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April 23, 2021

Kevin Beagan, Deputy Commissioner
Division of Insurance
Commonwealth of Massachusetts

Jatin Dave, MD, MPH, Chief Medical Officer
MassHealth
Commonwealth of Massachusetts

Dear Deputy Commissioner Beagan and Dr. Dave,

On behalf of the orthopaedic members of the MA Orthopaedic Association, thank you for conducting the helpful, productive, and transparent listening sessions related to the implementation of Chapter 260 of Acts of 2020, provision for telehealth services.

We are pleased to participate in these important sessions and for the opportunity to provide comments concerning matters addressed and discussed in the sessions. We have submitted comments and feedback for previous sessions held and this letter will focus on comments, feedback and suggestions related to the topics discussed during the fourth session held on April 14, 2021, which covered **Utilization Review for Telehealth** and **Telehealth Standards to be Added to Managed Care Accreditation Reviews**.

Utilization Review for Telehealth

Utilization review and management continues to be a barrier to care and an increasing burden on the health care system. A physician's clinical decision making is the guiding principle in the determination of care and treatment for patients regardless of the modality used, telehealth or in person. Creating a unique and separate telehealth utilization review process and different standards of care for telehealth would create a secondary UR process inconsistent with current carrier policies. These inconsistencies could cause consumer confusion regarding their telehealth coverage and care, limit access to care, potentially create a time delay in care while increasing the administrative burden on physician offices and staff.

For the reasons listed above, we request that no additional, different and/or separate utilization review processes be adopted for telehealth.

Utilization Review Criteria and Adverse Determinations

As indicated during the listening session of April 14, 2021, with a lack of specific medical necessity criteria for telehealth standards promulgated by national accreditation organizations to date and in the absence of national standards, the MOA requests that the current standards that apply for in person visits also apply to telehealth visits which is congruent with the language found in Section 16 of the statute. If/when national standards for telehealth are released in the future, it will be important for all

stakeholders to convene and review any proposed telehealth standards being considered to determine the appropriate adoptability in MA.

We are concerned with the possible time constraints imposed by existing Adverse determinations timelines of the carriers. Many patients seek a telehealth visit for urgent care within 24-48 hours of their injury and/or symptoms. The current timeline for review and determinations should be adjusted to accommodate the urgent nature of telehealth services to minimize time barriers to care.

What are the Rules for Managed Care

Out of Network (OON)

OON telehealth services should be made available if in network care is not available. The delivery of telehealth health care services to patients should not create a barrier to care for those who require OON care, nor should the carriers penalize OON physicians who provide the care.

We urge the Division of Insurance to maintain the current standards of OON care and reimbursement to maintain the consistency of a patient's insurance coverage while ensuring care is available by a physician regardless of network status.

Barriers

During the height of the pandemic, access to in person health care services, treatment and procedures was severely limited. The barrier created by the pandemic was lessened by the quick transition and adaptability to telehealth by physicians coupled with Governor Baker's telehealth emergency orders to allow for and require coverage for telehealth services.

There is a myriad of reasons why a patient seeks telehealth services and requiring a physician to document the barrier may cause some patients to forego telehealth services, creating an unintended barrier to care. The language in Sections 47, 49, 51 and 53, "a physician should not be required to document a barrier to in person care of patient seeking telehealth services" is supported by the MOA.

While documenting and/or reporting a barrier(s) to in person care is not necessary, the physical geographic location of the patient at the time the telehealth service is rendered is important to establish and document in order to ensure compliance with medical malpractice and state licensure requirements. We are encouraged by the initial involvement of the MA Medical Society regarding this matter and look forward to solutions promulgated by all concerned stakeholders, including the physician community, DOI and medical liability carriers.

Accreditation

Carrier standards to implement telehealth should be consistent for all carriers and include patient protections to ensure clear and concise communication from carriers regarding the standards and coverage benefits for telehealth services provided by their health care plan.

Standards to guide telehealth availability outside customary working hours, scheduling telehealth visits and physician communication with patients about telehealth visits are not necessary. The physician community determines the scheduling of their patient visits including outside of "customary working hours" as many orthopaedic surgeons also offer urgent care visits to ensure access to care regardless of time. In addition, physicians and/or their office staff are well adapted at this time with communicating and disclosing pertinent information to patients regarding their telehealth service and if it the remote encounter constitutes a visit, the patient and/or their insurance company will be billed as a telehealth visit.

Credentialling

Pending the provision and review of the current CMS Conditions of Participation for Telehealth Services as outlined in CMS-3227, and cited by the DOI in their documentation, the MOA urges the DOI, Department of Public Health and Office of Consumer Affairs ensure that all credentialing and privileging options be streamlined for telehealth medicine and telehealth services with the goal to increase timely access to care while reducing associated burdens on both physicians and hospitals.

