A DIVERSIFYRX + PHARMACY BADASS UNIVERSITY ADVOCACY ALERT

The Pharmacist RPM Comment Playbook

CMS wants to cut contracted pharmacists out of remote patient monitoring. Here's how to fight back — in about 10 minutes — before the **September 14, 2026** deadline.

From Dr. Lisa Faast, DiversifyRx

What CMS Just Proposed (and Why It Deserves Your Full Attention)

On July 14, 2026, CMS released its proposed rule for the 2027 Medicare Physician Fee Schedule (file code CMS-1848-P). Buried in those 700+ pages is one sentence that should make every pharmacy owner sit up straight:

> **CMS proposes to pay for RPM and RTM services only when they are performed by clinical staff employed by the billing practice — not when they are delivered by contractors.**

Translation: if you or your pharmacists are contracted with local physician practices to run their remote physiologic monitoring (RPM) or remote therapeutic monitoring (RTM) programs, that entire arrangement stops being billable on January 1, 2027 — unless enough of us convince CMS to change course.

One piece of good news: this proposal does NOT touch chronic care management (CCM) or advanced primary care management (APCM). Contracted staffing for those services continues as-is. But make no mistake — if the employed-only rule sticks for RPM/RTM, care management could be next.

The Fast Facts

What	CY 2027 Medicare Physician Fee Schedule Proposed Rule
File code	CMS-1848-P
The problem	RPM/RTM payment limited to clinical staff employed by the billing practice — contracted pharmacists and pharmacies would be excluded
Also proposed	Required initiating visit for RPM/RTM, established-patient requirement for RTM, downward revaluation of device supply codes, and a request for comment on bundling RPM/RTM into four new G-codes
Not affected	CCM and APCM — contracted staffing arrangements continue

Comment deadline	**September 14, 2026**
Where to comment	regulations.gov/document/CMS-2026-2377-0002 (or search “CMS-1848-P” at Regulations.gov)
Final rule expected	Around November 2026; changes effective January 1, 2027

Why Your Comment Actually Matters

Federal agencies are legally required to read and respond to substantive public comments before finalizing a rule. This is not a suggestion box. Proposed rules get softened, clarified, and even withdrawn because of comment volume and quality — it happens every single year.

CMS is trying to solve a real problem: out-of-state call centers billing thousands of “monitoring minutes” with zero patient relationship. Fair enough. But their fix throws out the local pharmacist who knows the patient by name, catches the blood pressure trend before it becomes a stroke, and answers the phone on the first ring. Our job is to show CMS the difference — with real stories from real pharmacies and real physician partners.

The math is simple: a few dozen form letters get a footnote. A few thousand personalized comments from pharmacists, physicians, and patients get a policy change.

Who Needs to Comment (Hint: Not Just You)

Every one of these voices carries different weight with CMS. Recruit all of them:

- **Pharmacy owners and pharmacists** — you’re the clinical staff being cut out. Tell your story.
- **Your physician partners** — CMS listens hardest to the practices that bill these codes. A two-paragraph comment from a physician saying “I cannot run RPM without my contracted pharmacist” is gold.
- **Practice managers and staff** — they can speak to the operational reality of small practices that cannot hire monitoring staff.
- **Patients and caregivers** — a patient who avoided a hospitalization because a pharmacist caught a bad reading is the most persuasive commenter there is.
- **State pharmacy associations and buying groups** — forward this playbook and ask them to activate their members.

How to Submit Your Comment in 10 Minutes

Go to **https://www.regulations.gov/document/CMS-2026-2377-0002** — confirm the page shows the “CY 2027 Payment Policies Under the Physician Fee Schedule” proposed rule with a comment deadline of September 14, 2026. Then:

1. **Click the blue “Comment” button** near the top of the page.

2. **Type your comment in the box, or attach it as a PDF on your letterhead** (you can do both). Lead with: "Re: CMS-1848-P — Proposed requirement that RPM/RTM services be furnished only by clinical staff employed by the billing practice."
3. **Fill in your name and info,** choose whether you're commenting as an individual or an organization, check the box acknowledging comments are public, and click Submit.
4. **Save the confirmation number** you receive — that's your proof of filing.

Prefer paper? Mail to: Centers for Medicare & Medicaid Services, Attention: CMS-1848-P, P.O. Box 8016, Baltimore, MD 21244-8016. Electronic is faster and confirmed instantly.

> **Heads up:** comments are public. Never include patient names or any protected health information. Describe outcomes in general terms ("a patient whose readings flagged early hypertension"), not identifiable details.

What to Say: Talking Points That Move the Needle

Pick two or three that match your situation. Depth beats breadth — one specific story outweighs ten generic bullet points.

1. The employment test doesn't measure quality — supervision does

Whether a pharmacist is W-2 or contracted changes nothing about their license, training, or accountability. Existing "incident to" and supervision requirements already make the billing practitioner responsible for the service. Ask CMS to target the actual problem — documentation, supervision, and audit standards — instead of using employment status as a blunt proxy for quality.

2. Small and rural practices can't hire their way out of this

A two-physician rural practice cannot employ a monitoring nurse or pharmacist. Contracting with the local pharmacy is the only way these practices offer RPM at all. Under this rule, they won't hire — they'll quit offering RPM. The patients lose the monitoring, and the monitoring goes back to being a big-health-system perk.

