

**To:** Third Way  
**From:** Actuarial Research Corporation  
**Subject:** Scoring Memo: Telehealth and Remote Patient Monitoring  
**Date:** January 29, 2016

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## Policy Background

Background information on the proposed policies for Medicare is described below and comes from Avalere's work.<sup>1</sup>

Policy 1: Telehealth and Remote Patient Monitoring (RPM) covered by Medicare under a waiver for providers who will be eligible for the Merit-Based Incentive Payment System (MIPS) established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The waiver will cover the timeframe from September 2016 until December 2018. MIPS-eligible provider types: physician, physician assistant (PA), nurse practitioners (NP), clinical nurse specialist (CNS), and certified registered nurse anesthetist (CRNA); starting in 2021 also certified nurse-midwife, clinical social worker, clinical psychologist, and registered dietitian or nutrition professional.

Policy 2: Telehealth and RPM covered by Medicare for providers who participate in Alternative Payment Models (APMs). The coverage will begin six months from the enactment of the legislation.

Policy 3: RPM covered by Medicare for all FFS physicians and practitioners. The coverage will begin six months from the enactment of the legislation.

Under all three policies, RPM is defined as services provided to beneficiaries with chronic conditions for which the Centers for Medicare & Medicaid Services (CMS)' Actuary determines there will be no net increase in Medicare expenditures resulting from the proposals.

This analysis looks at extending Policy 3 to the privately insured under 65 population and Medicaid and also estimates savings in private health insurance (PHI) and out-of-pocket (OOP) associated with the Medicare populations for Policies 1-3.

Telehealth coverage in private insurance and in Medicaid programs varies widely across states, and many states impose limits and restrictions on coverage and conditions of payment. Examples of barriers that currently exist in certain states include restrictions on patient settings, limits on eligible providers and covered benefits, and technology restrictions. In this analysis, we assume Federal rules will require states to implement policies that

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<sup>1</sup> Avalere Health. (January 29, 2016). Budget Impact Estimates of Telehealth and Remote Patient Monitoring Coverage. 20160129\_Telehealth and RPM Scoring Memo.pdf.

allow for such savings to be achieved in private insurance and Medicaid as estimated in Policy 3 for the Medicare population.<sup>2</sup>

We estimate illustrative savings consistent with the implied assumptions from Avalere’s findings in the Medicare population.<sup>3</sup> The estimates of projected costs and savings by payer for each of the three policies are shown in Tables 1-3. Table 4 shows the combined effect of Policies 1-3.<sup>4</sup>

## Estimation Process and Results

### Medicaid

The estimate of savings as a percent of baseline spending implied by the Medicare population in Policy 3 is adjusted and then applied to the assumed affected spending for Medicaid to generate an estimate of Medicaid savings. We assume that Medicaid would not achieve all of the savings implied by the savings rate for the Medicare population, but instead would capture a portion of the savings rate relative to the telehealth practices currently in place by each state. The illustrative factor used in adjusting the assumed savings as a percent of baseline spending is based on a recent study of state policies on coverage and reimbursement of telemedicine services in private insurance and Medicaid.<sup>5</sup>

Each state’s Medicaid plan received a score (grade) based on policies that enable or impede parity for telemedicine services. The authors also scored each state for Medicaid coverage using state policies on patient setting restrictions, eligible technologies, geographic restrictions, eligible providers, restrictions on conditions and type of services covered.<sup>6</sup> At the time of report, 48 states Medicaid programs had some type of telemedicine coverage. However, only 4 states + D.C. included comprehensive telemedicine coverage and received a score of an “A” rating.

We look at each state’s grade to estimate an adjustment factor to apply to the assumed rate of savings from Avalere’s work. We assume no additional savings would be generated from state’s already receiving an “A” rating. For state’s receiving a “B” rating, we assume minimal additional savings (10%) can be achieved. We assume 50% of the implied savings rate for state’s receiving a “C” rating and 100% of the implied savings rate for state’s receiving a failing grade. The grades are weighted by each state’s Medicaid population<sup>7</sup> in order to calculate a weighted average adjustment factor, which is then applied to the implied savings rate for the Medicare population<sup>8</sup> to generate an estimate of Medicaid savings.