Networks

Currently, carriers are required to adhere to network adequacy requirements. The MOA believes that additional segmentation for telehealth networks dissected into synchronous and asynchronous will create consumer confusion. In addition, the provider directories which have long been a source of inadequate updating by the carriers will not be accurate, reliable or time sensitive.

There is further risk that carriers may seek to establish and meet network adequacy by utilizing "telehealth only providers" which has the potential to severely limit access to in person care. A potential standard to safeguard patients regarding network adequacy would be to prohibit carriers from utilizing "telehealth only providers" to comply with current network adequacy rules.

Reporting

There is value in collecting data to inform future telehealth policies. The HPC proposed one-time reporting covering many aspects of the implementation of telehealth would provide an initial snapshot of the implementation. As technology, carriers, physicians, and patients adapt to telehealth services. A better understanding of the usefulness of telehealth as a service and care modality would benefit from future data collection as well. It may be beneficial to form a stake holder's working group dedicated to developing the appropriate data points and collection, useful reporting instruments and analysis. All reports should be made public.

In conclusion, the critical telehealth components for the orthopaedic surgeon community are:

1. Definition of Chronic Conditions- Centers for Disease Control's definition of Chronic Diseases
2. Coverage and Reimbursement Parity for Asynchronous and Synchronous Telehealth Modes
3. Consistent Carrier Telehealth Policies
4. Clear Telehealth Services, Polices and Coverage Communication to Patients

The orthopaedic community in Massachusetts extends our thanks to the DOI and MassHealth for the thoroughness of the discussions and the inclusion of the many stakeholders on this important future step in telehealth services, care and coverage. My colleagues and I would be happy to discuss any of these matters, answer any questions you may have and/or provide additional information. If we can be of assistance, please contact the MA Orthopaedic Association via email maorthoexec@gmail.com.

Thank you for your time and consideration.

All the best,

Walter Stanwood, MD
President
MA Orthopaedic Association

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April 26, 2021

Kevin Patrick Beagan
Deputy Commissioner, Health Care Access Bureau
Massachusetts Division of Insurance
1000 Washington Street
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Dear Deputy Commissioner:

On behalf of the Massachusetts Psychiatric Society, thank you for the opportunity to participate in the listening session on April 14, 2021 to discuss implementation of telehealth provisions within Chapter 260 of Acts of 2020. The Massachusetts Psychiatric Society (MPS) wishes to submit the following comments for your consideration:

A. <u>Utilization Review (UR)</u>

Massachusetts Psychiatric Society (MPS) notes that Section 54 subsection c of Chapter 260 of Acts of 2020 clearly states that "An organization may undertake utilization review, including preauthorization, to determine the appropriateness of telehealth as a means of delivering a health care service; **provided, however, that the determination shall be made in the same manner as if the service was delivered in person."** (emphasis added). MPS supports the position expressed by the *t*Med Coalition, Massachusetts Medical Society, Massachusetts General Brigham and others on the call, that there should be no additional **non-quantitative treatment limits (NQTL)** such as prior authorization dictating the appropriateness of telehealth as a modality or the platform used for telehealth. We strongly believe that the decision about the location and modality of the treatment including in-person versus telehealth should be a clinical and person-centered decision that should be determined together by clinicians and the patient, and is inherently dictated by the required standard of care. Creating different rules for the use of different telehealth rules vs. in-person treatment risks the unintended consequence of limiting access by limit use of telehealth. The utilization review process for telehealth needs to be exactly the same as that for in-person visits. UR is already overly burdensome and a separate process to determine the appropriateness of telehealth for a clinical encounter will increase administrative burden to providers which can increase cost and create delays in care delivery which can increase ED and urgent care utilization and decrease access to otherwise timely care.

Massachusetts is ranked 44th out of the 50 states in outpatient provider reimbursement rates and in the bottom half of the 50 states in other non-quantitative treatment limits (NQTL) on behavioral health according to the Milliman Research Report, "Addiction and Mental Health vs Physical Health; Widening Disparities in Network Use and Provider Reimbursement," (1) from 11/19/2019. This extremely high rate of use of NQTL in MA should not exacerbated by new NQTL such as the use of prior authorization for the use of telehealth.

B. Regarding Out of Network (OON)

MPS strongly advocates any insurance carrier's existing OON provisions should be the same for telehealth. There should be no difference in OON service provisions for in-person care and telehealth. The MA DOI and national organizations, e.g., the American Psychiatric Association, have data that demonstrate the severe inadequacy of current insurance-based behavioral health networks. There are multiple legitimate reasons why patients seek and clinicians provide out-of-network care, including access, geography, specific expertise, existing provider relationships, and others. Restricting or eliminating benefits for out-of-network care delivered via telehealth will only greatly exacerbate the existing inadequacy of these networks and therefore access to care.

