Boston Children's Hospital | Digital 2.0

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Boston Children's Hospital Priority for Division of Insurance Clarification

Session #1 to Discuss Implementation of Telehealth Provisions within Chapter 260 of Acts of 2020

February 26, 2021 10:00am-11:30am

Boston Children's Hospital – Presentation Outline

- In response to the Friday, February 26th hearing on Chapter 260 of the Acts of 2020, Boston Children's Hospital is providing the following information for DOI review:
  - Responses to DOI discussion questions on carrier communications/communications with providers and questions on telecommunication technology platforms (**slides 3-4**)
  - Questions for further clarification by DOI with corresponding BCH recommendations in the following areas:
    - Video Visits (interactive audio-video technology) (**slides 6-7**)
    - eConsults (asynchronous, online adaptive interview between providers) (**slides 8-11**)
    - eVisits (asynchronous, online adaptive interview between patient and provider (**slides 12-16**)
    - Remote Patient Monitoring devices (**slides 17-21**)

Please contact Shannon Moore, Director of State Government Affairs with questions - Shannon.Moore@childrens.Harvard.edu

Carrier Contracts/Communications with Providers

Chapter 260 of the Acts of 2020 - SECTIONS 47, 49, 51 and 53.

- (c) 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; provided, , however, that the determination shall be made in the same manner as if the service was delivered in-person. A policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within or without the commonwealth 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.

DOI DISCUSSION QUESTIONS

- How/when should utilization review/preauthorization standards be developed?
- How/when should utilizations review/preauthorization standards be communicated?
- How/when should utilization review/pre-authorization standards be implemented?

Response from Boston Children's Hospital

- Telehealth is another avenue to provide the same care that would be provided as in-person, the same prior-authorization process should be used and a net new prior-auth should not be enacted for telehealth as descripted in the Section "the determination shall be made in the same manner as if the service was delivered in-person"
- Given that every patient condition is different and no two patient cases are the same, it is unreasonable to have a blanket standard. Therefore, it needs to be up to the provider on the clinical judgement and appropriateness to extend telehealth for patients vs. being regulated

Telecommunication Technology Platforms

Chapter 260 of the Acts of 2020 - SECTIONS 47, 49, 51 and 53.

- (a) For the purposes of this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:- "Telehealth", the use of synchronous or asynchronous audio, video, electronic media or other telecommunications technology, including, but not limited to: (i) interactive audio-video technology; (ii) remote patient monitoring devices; (iii) audio-only telephone; and (iv) online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating or monitoring of a patient's physical health, oral health, mental health or substance use disorder condition.
- (h) Health care services provided via telehealth shall conform to the standards of care applicable to the telehealth provider's profession and specialty. Such services shall also conform to applicable federal and state health information privacy and security standards as well as standards for informed consent.

SECTION 61. Said section 6 of said chapter 176O, as so appearing, is hereby further amended by inserting after the word "provider", in line 34, the following words:- ; and (iii) a summary description of the insured's telehealth coverage and access to telehealth services, including, but not limited to, behavioral health services, chronic disease management and primary care services via telehealth, as well as the telecommunications technology available to access telehealth services.

DOI DISCUSSION QUESTIONS – Responses from Boston Children's Hospital

- Do any of the items in the definition of telehealth need to be clarified? **Slides 5-21 provide a defined set of technologies and modalities for telehealth, as defined by CMS or AMA, that need further clarification.**
- What are the applicable federal and state health information privacy and security standards that should apply to telehealth services? **To ensure appropriate patient privacy and security, all types of technologies that provide a telehealth direct patient care should meet the HIPAA requirements**
- Can carriers facilitate the use of certain telehealth platforms? **To ensure equity for provider systems and patients, as long as the technology meets the HIPAA requirements, there should not be limitations on which branded platforms and vendor companies would be permissible but it is important for provider systems to streamline operations of their platforms for optimal patient experience**