In Policy 3, this produces illustrative, projected savings to Medicaid of about \$0.9 billion over the ten-year period (2017-2026). We estimate the portion of Medicaid savings by the federal government and by states using the

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<sup>2</sup> Avalere Health. (January 2016). Estimated Federal Impact of Proposed Policies Changes to Expand Medicare Reimbursement of Telehealth and Remote Patient Monitoring. *Avalere 20160111\_Telehealth and RPM Scoring Memo.pdf*

<sup>3</sup> Ibid.

<sup>4</sup> Using the assumed overlap shown in the Summary Table from: Avalere Health. (January 2016). Estimated Federal Impact of Proposed Policies Changes to Expand Medicare Reimbursement of Telehealth and Remote Patient Monitoring. *Avalere 20160111\_Telehealth and RPM Scoring Memo.pdf*

<sup>5</sup> Thomas, L. and Capistrant, G. (2015). State Telemedicine Gaps Analysis: Coverage and Reimbursement. American Telemedicine Association.

<sup>6</sup> Additional details on the scoring system can be found in the full report: Thomas, L. and Capistrant, G. (2015). State Telemedicine Gaps Analysis: Coverage and Reimbursement. American Telemedicine Association.

<sup>7</sup> Medicaid population by state from CPS March 2015 data

<sup>8</sup> Estimated as the Medicare savings as a percent of baseline spending.

average Federal Medical Assistance Percentage (FMAP) for states in FY2017.<sup>9</sup> Of the \$0.9 billion in savings to Medicaid, the federal share is \$0.5 billion and the state share is \$0.4 billion.

## PHI

### *Under 65 Population*

The estimate of savings as a percent of baseline spending implied by the Medicare population in Policy 3 is adjusted for the privately insured under 65 population and then applied to the assumed affected spending for PHI to generate an estimate of PHI savings in the under 65 population. Again, we assume that private health insurance would not achieve all of the savings implied by the savings rate for the Medicare population, but instead would capture a portion of savings relative to the telehealth practices currently in place by each state. The illustrative factor used in adjusting the assumed savings as a percent of baseline spending is based on the study previously mentioned on state policies on coverage and reimbursement of telemedicine services in private insurance and Medicaid.<sup>10</sup>

The report reviews telemedicine parity laws for private insurance, and the authors scored each state for private insurance by reviewing state policies that enable or impede parity for telemedicine services under private health insurance plans. Currently, 24 states have telemedicine parity laws in place for private insurance, with 16 states scoring a grade of "A". Twenty-seven (27) states received failing scores for having either no parity law in place or many barriers.

The assumptions for PHI adjustments are the same as the assumptions for Medicaid adjustments. We assume no additional savings will be generated from state's already receiving an "A" rating. For state's receiving a "B" rating, we assume minimal additional savings (10%) can be achieved. We assume 50% of the implied savings rate for state's receiving a "C" rating and 100% of the implied savings rate for state's receiving a failing grade. The grades are weighted by each state's PHI population (under age 65)<sup>11</sup> in order to calculate a weighted average adjustment factor, which is then applied to the implied savings rate to generate an estimate of PHI savings in the under 65 population.

In Policy 3, this produces illustrative, projected savings to PHI (under 65) of \$3.1 billion over the ten-year period (2017-2026).

### *Medicare Population*

Implementing telehealth and RPM policies in Medicare can also produce savings through lower cost sharing associated with the Medicare population. Cost sharing in Medicare can be split into two components 1.) that which is paid for by private health insurance (PHI) and 2.) out-of-pocket (OOP). Private health insurance associated with the Medicare population is broken down further into employer sponsored insurance (ESI) (retiree medical) and Medigap. We estimate savings in ESI and Medigap as a result of telehealth and RPM policies using assumptions implied by Avalere's work.<sup>12</sup>

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<sup>9</sup> Average FMAP percentage for total US (51). Accessed: <http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/>

<sup>10</sup> Thomas, L. and Capistrant, G. (2015). State Telemedicine Gaps Analysis: Coverage and Reimbursement. American Telemedicine Association.

<sup>11</sup> PHI population (under 65) by state from CPS March 2015 data

<sup>12</sup> Avalere Health. (January 2016). Estimated Federal Impact of Proposed Policies Changes to Expand Medicare Reimbursement of Telehealth and Remote Patient Monitoring. *Avalere 20160111\_Telehealth and RPM Scoring Memo.pdf*

In Policy 1, the baseline PHI data for the Medicare population is adjusted by a factor of about 40% to reflect the Medicare baseline assumed for MIPS.<sup>13</sup> In Policy 2, the baseline PHI data for the Medicare population is adjusted by a factor of about 60% to reflect the assumed APM base.<sup>14</sup> In Policy, 3, the baseline PHI data for the Medicare population is not adjusted because it covers all FFS providers.