C. Billing/Location

MPS also strongly believes that behavioral health care provided on telehealth should be billed and guided by current Procedural Terminology (CPT) codes. Adding new billing criteria based on location of care provision (office or telehealth) or modality (audio visual or audio only) or provider status (an in-network or out-of-network) is anathema to the significant improvement to the CPT codes which are in universal use. CPT codes were developed by the American Medical Association (AMA) and universally adopted by the Center for Medicare and Medicaid Services (CMS) and insurance carriers. For the first time in 30 years, starting Jan. 1, 2021 CPT codes have incorporated streamlined documentation requirements for Evaluation and management (E/M) with a renewed emphasis on medical decision making instead of requiring a myriad of separate component parts of a visit. (See link #2 below and attached) The new proposed E/M CPT code changes were based on public comment with the goal of decreasing unnecessary documentation. In essence, the billing codes have less emphasis on a score for components of the documentation and have more emphasis on the degree of medical decision making and hence accurately reflect the actual practice of medicine. We also agree with comments made during the call that any determinations of location of telehealth as relevant to state licensure should be determined by the Board of Registration in Medicine and not DOI.

Thank you for considering these comments and for hosting the listening sessions. We are happy to answer any questions you may have about these comments.

Best Regards,

Sally Reyering, MD, DFAPA
President, Massachusetts Psychiatric Society

1 (http://www.milliman.com/insight/2017/Addiction-and-mental-health-vs_-physical-health-Analyzing-disparities-in-network-use-and-provider-reimbursement-rates/)
2 https://www.ama-assn.org/system/files/2020-04/e-m-office-visit-changes.pdf

MAHP Feedback on DOI Session #4 to Discuss Implementation of Telehealth Provisions within Chapter 260 of Acts of 2020 - April 14, 2021

1. What are the rules for managed care?

- Are there things the Division should consider regarding the utilization review process used to determine "the appropriateness of telehealth as a means of delivering health services"?
  - Are there items to consider regarding prior authorization?
  - What should be considered "necessary information" in order to make a decision whether to approve or not approved a request for telehealth services?
  - Should the process for denials, appeals and disclosure notices be the same?
  - Should a reconsideration process continue the same as for other utilization?
  - Should there be the same process for expedited reviews?
  - Should there be a similar external appeal process available through the Office of Patient Protection?

The Value of Utilization Review in Determining the Appropriateness of Telehealth

On behalf of our 17 member health plans providing comprehensive coverage to nearly 3 million state residents, the Massachusetts Association of Health Plans has participated in the previous implementation sessions facilitated by the Division of Insurance to express support for the continued use of telehealth to facilitate access to quality health care services. Under the state's new telehealth law, Chapter 260 of the Acts of 2020, care delivered via telehealth must be covered if: the health care services are a covered benefit, and the health care services may be appropriately provided through the use of telehealth. Chapter 260 also provides that coverage for telehealth services may include utilization review, including preauthorization, to determine the appropriateness of telehealth as a means of delivering a health care service. We appreciate this opportunity to provide specific details on how health plans will implement, develop, and communicate any changes to utilization management as a result of the provisions in Chapter 260. In accordance with the existing state managed care consumer protections laws, specifically sections 12 and 16 of Chapter 176O, health plans have a responsibility to ensure that members receive quality and clinically appropriate care in the right setting.

Utilization management processes and standards exist for the protection of patients and to ensure that members access safe and effective medical care. Medical necessity guidelines based on clinical evidence are in place to evaluate requests for health care services, tests, and treatments. Utilization management adds value by protecting consumers from unnecessary care – it is estimated that nearly a quarter of care is not medically unnecessary, confirmed by numerous studies - and by avoiding harmful care or inappropriate care, such as exposure to unnecessary radiation, false positives, and ineffective procedures and treatments.

Not all medically necessary covered services may be clinically appropriate for delivery via telehealth. An in-person physical examination or other form of direct face-to-face encounter may be essential to ensure quality care is delivered for the patient. Surgery, sensitive examinations and certain routine procedures still require physical presence at a hospital, doctor's office, laboratory or clinic. Preventative visits at clinically-recommended intervals must include an age-appropriate physical examination; "All well-child care should occur in person whenever possible and within the child's medical home where continuity of care may be established and maintained… Pediatricians should identify children who have missed well-child visits and/or recommended vaccinations and contact them to schedule in person appointments inclusive of newborns, infants, children, and adolescents." American Academy of

Pediatrics, Guidance on Providing Pediatric Well-Care During COVID-19 (May 2020). Further, in-person assessments may be essential to establishing a trusting patient-provider relationship vital to treatment across all medical specialties.