Massachusetts Telehealth Technology Coverage

Chapter 260 of the Acts of 2020 – Telehealth Definition

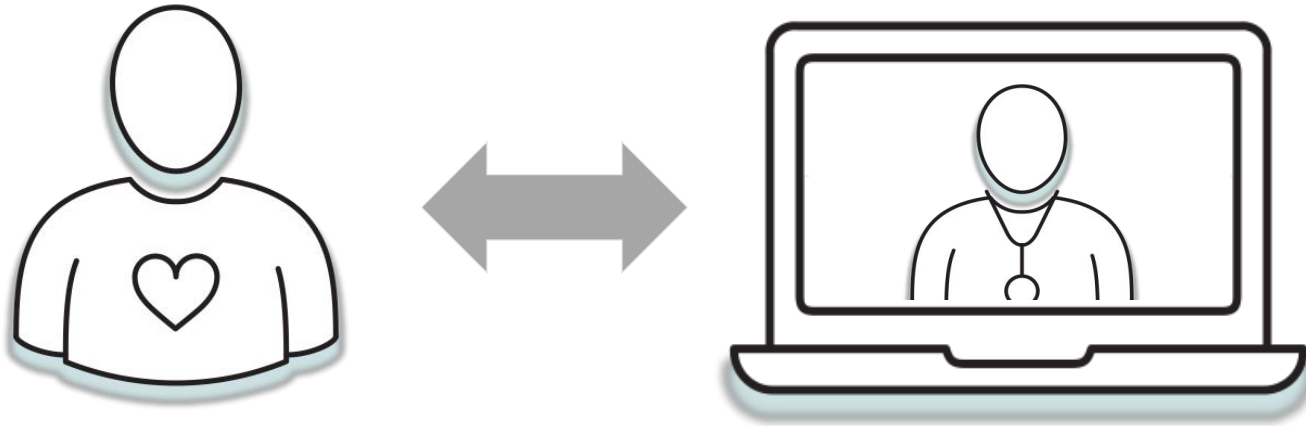
- The law currently defines Telehealth as "*the use of synchronous or **asynchronous** audio, video, **electronic media** or other telecommunications technology, including, but not limited to: (i) **interactive audio-video technology;** (ii) **remote patient monitoring devices**; (iii) audio-only telephone; and (iv) **online adaptive interviews**, for the purpose of evaluating, diagnosing, consulting, prescribing, treating or monitoring of a patient's physical health, oral health, mental health or substance use disorder condition*."

Areas for additional clarification and BCH recommendations (slides 6-21)

- **Video Visits** (interactive audio-video technology)
- **eConsults** (asynchronous, online adaptive interview between providers)
- **eVisits** (asynchronous, online adaptive interview between patient and provider)
- **Remote Patient Monitoring devices**

Video Visits

Patient to Provider Video Visits



interactive audio-video technology
(e.g., outpatient follow-up)

Video Visits – Recommendations for documentation and billing

Prior Authorizations, referrals

- **Recommendation**: keep consistent and do not require additional telehealth specific authorizations or referrals

Modifiers (currently use of GT or 95)

- How will we ensure consistency with modifier use for both professional (1500 form) and technical (UB04) billing?
- **Recommendation:**
  - **For professional & facility billing (e.g. using a 1500 and/or UB04 billing form),** require consistency in use of the GT modifier (interactive audio, video) across carriers to reduce administrative burden on the provider systems
  - **For payers:** Reimbursement should be the same today regardless of the GT/95 modifier. Transitioning to one modifier (GT is most predominant and recognized today) would benefit payer systems

