (I) Commercial payers.

13 (J) Any other entity determined appro-
14 priate by the Secretary.

15 (c) DEFINITIONS.—In this section:

16 (1) REMOTE MONITORING.—The term “remote
17 monitoring” means remote physiologic monitoring
18 and remote therapeutic monitoring.

19 (2) REMOTE PHYSIOLOGIC MONITORING.—The
20 term “remote physiologic monitoring” means non-
21 face-to-face monitoring and analysis of physiologic
22 factors used to understand a patient’s health status,
23 including the collection and analysis of patient phys-
24 iologic data that are used to develop and manage a

1 treatment plan related to chronic or acute condi-
2 tions.

3 (3) REMOTE THERAPEUTIC MONITORING.—The
4 term “remote therapeutic monitoring” means the
5 use of medical devices to monitor a patient’s health
6 or response to treatment using non-physiological
7 data.

○