2. **Are there things the Division should consider regarding the development of the relevant medical necessity criteria when applied to telehealth?**
    - Should certain providers be involved in the process of developing criteria?
    - Are there any standards developed or adopted by national accreditation organizations?

In strict accordance with comprehensive state consumer protection laws, MAHP member plans have formal processes in place to develop, evaluate, and update their utilization review policies on both an annual and ad hoc basis. Health plans develop medical necessity guidelines and criteria in compliance with state law to review the medical appropriateness of particular services. Medical necessity is defined as health care services that a physician exercising prudent clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are in accordance with generally accepted standards of medical practice, clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, or disease.

Chapter 176O requires that medical necessity guidelines be **evidence-based**. The development of evidence-based clinical criteria and procedures for approving and denying care ensures that a plan's decisions are objective and based on clinical evidence. Medical necessity guidelines are developed by Medical Policy Committees and/or Pharmacy and Therapeutics Committees with relevant clinical expertise. Health plans employ an ongoing process that includes a rigorous review of the most current evidence-based literature, input from clinical and program staff, and from external clinical experts. Specifically, state law requires that medical necessity guidelines be developed with input from Board-certified, actively-practicing physicians within a plan's service area, and allied health professionals from the medical specialties and subspecialties. State law also requires that criteria be developed under the standards adopted by national accreditation organizations. Most plans follow the National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans. Accredited health plans face a rigorous set of more than 60 standards and must report on their performance in more than 40 areas in order to earn NCQA's seal of approval. Health plans' utilization management criteria and policies are reviewed at least annually and criteria are updated more often as new treatments, applications and technologies are adopted as generally-accepted professional medical practice or where concerns about safety or effectiveness are demonstrated in clinical evidence.

Further, state law requires that each health plan consider the individual health care needs of an insured in applying guidelines. Care Managers within a health plan are responsible for evaluating all relevant clinical information before making a determination of medical necessity, including factors unique to a given member such as his or her age, co-morbidities, complications, progress of treatment, and psychosocial situation, including home and family environment, when applicable. Additionally, the care manager (CM) and reviewing physician consider the characteristics of the local delivery system available to the member, specifically the availability of institutional care, home care or outpatient care, within the network to provide all recommended services. Supplementary information obtained through direct communication with the primary care physician or attending practitioner to determine the context and rationale for the requested care is considered by the CM and reviewing physician when applying criteria.

3. **Are there things the Division should consider regarding the information being available on websites or otherwise being available to insureds?**

Changes to utilization review policies are always communicated to providers at least 60 days in advance of the change via provider newsletters, messages on the provider portal, and links on the payer's webpage. Additionally, health plans communicate the development process for utilization review at member enrollment, in the Evidence of Coverage, and upon request in accordance with Sections 7 and 9 of Chapter 176O. Finally, carriers are required by section 9 to provide an annual attestation of UR compliance to the DOI.

The Massachusetts Medical Society, representing more than 25,000 physicians, residents, and medical students, would like to thank the Division of Insurance and MassHealth for the productive listening session held on April 14th, 2021 relative to the implementation of telehealth provisions within Chapter 260 of Acts of 2020. We appreciate the opportunity to provide written comments in follow up to the thoughtful discussion about utilization review and telehealth standards for accreditation review.

Utilization Review

The Medical Society strongly believes that at its core, whether a service can be appropriately delivered via telemedicine is a clinical decision that should be determined by clinicians and is inherently dictated by the requisite standard of care.

Consistent with BORIM Policy 2020-01 (amended June 25, 2020), physicians are bound by the same medical standards of care whether that care is delivered in-person or via telemedicine; the standard of care does not deviate based on the modality of care delivery. As was detailed in DOI Bulletin 2020-04 and reiterated in DOI Bulletin 2021-04, it is the physician offering care through telemedicine who is most apt and responsible to ensure they are able to deliver services to the same standard of care as required for in-office care and in compliance with the physician's licensure regulations and requirements, programmatic regulations, and performance specifications related to the service. When the appropriate standard of care cannot be met via telemedicine, physicians are already obligated to make this determination prior to delivery of services and to notify the patient and advise them instead to seek appropriate in-person care. Physicians already make these determinations when triaging patients; when a patient contacts the physician practice by phone, the practices make the determination whether it is most appropriate for a patient come to the office, to speak by phone with a nurse, to have a telehealth visit, etc.

Telemedicine has the power to improve access to health care by removing physical and logistical barriers for patients. While we believe appropriateness is a clinical determination, given that c. 260 gives carriers statutory authority to develop utilization review protocols, we strongly encourage the state to explore and implement critical safeguards to ensure that we do not create new barriers to accessing care through telemedicine by allowing unfettered, unnecessary, or burdensome utilization review and prior authorization requirements. For example, a sensible limitation would prohibit the use of prior authorization for services delivered via telehealth only to where it is required for that same service delivered in-person.

