May 18, 2021

Kevin Beagan, Deputy Commissioner
Massachusetts Division of Insurance
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Jatin Dave, MD, MPH, Chief Medical Officer
MassHealth, Executive Office of Health and Human Services
jatin.dave@mass.gov

Re: Implementation of Telehealth Provisions under Chapter 260 of the Acts of 2020

Dear Deputy Commissioner Beagan and Dr. Dave,

On behalf of Health Care For All (HCFA) and Health Law Advocates (HLA), thank you for the opportunity to submit comments regarding implementation of the telehealth provisions of Chapter 260 of the Acts of 2020. We appreciate the efforts by the Division of Insurance ("the Division") and MassHealth to engage stakeholders in this process through listening sessions and an open opportunity to submit written comments. HCFA is also a member of the *t*MED Coalition and broadly supports the feedback provided by the coalition. HCFA and HLA would like to provide additional responses and comments regarding the questions and issues the Division and MassHealth raised during the listening sessions.

Carrier Communication with Members

HCFA strongly believes that the consumer protections included in Chapter 260 – and additional protections that the Division and MassHealth implement through guidance and regulation – should be clearly communicated to consumers so they understand the rights and restrictions for receiving health care services via telehealth. Consistent and accurate consumer information also relies on carrier communication with providers, who should be educated about health plan policies and practices pertaining to telehealth modalities. Written and oral communications should be widely accessible, taking into account factors including language, culture, disability, and literacy level. As a baseline, carrier, MassHealth, and managed care entity communications should be available in multiple languages and formats, ensuring accessibility for people with Limited English Proficiency (LEP), individuals who are deaf/hard of hearing and/or blind/visually impaired.

Cost-Sharing

Chapter 260 states that carriers may charge cost-sharing for services provided via telehealth as long as it does not exceed the cost-sharing for the in-person delivery of the same service. Just as with in-person services, it is crucial that health plan enrollees using telehealth understand their coverage and any cost-sharing associated with receiving specific services. Carriers should be held to the same existing obligations under M.G.L. c. 176O § 6 with regards to communicating cost-sharing information to members, which should include at a minimum a clear reference to the aforementioned

protections in Chapter 260 that prohibit higher cost-sharing for telehealth services and any allowable cost-sharing differences that carriers may choose to implement (e.g., waiving cost-sharing for certain/all telehealth services). Carriers and providers retain the obligation to provide consumers with cost estimates for certain services, which is applicable for in-person and telehealth care, as required under M.G.L. c. 176O § 23 and Chapter 224 of the Acts of 2012.

We support *t*MED's suggestions to encourage carriers to continue (or re-start) waiving co-pays for telehealth services through 90 days after the end of the public health emergency. Several carriers already resumed cost-sharing for services provided via telehealth in 2021, but carrier communication to enrollees about this change was inconsistent or non-existent. Many consumers learned about the return to cost-sharing through their providers (including a HCFA staff person). Any changes in cost-sharing policy, regardless of treatment modality, should be communicated to consumers as quickly and clearly as possible.

Receipt of Services via Telehealth

Health insurance carriers, MassHealth, and managed care entities should clearly communicate how receiving services via telehealth works, including any coverage limitations. This information should be part of plan summary documents and clearly indicated in a FAQ or telehealth information section on each carrier's website. In addition to cost-sharing and network information, consumers need to be informed about any restrictions, such as whether their telehealth encounter will be covered while temporarily visiting another state (e.g. for vacation or family obligations). In addition, while the primary responsibility is with the provider, carriers, MassHealth, and managed care entities should also inform members that they may decline receiving services via telehealth in order to receive in-person services, as stipulated in Chapter 260. Finally, carriers, MassHealth, and managed care entities should provide consumers with information about available technical and financial assistance that can help patients successfully engage in telehealth services, such as the Comcast Internet Essentials program.

Provider Network Status

Chapter 260 prohibits carriers, MassHealth, and managed care entities from meeting network adequacy through significant reliance on telehealth providers. Provider networks should not be considered adequate if patients are not able to access appropriate in-person services in a timely or geographically accessible manner, nor if coverage is limited to services provided by third-party telehealth providers. To the extent practicable, payers should include a clear indication in provider directories about whether a provider offers services via telehealth and whether a provider *only* provides services through telehealth. During its network adequacy reviews, the Division and MassHealth should closely analyze whether carriers and managed care entities are substantially relying on telehealth providers, especially national or third-party telehealth vendors rather than local providers who can provide services both via telehealth and in-person.