3. Local contracted pharmacists are the opposite of the abuse CMS is targeting

Acknowledge the legitimate concern: remote call-center vendors with no patient relationship. Then draw the line. A community pharmacist contracted by a practice in the same town, seeing the same patients face-to-face, is exactly the high-touch model CMS says it wants. Suggest CMS distinguish between anonymous offshore monitoring mills and licensed local clinicians with documented patient relationships.

4. Pharmacist-led monitoring gets results

Pharmacist involvement in hypertension and diabetes monitoring is backed by years of published evidence on improved adherence, better control, and fewer hospitalizations. If you have your own numbers — enrollment counts, blood pressure improvements, ER visits avoided — this is where they go.

5. Give CMS a workable alternative

Agencies respond best to comments that offer a path, not just a protest. Ask CMS to: (1) withdraw the employed-only restriction; or (2) permit contracted auxiliary personnel under existing incident-to supervision rules with enhanced documentation requirements; or (3) at minimum, create an exception for clinicians with an in-person patient relationship or located in the same community or state as the billing practice.

Copy, Customize, Submit: Your Comment Template

This is a skeleton, not a script. CMS gives less weight to identical form letters — the bracketed sections are where your comment earns its keep. Rewrite at least the story paragraph in your own words.

Re: CMS-1848-P — Proposed requirement that RPM/RTM services be furnished only by clinical staff employed by the billing practice

Dear Administrator:

I am a [pharmacist / pharmacy owner / physician / patient] in [City, State]. I am writing to oppose the proposal to limit payment for remote physiologic monitoring and remote therapeutic monitoring to clinical staff employed by the billing practice.

[YOUR STORY — 2 to 4 sentences. Who do you serve? How does your contracted RPM arrangement work? What has it done for patients? Use numbers if you have them: patients enrolled, readings reviewed, conditions caught early, hospitalizations avoided.]

I share CMS's concern about remote monitoring vendors that have no relationship with the patients they monitor. But a licensed clinician contracted by a local practice — operating under the practice's supervision, subject to incident-to requirements, and often seeing these patients in person — is not that problem. Employment status does not determine quality of care; supervision, documentation, and clinical accountability do.

If finalized, this restriction would not cause small and rural practices to hire monitoring staff. It would cause them to stop offering these services, and patients in communities like mine would lose access to monitoring that catches problems before they become hospitalizations.

I respectfully ask CMS to withdraw the employed-only restriction, or in the alternative, to permit contracted auxiliary personnel to furnish RPM/RTM under existing supervision and incident-to requirements, with any additional documentation safeguards CMS deems necessary.

Thank you for considering this comment.

[Name, credentials]

[Pharmacy / practice name, City, State]

Do's and Don'ts

- **DO** personalize. One real story beats a thousand copied paragraphs.

- **DO** comment twice if you can — once as an individual clinician, once on behalf of your business.
- **DO** ask your physician partners to submit their own comments. Their voice on these codes is the loudest in the room.
- **DO** stay professional and constructive. Angry comments get skimmed; specific ones get cited in the final rule.
- **DON'T** include patient names or any identifiable health information — comments are public forever.
- **DON'T** wait. The deadline is September 14, 2026, and late comments are not considered.
- **DON'T** assume someone else has it covered. The other side — whoever benefits from consolidation — is commenting too.

Spread the Word

Forward this playbook to every pharmacy owner, pharmacist, and physician partner you know. Here's ready-to-use copy:

Email / newsletter blurb

> CMS has proposed cutting contracted pharmacists out of Medicare remote patient monitoring starting in 2027. If your pharmacy provides RPM or RTM services for physician practices — or ever plans to — this affects you. The public comment window closes September 14, 2026, and comments genuinely change these rules. It takes about 10 minutes: go to regulations.gov/document/CMS-2026-2377-0002 and tell CMS why local contracted pharmacists should stay in remote monitoring. A playbook with talking points and a template is attached.

Social post

> Pharmacy owners: CMS wants to ban contracted pharmacists from Medicare RPM/RTM starting Jan 2027. Employed-only staff would qualify. Small and rural practices can't hire their way out of this — they'll just drop monitoring, and patients lose. Comments are open until Sept 14, 2026 at regulations.gov/document/CMS-2026-2377-0002. Ten minutes of your time can change a federal rule. Comment, then tag a pharmacy owner who needs to see this.

Text to your physician partners

> Hey [Name] — heads up: CMS's proposed 2027 fee schedule would block practices from using contracted staff (like us) for RPM/RTM billing. If our monitoring arrangement has been valuable to your patients, a short comment from you before Sept 14 would carry serious weight. Takes 10 min at regulations.gov/document/CMS-2026-2377-0002. Happy to send you talking points.

The bottom line: this is a proposed rule, not a done deal. CMS is required to listen — but only to the people who actually speak. Ten minutes before September 14 could protect a revenue stream and, more importantly, keep pharmacists doing the clinical work our patients need. Let's flood the docket.

— Dr. Lisa Faast, DiversifyRx | diversifyrx.com

This playbook is for general information and advocacy purposes only and is not legal, billing, or regulatory advice. Verify current deadlines and rule text at Regulations.gov (docket CMS-2026-2377) and CMS.gov before relying on them. Sources: CMS CY 2027 PFS Proposed Rule fact sheet, released July 14, 2026 (cms.gov); Federal Register publication, July 16, 2026.