Appropriate limitations on the utilization management protocols is not only critical in telehealth, but relates to broader policy concerns relative to the use of prior authorization and other utilization management techniques. The Health Policy Commission has consistently highlighted concerns associated with prior authorizations, including barriers to care and unnecessary administrative burden, and targeted this area for reform. A recent AMA study noted that "medical practices complete an average of 40 prior authorizations per physician, per week, which consume the equivalent of two business days (16 hours) of physician and staff time. To keep up with the administrative burden, two out of five physicians employ staff members who work exclusively on tasks associated with prior authorization." It is imperative that we do not allow overuse of prior authorization to create barriers to accessing care via telehealth.

All processes for denials, appeals, disclosure notices, reconsideration, and expedited review should be consistent with the applicable processes for care delivered in-person, including external appeals processes. To the extent that such statutorily mandated processes laid out in Chapter 176O are not applicable to MassHealth, we would encourage MassHealth to apply substantially similar processes and to the extent possible, align these processes with 176O.

Lastly, the Division's asked several questions relative to the development of medical necessity criteria for telehealth. Chapter 260 does not authorize, and the Medical Society does not believe carriers should, develop novel medical necessity criteria to apply to care delivered via telehealth; care delivered via telehealth is the same care that is being offered in-person and the same medical necessity criteria should apply. Chapter 1760 already mandates provider involvement in the development of medical necessity criteria.

Out-of-Network Coverage of Telehealth Services

The Medical Society does believe the language quoted by the Division from subsection (c)[1] requires coverage and reimbursement of an out-of-network provider for telehealth services provided when a "medically necessary covered benefit is not available to an insured within the carrier's network." To the extent that c. 260 in conjunction with c. 176O of the general laws requires carriers to cover telehealth services by an out-of-network provider, we believe the same reimbursement rules should apply for coverage by out-of-network providers under these circumstances. So for example, when there are network adequacy issues or a particular service is not available to a member through an in-network provider, clause 4 of section 6 of chapter 176O requires carriers cover the service from out-of-network provider and the patient will not be responsible to pay more than the amount which would be required for service if it were available from a provider within the carrier's network. In this case, and to the extent that 176O requires carriers to cover services by an OON provider, we believe the same reimbursement rules should apply for coverage by OON providers under these circumstances. It should be treated the same as if the care were provided on an in-person basis and subject to negotiation between the physician and the plan with all required notice provided to the patient.

Barriers to Reimbursement

The Division asked whether it should provide guidance clarifying what constitutes a barrier to accessing services in-person and referenced a different section of c.260 that permits a carrier to apply utilization review and prior authorization to determine whether something is covered under the plan. The Medical Society does not believe further guidance on what constitutes a barrier is necessary. Chapter 260 explicitly prohibits requiring documentation of a barrier to in-person care in order to access telehealth services. Barriers to in-person care should have no bearing on a carrier's utilization review protocols relative to the appropriateness of telehealth as a means to deliver a particular service. Further, there is no reason an insurance carrier should request documentation of the originating and distant sites, especially since the statute expressly prohibits limitations based on these factors.

[1] SECTIONS 47, 49, 51 and 53. (c) …An organization shall not be required to reimburse a health care provider for a health care service that is not a covered benefit under the plan or reimburse a health care provider not contracted under the plan except as provided for under subclause (i) of clause (4) of the second sentence of subsection (a) of section 6 of chapter 176O.

Credentialing

Proxy-credentialing allows a hospital or health care provider organization receiving the telemedicine services to rely on the privileging and credentialing decisions made by the hospital or entity providing the telemedicine services, provided certain requirements are met. MMS supports proxy credentialing, as it can alleviate complications and administrative burden associated with the credentialing process by allowing hospitals and other entities to facilitate access to telemedicine and comply with the Conditions of Participation without incurring the full administrative burden associated with the traditional credentialing process. This could be particularly helpful for smaller or rural hospitals.

Networks

MMS strongly supports the provisions in C.260 that an insurer cannot meet network adequacy through significant reliance on telehealth providers and shall not be considered to have an adequate network if patients are not able to access appropriate in-person services in a timely manner upon request. While telemedicine is a critical means to improving access to care for many, we support provisions allowing patients to decline receiving services via telehealth to receive in-person services. Network adequacy must not be wholly reliant on telehealth providers.