Telehealth Technology

Chapter 260 includes audio-only telephone in its definition of telehealth. The Division and MassHealth should work with carriers, managed care entities, and providers to ensure that audio-only telephone is available as widely as possible. Audio-only telephone access has been particularly useful in the provision of behavioral health services during the pandemic. The ability to connect with providers by telephone has also been an important way to ensure that consumers impacted by the so-called "digital divide" can access care. The digital divide refers to the gap between people who have ready access to computers or devices and sufficient internet connectivity and those who do not,

which can be tied to socioeconomic, sociocultural, technical knowledge, and other barriers. Some consumers may also feel more comfortable receiving telehealth services by phone due to issues such as privacy concerns and language access, or simply patient preference. Regardless of the platform or modality, interpreters must be available for LEP populations and those who are deaf or hard of hearing. Services provided through audio-visual means should additionally put accessibility measures into place for people who are blind or visually impaired.

Defining a Telehealth "Visit"

While we are not commenting on the overall definition of a visit, HCFA and HLA caution against any definition that would result in increased cost-sharing for consumers. Provider payment aside, cost-sharing is only relevant for encounters that entail providing care directly to and with the patient. For example, asynchronous communications and e-consults *between providers* should not result in any consumer financial liability. Similarly, individuals should not be charged cost-sharing for services such as calling a nurse triage line or requesting a prescription refill by phone. Further, separate standards of care should not be developed simply because a service is provided via telehealth. Providers should be held to the same standards whether services are provided in-person or through telehealth and work collaboratively with their patients to determine the best course of care and modalities for receiving that care.

Utilization Review for Telehealth

Chapter 260 states that utilization review, including prior authorization, may be used to determine coverage of services via telehealth as long as it is made in the same manner as determinations for in-person services. There should not be any additional requirements for prior authorizations or other utilization review to receive services through telehealth. In some instances, consumers may be able to access services via telehealth more quickly than in person, which should be taken into account with any utilization review processes.

Carriers must continue to comply with consumer protections under M.G.L. c. 176O and requisite Medicaid and Children's Health Insurance Program (CHIP) rules regardless of whether a service is provided in-person or through telehealth. Carriers are required to comply with the federal mental health and substance use disorder parity law; Medicaid and CHIP are also required to comply with parallel statutes and regulations that apply to those programs specifically. The parity law requires that non-quantitative treatment limits, such as prior authorization restrictions, must be "comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification." 45 CFR 146.136(c)(4); 29 CFR 2590.712(c)(4). For example, restrictions on behavioral health services must be compared to those existing restrictions on medical services within the entire classification group, such as outpatient services.

Chapter 260 also made clear that a "health care provider shall not be required to document a barrier to an in-person visit" in the process of requesting or delivering telehealth services. Therefore, information or documentation of such barriers must not be included in the scope of the "necessary information" that relates to the medical necessity and appropriateness of the requested telehealth service. As with all decisions and determinations by carriers regarding medical necessity, the Division should remind carriers that the appropriateness of telehealth services requested in any individual circumstance must be evaluated in light of "the individual health care needs of the insured," as required under M.G.L. c. 176O § 16(b). Thus, the Division should advise carriers to focus on information regarding the "individual health care needs of the insured" and how the proposed telehealth services could meet those needs. Disclosure notices should clearly indicate how

utilization review processes apply to receipt of care via telehealth, including a statement that refers to language within Chapter 260 that telehealth services are covered in the same manner as in-person services with regards to prior authorizations and other utilization management processes.

Denials and Appeals

The processes for telehealth denials, appeals, disclosures, reconsiderations, and expedited reviews should be the same as for in-person services, including a consumer's right to appeal a denial of receiving care through telehealth. We request that the Division also explore a more permissive policy to allow expedited review for denials of receiving services via telehealth. A consumer may be forced into the difficult position of choosing to wait to receive in-person services, potentially putting themselves at risk in order to fully assert their appeal rights, and receiving an appeals decision about telehealth access for the services. At the same time, a consumer should also have the right to choose to receive any service in-person at any point.