For each policy, we calculate the costs or savings as a percent of baseline spending implied by the Medicare population.<sup>15,16</sup> The estimate of savings as a percent of baseline spending implied by the Medicare population is then applied to the aggregate ESI and Medigap spending associated with the Medicare reductions to generate an estimate of PHI savings for the Medicare population. This produces illustrative, projected costs to PHI of about \$0.2 billion (\$0.04 billion Medigap and \$0.1 billion ESI) in Policy 1. Policies 2 and 3 produce illustrative projected savings of \$0.3 billion (\$0.1 billion Medigap and \$0.2 billion ESI) and \$0.4 billion (\$0.1 billion Medigap and \$0.3 billion ESI) respectively over the ten-year period 2017-2026.

### Out-of-Pocket

#### *Medicaid and PHI Under 65 Population*

To estimate the effect on OOP spending associated with Medicaid and PHI for the under 65 population, we use an assumption of how much OOP is associated with each dollar of payment. We assume OOP savings associated with Medicaid are equal to 5% of the estimated change in Medicaid spending, and we assume the OOP savings associated with PHI (under 65) are equal to 20% of the estimated change in PHI (under 65) spending.

Projected OOP savings associated with Medicaid total \$0.1 billion and projected OOP savings associated with PHI for the under 65 population total \$0.6 billion in Policy 3 over the ten-year period 2017-2026.

#### *PHI Medicare Population*

The baseline OOP data associated with the Medicare population is adjusted to reflect the population affected by the Medicare policy. The estimate of savings as a percent of baseline spending implied by the Medicare population is then applied to the aggregate OOP associated with the Medicare reductions to generate an estimate of OOP savings. This produces illustrative, projected OOP costs associated with the Medicare population of about \$0.4 billion in Policy 1 over the ten-year period 2017-2026. Policies 2 and 3 produce illustrative projected OOP saving associated with the Medicare population of about \$0.7 billion and \$1.0 billion respectively over the ten-year period 2017-2026.

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<sup>13</sup> Based on the assumption that 60% of Medicare physician spending in 2019 is expected to be in APMs. CMS Office of the Actuary: Estimated Financial Effects of the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2). Access: <https://www.cms.gov/research-statistics-data-and-systems/research/actuarialstudies/downloads/2015hr2a.pdf>

<sup>14</sup> Ibid.

<sup>15</sup> Avalere Health. (January 2016). Estimated Federal Impact of Proposed Policies Changes to Expand Medicare Reimbursement of Telehealth and Remote Patient Monitoring. *Avalere 20160111\_Telehealth and RPM Scoring Memo.pdf*

<sup>16</sup> ARC's baseline Medicare spending is adjusted for MIPS and APM based on assumptions from CMS Office of the Actuary: Estimated Financial Effects of the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2). Access: <https://www.cms.gov/research-statistics-data-and-systems/research/actuarialstudies/downloads/2015hr2a.pdf>

**Final Draft Estimates for Third Way**

Estimated change in spending due to Telehealth and Remote Patient Monitoring Policies

ARC

Table 1: Estimated change in spending due to Telehealth/RPM Policy 1, by payer (\$ in billions, by fiscal year)

|                                     | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2017-2026 |
|-------------------------------------|------|------|------|------|------|------|------|------|------|------|-----------|
| Medicare                            | 0.5  | 0.5  | 0.1  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 1.1       |
| Medicaid-federal                    | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0       |
| total federal                       | 0.5  | 0.5  | 0.1  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 1.1       |
| Medicaid-state                      | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0       |
| Private health insurance            | 0.1  | 0.1  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.2       |
| Out-of-pocket spending              | 0.2  | 0.2  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.4       |
| total-Medicare, Medicaid, PHI + OOP | 0.8  | 0.8  | 0.1  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 1.7       |