We would encourage the Division to provide more concrete guidance as to what would be considered "significant reliance" on telehealth providers in the context of general prohibition on meeting network adequacy through significant reliance on telemedicine providers outside the context of the state of emergency. While we continue to believe that telehealth offers great options to patients for alternative modalities to access care, patients should continue to have access to have in-person visits with physicians who are geographically close and are available to accept patients. Telehealth should not be used to justify the adequacy of network, but instead to supplement alternative access to a network with broad in-person physician access.

Another important safeguard the legislature included was prohibiting carriers from limiting coverage to services delivered by third-party providers. This provision is important to protecting the physician-patient relationship and promoting continuity of care by prohibiting requiring patients to use a contracted 3rd party telemedicine-only provider when the patient may prefer to receive the care from their physician with whom they already have an established relationship.

Reporting

Chapter 260 requires the Health Policy Commission, in consultation with the Center for Health Information and Analysis, the Executive Office of Health and Human Services, and the Division of Insurance to issue a report on the use of telehealth services. The list of topics for the report is not exhaustive and we would strongly encourage the Division additionally to consider additional measures or qualitive metrics for reporting, including from the patient perspective. There is much included in the reporting, focusing heavily on utilization and health care expenditures and costs to the system, which are important to understand, but we should also be focusing on the tangible benefits in terms of expansion of access to care and improved quality of care – for example, we know anecdotally that telehealth is decreasing no show rates – particularly among Black and brown patients and thereby improving inequities in access to care, decreasing the length of stay in hospitals, preventing urgent and emergency care, improving patient compliance with care plans, and overall improving health outcomes.

We should – to the extent possible – be focusing on and measuring these and other positive outcomes, such as: clinical outcomes, quality, and safety; access to care; patient and family experience; and clinician experience.

Thank you very much for your time and your consideration of these matters. We appreciate the opportunity to offer these comments as you craft and formulate policies to implement Ch. 260 of the Acts of 2020 to advance and expand access to telehealth services in Massachusetts. Should you have any questions or concerns, please do not hesitate to reach out to Leda Anderson, Legislative Counsel, at (781) 434-7668 or landerson@mms.org or Yael Miller, Director of Practice Solutions & Medical Economics, at ymiller@mms.org .

The *t*MED Coalition, representing more than 40 healthcare provider organizations, consumer advocates, technology organizations and telecommunication associations, would like to thank the Division of Insurance (DOI) and MassHealth for the productive listening session held on April 14, 2021 relative to the implementation of telehealth provisions within Chapter 260 of the Acts of 2020.

We appreciate the opportunity to provide written comments in follow up to the thoughtful discussion about utilization review for telehealth and telehealth standards to be added to managed care accreditation reviews.

A. What are the rules for managed care?

a. Utilization review

The *t*MED Coalition strongly believes that the modality that a clinician uses, whether telehealth or in-person, is a clinical decision and does not represent the clinical content of an encounter, per se. It is unnecessary to establish special rules for telehealth and there is no reason not to treat telehealth in the same manner as in-person visits for the purposes of utilization review. Chapter 260 specifies that any utilization review would be to assess the appropriateness of providing a healthcare service via a telehealth modality. The Coalition would like to underscore that utilization reviews of telehealth services should avoid contributing to inequities regarding access to technology. For instance, in Massachusetts, we know, based on census data and telecommunications industry data, that there is wide variation in access to internet, broadband, and video-capable computing devices by age, region, and demographics. Older adults, for instance, may only have access to audio-only services. We caution that any utilization review should not presume access to a wider range of telehealth technologies and that access inequities should not lead to utilization review determinations of appropriateness. Any differentiation of services based on type of technology rather than clinical content of an encounter will exacerbate inequities and may harm and confuse patients. By using the same documentation standards for telehealth and in-person encounters for denials, appeals, reconsideration, external review, and disclosures, we would also adhere to the spirit of the federal CURES Act which aims for simplicity, transparency and patient access to information. Creating two standards of documentation for telehealth and in-person visits for the purpose of utilization review would lead to unnecessary administrative complexity and would not benefit patients. The only exception for new utilization review standards may be for those services that are provided via telehealth that have currently have no in-person equivalent.

Additionally, we would encourage the Division and MassHealth to guard against the development of separate medical necessity criteria for telehealth. Ch. 260 does not authorize nor direct carriers to

develop new medical necessity criteria for telehealth services and carriers should not be creating separate medical necessity criteria for care delivered via telehealth. The modality used to provide care – whether telehealth or in-person services – has no bearing on the medical necessity of the care to be provided. A two-tiered approach to medical necessity would only confuse providers and patients, and possibly create unintended medico-legal consequences. And as with in-person services, telehealth services should have transparent medical necessity criteria freely available to covered patients, the public, and made available online. The expanded use of telehealth is relatively new, and it is important to allow time for processes to settle and be evaluated for efficacy, cost, and convenience without prematurely and unnecessarily creating administrative burdens and obstacles to providing services.