Carriers should work to ensure that their customer service and appeals department staff understand that a denial of telehealth as a method of receiving a service does not necessarily mean that the service itself is denied or not covered under the plan. However, it is clear that such a determination by a carrier is really an exercise of medical judgement under the "appropriateness" requirement under Chapter 260. Therefore, in order to safeguard consumer appeal rights under M.G.L. c. 176O § 14, in light of expanded access to telehealth under Chapter 260, we request that the Division require carriers to be clear in their denial letters or denial notices that any prior authorization denial of telehealth services by the carrier regarding whether "the health care services may be appropriately provided through the use of telehealth" under M.G.L. c. 176G, § 33(b)(ii) is an exercise of medical judgement by the carrier that is subject to external review by Office of Patient Protection under M.G.L. c. 176O § 14. In addition, we respectfully request that the Division collaborate with the Health Policy Commission to exercise its authority under M.G.L. c. 6D § 18 to issue regulations to implement this policy as an external review appeal right under chapter M.G.L. c. 176O § 14.

Thank you for your time and consideration of the issues raised in this letter regarding implementation of telehealth provisions in Chapter 260 of the Acts of 2020. Please do not hesitate to contact us with any questions or to discuss these comments further.

Sincerely,

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Lydia Conley PRESIDENT / CEO
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June 8, 2021

Kevin Beagan, Deputy Commissioner
Division of Insurance Health Care Access Bureau
1000 Washington St
Boston, MA 02118

Re: Implementation of Telehealth Provisions within Chapter 260 of the Acts of 2020

As you may know, the Association for Behavioral Healthcare (ABH) is a statewide association representing 80 community-based mental health and addiction treatment provider organizations. ABH's members are the primary providers of publicly-funded behavioral healthcare services, serving approximately 81,000 Massachusetts residents daily, 1.5 million residents annually, and employing over 46,500 people. ABH appreciates the opportunity to submit testimony relative to the implementation of telehealth provision within Chapter 260 of the Acts of 2020.

Utilization of telehealth services for behavioral healthcare has been exceedingly popular throughout the pandemic, decreasing barriers to care during a time of increased stress and isolation. When ABH members were surveyed about telehealth services from March-May 2020, we found that **56,571 individuals were served** with telehealth consisting of:

- 20,186 individuals receiving services telephonically;
- 10,996 individuals receiving services via videoconferencing; and
- 25.389 individuals receiving services via non-specified means of telehealth.

Telehealth services **improved the average "no show" rate by 25.8% and decreased wait times by 35.7%** as compared to the year prior. Access to behavioral healthcare via telehealth is also a matter of equity, improving the ability to provide culturally and linguistically competent services. ABH found that telehealth had enabled individuals whose primary language is other than English to enjoy a 52.8% reduction in wait times.

Our survey confirms trends that have been observed through Health Policy Commission reporting and claims data, which showed that telehealth was employed in behavioral healthcare to a far greater extent (41%) than for any other specialty (followed by endocrinology at 14%).

As a member of the Massachusetts Telemedicine (*t*MED) Coalition, ABH is in support of the comments already submitted by the coalition. However, we appreciate the opportunity to comment on areas that were not addressed by the broader coalition, particularly as it relates to behavioral health services.

Question 2A. <u>What constitutes a telehealth visit?</u>
As is the practice now, encounters with providers should continue to be driven by procedure codes and the complexity of the encounter. This does not require a new definition of a "visit",

nor does it require additional standards to establish the appropriateness of encounters. ABH additionally **cautions against allowing individual plans to develop standards similar to medical necessity.** As was established in *Wit v. UBH*, insurance companies that use flawed medical necessity criteria that result in the inappropriate denial of behavioral health claims can face consequences resulting from violations of parity laws or their fiduciary obligations. The decision clearly upheld the understanding that there are generally accepted standards for making coverage determinations, particularly for substance use and mental health treatment, that managed behavioral health care organizations are expected to follow. Thus, instead of allowing for the development of internally-developed coverage determination and level of care guidelines, wherever possible, standards of care should rely on already-established guidelines from clinical specialty organizations like the American Society of Addiction Medicine (ASAM).

As has been iterated by the *tMED* Coalition**, the modality being utilized should hold no bearing on the appropriateness of a clinical encounter**. In particular, the ability to utilize audio-only telehealth has been a useful tool for our member organizations that serve individuals with significant barriers to accessing care, including individuals who are homeless, unstably housed, elderly, or are otherwise unable to access or uncomfortable using video technology. It is important to recognize that any alteration in payment parity for audio-only services would disproportionately impact vulnerable individuals who already have difficulty accessing and remaining in care.