Table 2: Estimated change in spending due to Telehealth/RPM Policy 2, by payer (\$ in billions, by fiscal year)

|                                     | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2017-2026 |
|-------------------------------------|------|------|------|------|------|------|------|------|------|------|-----------|
| Medicare                            | *    | *    | *    | -0.1 | -0.1 | -0.2 | -0.3 | -0.4 | -0.5 | -0.6 | -2.2      |
| Medicaid-federal                    | *    | *    | *    | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0       |
| total federal                       | *    | *    | *    | -0.1 | -0.1 | -0.2 | -0.3 | -0.4 | -0.5 | -0.6 | -2.2      |
| Medicaid-state                      | *    | *    | *    | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0       |
| Private health insurance            | *    | *    | *    | 0.0  | 0.0  | 0.0  | 0.0  | -0.1 | -0.1 | -0.1 | -0.3      |
| Out-of-pocket spending              | *    | *    | *    | 0.0  | 0.0  | -0.1 | -0.1 | -0.1 | -0.2 | -0.2 | -0.7      |
| total-Medicare, Medicaid, PHI + OOP | *    | *    | *    | -0.1 | -0.1 | -0.3 | -0.4 | -0.6 | -0.7 | -0.9 | -3.2      |

| Table 3: Estimated change in spending due to RPM Policy 3, including expansion to Medicaid and PHI (under 65), by payer (\$ in billions, by fiscal year) |      |      |      |      |      |      |      |      |      |      |           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|------|------|------|------|------|------|------|------|------|------|-----------|
|                                                                                                                                                          | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2017-2026 |
| Medicare                                                                                                                                                 | *    | *    | *    | -0.1 | -0.2 | -0.3 | -0.4 | -0.5 | -0.7 | -0.8 | -3.0      |
| Medicaid-federal                                                                                                                                         | *    | *    | *    | 0.0  | 0.0  | -0.1 | -0.1 | -0.1 | -0.1 | -0.1 | -0.5      |
| total federal                                                                                                                                            | *    | *    | *    | -0.1 | -0.2 | -0.4 | -0.5 | -0.6 | -0.8 | -0.9 | -3.5      |
| Medicaid-state                                                                                                                                           | *    | *    | *    | 0.0  | 0.0  | 0.0  | 0.0  | -0.1 | -0.1 | -0.1 | -0.4      |
| Private health insurance                                                                                                                                 | *    | *    | *    | -0.1 | -0.2 | -0.4 | -0.5 | -0.6 | -0.8 | -0.9 | -3.5      |
| Out-of-pocket spending                                                                                                                                   | *    | *    | *    | -0.1 | -0.1 | -0.2 | -0.2 | -0.3 | -0.4 | -0.4 | -1.7      |
| total-Medicare, Medicaid, PHI + OOP                                                                                                                      | *    | *    | *    | -0.3 | -0.6 | -0.9 | -1.2 | -1.5 | -2.1 | -2.4 | -9.1      |

| Table 4: Summary of All 3 Policies by payer (\$ in billions, by fiscal year) |      |      |      |      |      |      |      |      |      |      |           |
|------------------------------------------------------------------------------|------|------|------|------|------|------|------|------|------|------|-----------|
|                                                                              | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2017-2026 |
| Medicare                                                                     | 0.5  | 0.5  | 0.1  | -0.1 | -0.2 | -0.3 | -0.4 | -0.5 | -0.7 | -0.8 | -1.8      |
| Medicaid-federal                                                             | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | -0.1 | -0.1 | -0.1 | -0.1 | -0.1 | -0.5      |
| total federal                                                                | 0.5  | 0.5  | 0.1  | -0.1 | -0.2 | -0.4 | -0.5 | -0.6 | -0.8 | -0.9 | -2.4      |
| Medicaid-state                                                               | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | -0.1 | -0.1 | -0.1 | -0.4      |
| Private health insurance                                                     | 0.1  | 0.1  | 0.0  | -0.1 | -0.2 | -0.4 | -0.5 | -0.6 | -0.8 | -0.9 | -3.4      |
| Out-of-pocket spending                                                       | 0.2  | 0.2  | 0.0  | -0.1 | -0.1 | -0.2 | -0.2 | -0.3 | -0.4 | -0.4 | -1.3      |
| total-Medicare, Medicaid, PHI + OOP                                          | 0.8  | 0.8  | 0.1  | -0.3 | -0.6 | -0.9 | -1.2 | -1.5 | -2.1 | -2.4 | -7.5      |
| Note: Numbers may not add to total due to rounding                           |      |      |      |      |      |      |      |      |      |      |           |