The *t*MED Coalition continues to support the prior authorization interpretation put forward by the Division of Insurance Bulletin 2020-04, which is the policy that had been in place during the state of emergency. It stated that, "Carriers are directed not to impose any prior authorization barriers to obtain medically necessary health services via telehealth that would not apply to receipt of those same services on an in-person basis." The Coalition believes that this policy ensured that there were not undue barriers placed on telehealth services solely because the service was being provided via telehealth. Prior authorization should not be used by insurance carriers and government programs solely to determine whether a service is suitable to be performed via telehealth. Additionally, Section 67 of Ch. 260, in clause (xi), specifically requires the Health Policy Commission, in its report on telehealth, to provide an analysis on any impact of "pre-authorization" or other utilization management tools on access to care via telehealth and recommendations for appropriate limitations on those tools to ensure access to care.

A. What are the rules for managed care?

b. Out-of-network

Under this section of questions, DOI asks if the provisions of the commercial payer sections of Ch. 260 allow for an out-of-network provider to provide telehealth services when "a medically necessary covered benefit is not available to an insured within the carrier's network. Again, the same criteria and utilization review should be applied for out of network telehealth services as is used for in-person services. Chapter 260 is explicitly clear with regards to the provisions of Ch. 176O, Section 6 (a) (4) (i), that an insured will not be responsible to pay more than the amount which would be required for similar services offered within the carrier's network when that service is not available in-network.

A. What are the rules for reimbursement?

c. Barriers

The *t*MED Coalition believes that Sections 47, 49, 51 and 53 of Chapter 260 were intended to guard against the application of artificial impediments aimed at limiting the utilization of telehealth. We would note that, prior to the pandemic, payers tended to put in place geographic or transportation barriers to limit the use of telehealth only to patients who were located certain distances away from hospitals or could not access services due to transportation constraints. Indeed, under Medicare, outside of the public health emergency, there are both geographic restrictions and originating site restrictions for

telehealth. The *t*MED Coalition believes that these are two prime examples of "barriers" to telehealth. For continuity and access, geographic barriers are clearly not the only limitations to timely or regular care as efforts to address social determinants of health have shown. Indeed, socially vulnerable people - whether due to race, ethnicity, gender, disability, age, primary language, income, housing, or transportation - have been at increased risk of adverse health-related outcomes and health-related costs. Massachusetts has been a leader in prioritizing care during the pandemic to people with high social vulnerability indices whether for treatment, vaccination, or outreach services. Similarly, the *t*MED Coalition believes that both DOI and MassHealth must continue to allow the provision of telehealth without the need to document barriers to permit its application broadly and appropriately. We believe that timely telehealth or in-person care without barriers may reduce costly late responses whether conducted in-person or via telehealth. Ch. 260 explicitly prohibits requiring documentation of a barrier to in-person care to access telehealth services. Barriers to in-person care should have no bearing on a carrier's utilization review protocols relative to the appropriateness of telehealth to deliver a particular service.

Regarding documentation, as we have previously noted, the *t*MED Coalition does not believe that any additional documentation, beyond what has been included in MassHealth All Provider Bulletin 289, is necessary.

B. Accreditation

Section 59 of Ch. 260 seeks to establish minimum standards for accreditation of carriers related to access to services to be provided via telehealth. However, the questions from the Division have far-reaching implications for providers. In particular, the *t*MED Coalition discourages any formal standards established for: the availability of telehealth outside customary working hours; scheduling of telehealth visits; and expectations about provider communication with patients about telehealth visits. Providers already have processes in place for visits with patients outside of working hours for in-person visits to ensure access to care regardless of the time of day. There do not need to be new standards established for the scheduling of telehealth visits, as they should be the same as for in-person visits. And finally, the *t*MED Coalition would note that healthcare providers are now acclimated to communicating information to patients regarding telehealth visits, as the federal CURES Act mandates sharing of information, and insurer standards are not necessary to address provider/patient communications regarding telehealth visits.

C. Credentialing

The *t*MED Coalition notes that the CMS Conditions of Participation document CMS-2377F is the correct and most recent document. We would also like to note that National Association of Medical Staff Services (NAMSS), in conjunction with the American Telemedicine Association (ATA), has developed this proxy by credentialing guidebook (CBP Guidebook - NAMSS Finalv2.pdf) which may be helpful to your sister agencies at the Department of Public Health and the Office of Consumer Affairs and Business Regulation as they seek to implement the proxy credentialing provisions included in Section 65 of Ch. 260.