Question 2B. <u>Definitions of services</u>

Section 55 of Chapter 260 requires that outpatient behavioral health services be delivered by "licensed mental health professionals acting within the scope of his license". ABH asserts that any guidelines must not unnecessarily limit the staff and clinicians that are currently providing behavioral health services by only allowing those professionals defined under MGL Chapter 176G, Section 4M(i) to deliver care. This follows guidelines already established under certain plans and under DOI Bulletin 2018-07 for child-adolescent services, which states, "*Carriers shall ensure that if a provider is not independently licensed at the Masters/PhD/MD level, then the supervisor – who must be a Masters Level independently licensed provider – must sign off on the treatment plan whenever the child's or adolescent's condition changes*". **ABH recommends that similar guidelines allowing for the supervision of providers be incorporated into guidelines**. Community-based organizations often serve as training grounds for providers, and guidelines should not prohibit professionals who are under supervision from being able to provide covered telehealth services.

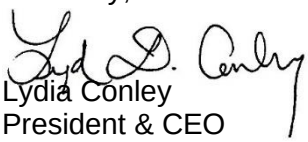
Question 3. <u>How should providers bill for telehealth services?</u>

Eight of ten most common procedures with telehealth codes in Massachusetts were for behavioral therapy codes during the pandemic (COVID-19 Research Database, 2020). It is clear that telehealth is an exceedingly important modality for the provision of behavioral health services, and we are grateful that Chapter 260 acknowledges its importance by ensuring reimbursement parity for behavioral health services continue in perpetuity. However, reimbursement parity is effective only so long as all relevant billing codes for behavioral health services are covered. Some codes which were opened to behavioral health providers early in the pandemic, like audio-only assessment and management CPT codes, do not always reflect the nature of the service being billed. Billing must instead reflect, to the maximum extent possible, service being delivered, regardless of the modality. In these instances, carriers and public payers appropriately determined that services being delivered did, in fact, meet the criteria for evaluation and management codes, and in the behavioral healthcare space, these services can generally be delivered by via telehealth

When considering billing processes for telehealth services, ABH encourages consistency and standardization across payers. Providers have had to adjust to constantly changing standards for the provision of services throughout the pandemic, disrupting care and adding to organizational and documentation burdens on already-strained staff. As we look forward to the end of the Governor's declared State of Emergency, we hope that a streamlined and simplified process can emerge that enables the broad uptake of telehealth, without sacrificing already established gains.

Thank you for your consideration of these comments. If you have any questions or comments, please do not hesitate to contact me.

Sincerely,



Lydia Conley
President & CEO

MASSACHUSETTS FOOT & ANKLE SOCIETY

Massachusetts Foot & Ankle Society

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July 12, 2021

Mr. Kevin Beagan, Deputy Commissioner
Massachusetts Division of Insurance
1000 Washington Street, Suite 810
Boston, Massachusetts 02118

Dear Deputy Commissioner Beagan,

On behalf of the approximately 300 members of the Massachusetts Foot and Ankle Society (MFAS), I am writing to provide comments relative to the Massachusetts Division of Insurance's (Division's) deliberations on the future of telehealth within the Commonwealth. While the practice of podiatry often relies on in-person visits, there are many elements of the practice that lend itself to being conducted through virtual, electronic or other means ("telehealth") that allow a podiatrist to have a meaningful interaction with a patient.

The use of telehealth increased markedly throughout the evolution of the COVID-19 pandemic. While health care providers and patients recognized that successful health care services could be provided through virtual, electronic and other means, it was still a "work in progress" to determine what "worked and what did not". To that end, Chapter 260 of the Acts of 2020 recognized that telehealth is here to stay, but that we need clear guidelines to create a mechanism that is both effective and cost efficient. The Division is to be applauded for conducting a thorough and thoughtful review of the myriad of issues associated with telehealth. For its part, MFAS would like to comment on three of those areas: defining telehealth visits; the defining chronic disease and telehealth technology.

- Defining Telehealth Visits. The COVID-19 pandemic has shown that telehealth works for a wide variety of health care providers in a wide array of settings to the benefit of patients and their families, friends and employers. Unfortunately, the pandemic further underscored that we are a disparate Commonwealth when it comes to patient access to technology and health care. As a result, MFAS encourages the Division to adopt a broad definition of what constitutes a "telehealth visit". To limit a "telehealth visit" to only those encounters that occur through the most advanced virtual means possible will disadvantage those patients without access to the required technology. Telehealth may involve the provider, the patient, and third parties such as visiting nurses in the home, or nursing and therapy staff at short term rehabilitation facilities. A range of clinical situations and locations of care should meet the eligibility criteria for telehealth. Likewise, whether a patient speaks with a health care provider over the telephone or a secure video platform, the patient is receiving health care services that are meant to improve the patient's clinical outcome. As with any patient encounter, the health care provider is governed by a legal standard of care that dictates whether the means by which the health care provider ascertains certain information is sufficient for meeting the necessary standard of care. For example, if a health care provider can ascertain a patient's needs and appropriate treatment through a telephone call, then the encounter should qualify for reimbursement under the applicable telehealth regulations.

