December 10, 2020

To: National Council of Insurance Legislators, Health Insurance & Long Term Care Issues Committee

From: Jen DeYoung, Director of Policy, Building Blocks of Health Reform, United States of Care

CC: Joanna Dornfeld, Sr. Director of External Affairs and Partnerships, United States of Care
Catherine Jacobson, Building Blocks of Health Reform Policy Coordinator, United States of Care

RE: Recommended Amendments to the Telemedicine Authorization and Reimbursement Act Model Legislation

United States of Care (USoC) is honored to present at the NCOIL Annual Meeting to the Health Insurance & Long Term Care Issues Committee. The following letter is a supplement to the presentation.

USoC is a non-partisan non-profit with a mission to ensure that everyone has access to quality, affordable health care regardless of health status, social need, or income. We were founded by a diverse Board and Founder's Council to advance state and federal policies that solve the challenges that people face with our health care system. We seek to understand people's unique needs to drive health care policy innovation and partner with elected officials and stakeholders to pass and implement those ideas.

USoC commends the creation of this model legislation, which will undoubtedly increase access to telemedicine for many across the country. USoC would like to recommend several amendments to the proposed model legislation titled 'Telemedicine Authorization and Reimbursement Act'.

As policymakers evaluate next steps for virtual care and consider making permanent action, it is critical that policies are evaluated against criteria that place the needs of patients at the center. USoC has been working to understand and compile the experiences that patients have while accessing and utilizing virtual care, both prior to and during the COVID-19 pandemic. Our work includes national poll surveys, focus groups, one-on-one conversations, and scans of existing public opinion and utilization and outcomes research. This extensive work to understand what patients need to fully and equitably access virtual care has informed our recommendations to adjust the model legislation.

USoC Recommendations

1. Section 3 (E): Adjust the definition of "originating site" to require that the patient's home and school-settings are reimbursable locations for patients to be located at the time of care services.

Virtual care in its nature allows for greater convenience for the patient. This should include flexibilities on where the patient is located. We believe that at a minimum, reimbursable originating sites should be required to include the patient's home and school-settings, in addition to other sites agreed upon by insurers and providers. Our national poll data found that 46% of people who have utilized virtual care most liked the convenience of not having to leave their place of residence.

Example:
Michigan H.B. 5416 (enacted): Covers telemedicine services for Michigan's Medicaid programs if the patient is at their home, a school, or another site considered appropriate by the provider.

2. Section 4 (D): Require the given state Medicaid program reimburse Rural Health Clinics (RHC), Indian Health Services (IHS), and Community Health Centers including Federally Qualified Health Centers (FQHC) for telemedicine services provided to Medicaid recipients on the same basis that the Medicaid program is responsible for coverage of the same service through in-person contact.

Underserved populations, care clinics, and their providers should be allowed the option of telemedicine and telehealth services. Reimbursement for providers and services at these critical facilities and to these specific populations is needed to work towards more equitable access to virtual care. We have heard this need from several information interviews including from national provider groups.

Example: Colorado S.B. 20-212 (enacted) Requires state Medicaid program to reimburse FQHCs, RHCs, and the federal Indian Health Services for telemedicine services provided to Medicaid recipients at the same rate as in-person services.

3. Add provision requiring a study on health equity, quality, cost, and/or access of virtual care in the given state.

Virtual care is not a new concept, however it is rapidly increasing and has the capacity to constantly innovate to meet the changing needs of patients and the health care infrastructure. Accepting that the best practices will take time and trials to determine, it is critical to set forth studies and evaluations in these early stages to inform future policies and implementation practices related to virtual care and telemedicine.

As a final note we want to make clear that we believe when clinically appropriate, patients must have the flexibility to choose how they would like to receive care whether it is in-person or through any of the multiple virtual modalities. State governments should ensure providers are not incentivized to steer patients to certain methods of care based on reimbursement. By putting the patient first, these policy measures have the potential to close gaps in virtual care access.