Regarding the impact of proxy credentialing impacting providers' ability to provide for and bill for telehealth services within insured or MassHealth coverage, the *t*MED Coalition reminds the Division that the current credentialing process requires a provider to go through an extensive review at each site of care which includes detailed documentations of Primary Source Verification of each clinician's education, skills, trainings, and more. The current process adds to the overall cost and internal resources for each facility at which the provider is seeking to provide remote telemedicine services. The proxy credentialing provisions in Section 65 and its companion provision for physicians in Section 27 will enable providers to efficiently provide telehealth services and reduce the overall cost and internal resources dedicated to verifying a telehealth provider's credentials.

D. Networks

Now that the governor's declaration of a state of emergency has been terminated, the *t*MED Coalition believes that the DOI and MassHealth should follow the provisions included in the commercial insurance, GIC and MassHealth provisions included in Ch. 260. These provisions clearly state that an insurer is disallowed from meeting network adequacy through a significant reliance on telehealth providers and insurers shall not be considered to have an adequate network if patients are not able to access appropriate in-person services in a timely manner, upon request of the patient.

E. Reporting

The *t*MED Coalition agrees that there should be periodic and regular reporting of information collected and reported by carriers to DOI and MassHealth. Since the Health Policy Commission, under Section 67 of Ch. 260, is required to consult with DOI regarding its report on the use of telehealth and its effect on health care access and system costs, the *t*MED Coalition would encourage DOI to work with its sister agencies to review telehealth claims using the existing claims data and the criteria outlined in Section 67 for the HPC report. This includes the number of telehealth services provided by:

- type of service including the suggested behavioral health, primary care, chronic disease management, and other categories;
- provider;
- provider organization;
- payer;
- patient demographics including race, gender identity, age, primary language, ethnicity, sexual orientation, disability, income status, and geographic region;
- and modality of the service whether interactive audio-video, asynchronous, audio-only, etc.

For the collection of the modality data, the *t*MED Coalition believes that the use of modifiers will be critically important, especially for data regarding the use of audio-only technology. We would be happy to work with the Division and MassHealth to recommend the appropriate modifier to code these services. Additionally, the Coalition would encourage, if possible, the collection of patient and provider experience data for the various modalities that are being utilized to understand how patients and providers understand the utility of these modalities.

As many of our providers noted during the listening session, the two-year study called for in Section 67 is not enough time to analyze the utilization of telehealth in steady state, particularly since we are just emerging from a declared state of emergency. It would be incumbent upon the Division to collect data for at least the next 3-4 years so that we can see what telehealth utilization looks like in a post-pandemic care delivery environment.

Thank you very much for your time and your consideration of these matters. We appreciate the opportunity to offer these comments as you craft and formulate policies to implement Chapter 260 of the Acts of 2020 to advance and expand access to telehealth services in Massachusetts. Should you have any questions or concerns, please do not hesitate to reach out to Adam Delmolino, Director, Virtual Care & Clinical Affairs at the Massachusetts Health & Hospital Association (MHA) at (617) 642-4968 or adelmolino@mhalink.org, Akriti Bhambi, Director, Policy and Government Advocacy at MHA at (661) 345-5036 or abhambi@mhalink.org, or Leda Anderson, Legislative Counsel at the Massachusetts Medical Society at (781) 434-7668 or landerson@mms.org.

List of *t*MED Coalition Members

- Massachusetts Health & Hospital Association
- Massachusetts Medical Society
- Massachusetts League of Community Health Centers
- Conference of Boston Teaching Hospitals
- Massachusetts Council of Community Hospitals
- Hospice & Palliative Care Federation of Massachusetts
- American College of Physicians – Massachusetts Chapter
- Highland Healthcare Associates IPA
- Health Care For All
- Organization of Nurse Leaders
- HealthPoint Plus Foundation
- Massachusetts Association of Behavioral Health Systems
- Massachusetts Academy of Family Physicians
- Seven Hills Foundation & Affiliates
- Case Management Society of New England
- Massachusetts Association for Occupational Therapy
- Atrius Health
- New England Cable & Telecommunications Association
- Association for Behavioral Healthcare
- National Association of Social Workers – Massachusetts Chapter
- Massachusetts Psychiatric Society
- Massachusetts Early Intervention Consortium
- Digital Diagnostics
- Zipnosis
- Perspectives Health Services
- Bayada Pediatrics
- American Heart Association / American Stroke Association
- Planned Parenthood Advocacy Fund of Massachusetts

- Mass. Family Planning Association
- BL Healthcare
- Phillips
- Maven Project
- Upstream USA
- Cambridge Health Alliance
- Heywood Healthcare
- Franciscan Children's Hospital
- American Physical Therapy Association – Massachusetts
- Community Care Cooperative
- Fertility Within Reach
- Virtudent
- Resolve New England
- Massachusetts Association of Mental Health
- AMD Global Telemedicine
- hims | hers
- Asian Women for Health