MASSACHUSETTS FOOT & ANKLE SOCIETY

Massachusetts Foot & Ankle Society

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- Definition of Chronic Disease. In unison with many other commenters, MFAS strongly encourages the Division to adopt a broad definition of "chronic disease". In particular, our organization shares the sentiment expressed by the tMed Coalition, the Massachusetts Orthopedic Association and the Massachusetts Medical Society that references the Centers for Disease Control and Prevention's (CDC's) definition that "[c]hronic diseases are defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both.". Among other diseases and conditions, podiatrists treat lifelong diabetic patients who exhibit a wide variety of short- and long-term complications from this devastating disease. Likewise, our peers in other areas of medicine treat diseases and conditions, which last longer than one year, that would benefit from the cost-savings and ease of access that telehealth visits provide.

- Telehealth Technology. Chapter 260 of the Acts of 2020 specifically reiterated the point that telehealth technology must confirm to federal and state information privacy laws. For any health care provider, it has always been understood that the provision of telehealth services must be conducted over secure means that provide protections for patients' privacy. That said, many of the existing means for telehealth already provide for patient privacy and the ability to effectively consult with a patient. As a result, MFAS respectfully requests that the Division not implement additional "technological protections" to those already provided for under existing law. Creating potentially burdensome technology standards in addition to the existing privacy protections may prevent health care providers from being able to affordably offer telehealth services. Not only would additional technology requirements harm health care providers, it will likely create a situation where certain patients would be unable to access telehealth services due to a lack of means to acquire or access the heightened technological requirements.

Podiatry is a field of medicine that strives to improve the overall health and well-being of patients by focusing on preventing, diagnosing, and treating conditions associated with the foot and ankle. As doctors of podiatric medicine (DPMs) are physicians and surgeons who practice on the lower extremities, primarily on feet and ankles, telehealth can play a significant role in improving access to high quality health care services for our patients throughout the Commonwealth. Whether working as part of a team ensuring a patient's diabetes does not result in the loss of a limb or simply following up with a patient after surgery, podiatrists have been able to use telehealth visits to improve patient outcomes and access. Please continue to allow for a broad use and application of telehealth services at a rate that ensures patients will continue to have access to these services.

I appreciate your consideration of these comments and, again, thank you for leading the Division's work on this important matter. If you have any questions or concerns, please do not hesitate to contact me.

Sincerely,

Dr. Frank Campo, DPM
President

August 11, 2021

Kevin Beagan
Deputy Commissioner, Health Care Access Bureau
Massachusetts Division of Insurance
1000 Washington Street, Suite 810
Boston, MA 02118

Re. Chronic disease management provisions within Chapter 260 of the Acts of 2020

Dear Deputy Commissioner Beagan,

The Massachusetts Academy of Nutrition and Dietetics appreciates this opportunity to provide comments pertaining to telehealth provisions within Chapter 260 of the Acts of 2020, specifically relating to the definition of and reimbursement for chronic disease management. We request consideration of the inclusion of language related to the provision of nutrition services provided by registered and licensed dietitian/nutritionists through telehealth.

The Massachusetts Academy of Nutrition and Dietetics (MAND) is a state affiliate of the Academy of Nutrition and Dietetics, the world's largest organization of food and nutrition professionals and the association that represents credentialed nutrition and dietetics practitioners, including registered dietitian nutritionists (RDNs, also known as RDs). MAND and the roughly 2,700 credentialed practitioners it represents are committed to helping Massachusetts residents thrive through the transformative power of food and nutrition, and support legislative efforts focused on promoting health through nutrition interventions.

RDNs are food and nutrition experts who have met academic and professional requirements to qualify for the 'RDN' credential, which include at minimum a bachelor's degree, an accredited supervised practice program and passing the national Registration Exam. To ensure that RDNs keep current on emerging science, they must complete continuing professional educational requirements to maintain registration. To protect the public from harm from incompetent or unqualified practitioners, MAND worked with the legislature to pass the law creating the voluntary practice license and Licensed Dietitian/Nutritionist (LDN) designation, providing further credentials for qualified practitioners, and now required by most Massachusetts healthcare organizations and health insurance companies.

Access to qualified dietitians is particularly important for people with medical diagnoses for which medical nutrition therapy (MNT) is indicated. MNT is nutritional diagnostic, therapy and counseling services furnished by an RDN for the purpose of disease prevention, management, or treatment. MNT is an evidence-based, cost-effective component of treatment that can help combat many of the nation's most prevalent and costly chronic conditions, including obesity, diabetes, hypertension and dyslipidemia. Counseling provided by an RDN as part of a health care team can positively impact weight, blood pressure, blood lipids and blood sugar control.[1-7]

According to the CDC's National Center for Chronic Disease Prevention and Health Promotion, 90% of the nation's $3.5 trillion annual health care expenditure is spent on treating chronic and mental health conditions.[8] In Massachusetts in 2020, health care costs attributed to the 507,000 (9.3%) of adults with diagnosed diabetes were $7.6 billion.[9,10] With over a year's worth of data, it is clear that chronic conditions such as diabetes are contributing to poor COVID-19 outcomes.[11-14]

RDNs provide MNT in a variety of settings to prevent and manage chronic conditions.[15] Medicare covers MNT in the outpatient setting, notably with no copay since 2011, after the passage of the Affordable Care Act and removal of fees for evidence-based preventive services. Although generally with copay, many third-party payers also cover MNT, including in the private practice setting.

Until recently, barriers to the utilization of MNT services included: lack of awareness of the benefits of MNT; lack of health insurers' coverage of MNT; inability to locate or travel to, or costs associated with travel to the location of qualified dietitians; patients' and dietitians' lack of appropriate secure videoconferencing tools; and restrictive pre-COVID telehealth requirements. However, since the declaration of the state of emergency in March 2020, RDNs have been providing MNT services via telehealth, including audio-only, reducing many of the barriers to receiving these important services, such as lack of broadband access, laptop, tablet or smart phone. This has been especially important for reaching those most at-risk patients who suffered from chronic health disparities even prior to the pandemic.[16,17]

MAND was pleased that Chapter 260 of the Acts of 2020 mandated permanent coverage for mental health telehealth services and, as we interpret Section 69, two years of rate parity for primary care and chronic disease management. We are concerned with the potential expiration of rate parity for all modalities of telehealth services, however, as relates to MNT, which is not specified under either primary care or chronic disease management. Our concerns include the return of increased barriers to care as well as lost revenue on the part of those RDNs whose patients cannot or will not travel for MNT services provided in person or who lack the technology (i.e., smart phone, computer, broadband).

Given the role nutrition plays in the management of many chronic conditions, the continuation of access to MNT provided by RDNs via telehealth is important both to reducing barriers to this important aspect of care as well as managing health care costs. Doing so will increase opportunities for Massachusetts residents to receive the right care at the right time in the most cost-effective manner.[18]

As we re-shift the focus of the provision of medical care from the acute phase of the COVID-19 pandemic towards to the "new normal," we must not forget that many Massachusetts residents struggle with chronic health conditions requiring ongoing treatment, many very likely requiring higher levels of care after decreased access to an overwhelmed health care system during the pandemic.

MAND believes that the continuation of reimbursement for MNT provided via telehealth is part and parcel of the legislature's commitment to supporting chronic disease management, as put in place in Chapter 260 through December 31, 2022. MAND encourages the Division of Insurance to facilitate continued access to MNT via telehealth – audio-only as well as videoconferencing via non-secure systems for those without computers in the home – and support inclusion of MNT in future guidance related to telehealth provisions within Chapter 260 of the Acts of 2020. Moreover, MAND encourages the Division of Insurance and other agencies to include MNT in the proposed study on the use of, access

to and cost of telehealth during the pandemic, as publicly funded research on telehealth should be nationally representative and include a wide variety of services and providers, including dietitians.[19]

Thank you for your consideration of these comments as you formulate regulations to continue expanded access to telehealth services in Massachusetts. We would be happy to provide additional information or answer any questions you have. Please email president@eatrightma.org if so.

Sincerely,

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President, Massachusetts Academy of Nutrition and Dietetics

Sarah Conca, MPA, RDN, LDN
Director of Public Policy, Massachusetts Academy of Nutrition and Dietetics

Kelly Kane, MS, RD, LDN, CNSC
Nutrition Payment Specialist, Massachusetts Academy of Nutrition and Dietetics

Cc: Rebecca Butler

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