Fee schedule

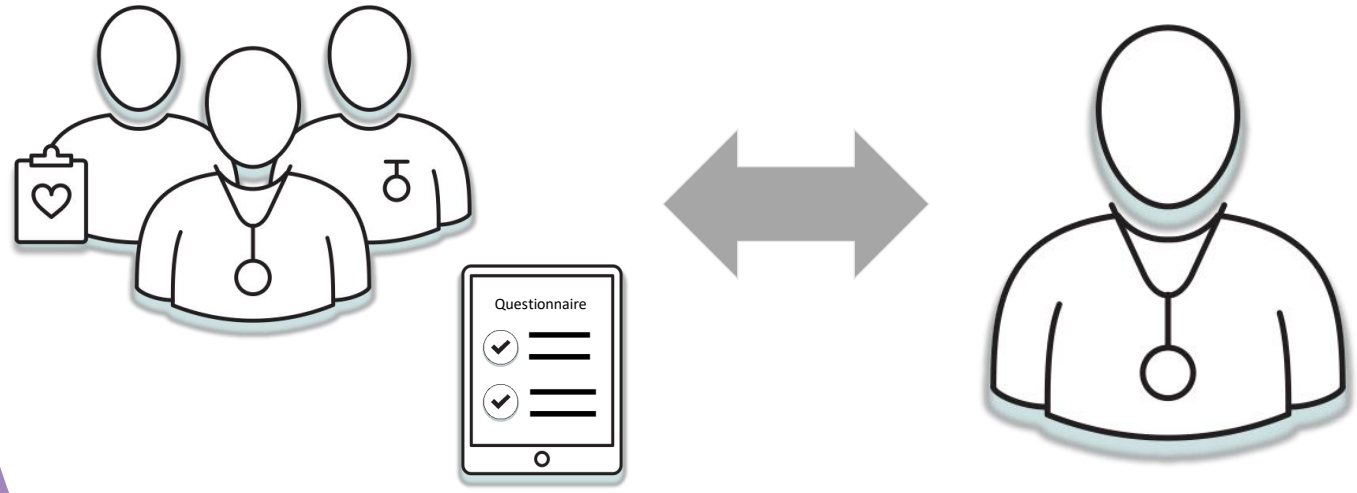
- Should video visits be reimbursed at the facility or non-facility rate?
- **Recommendation:** Have consistency across payers with reimbursement at parity with in-person office visits; reimburse at the non-facility rate when provider renders the telehealth service in a non-facility setting, i.e. the telehealth visit takes place either from the provider's practice office or exam room where the same cost as in-person visits are incurred (i.e. full Practice Expense, the same Malpractice Expense and the physician Work expense)

For pediatrics - Patient present during visit

- **Recommendation**: For pediatrics, patient does not need to be present during entire visit session however must be present for the clinician's assessment (similar to what would normally take place during an in-person encounter); additional time may be spent consulting with the patient family or care taker.

eConsults

Provider to Provider eConsults



asynchronous, online adaptive interview between providers

(e.g., protocolized questionnaire submitted by PCP to specialist)

Background - What are eConsults?

eConsults or an interprofessional telephone/internet/electronic consultation are defined by the AMA as an "assessment and management service in which a patient's treating (e.g., attending or primary) physician/other qualified health care professional (QHP) requests the opinion and/or treatment advice of a consultant with specific specialty expertise to assist the treating physician/QHP in the diagnosis and/or management of the patient's problem without the need for the patient's face-to-face contact with the consultant."

- **Starting in 2019 CMS introduced CPT codes that will reimburse both the referring provider (PCPs) and the consulting provider (Specialist) for performing an eConsult.**

Boston Children's Hospital Primary Care Longwood eConsult Pilot Results[1]

- 82 clinicians at Primary Care Longwood completed 510 eConsults to GI and Neurology over two years
- Key Metrics:
  - 84% of specialist responses included a triage component
  - Wait time for specialty appointments decreased ~30% (48 to 34 days)
  - Referral completion rates improved from 58% to 70% (12 points)

1. Corinna Rea, et al.; Shared Care: Using an Electronic Consult form to Facilitate Primary Care Provider – Specialty Care Coordination. Academic Pediatrics. Volume 18, Issue 7, October 2018, Pages 797-804, https://doi.org/10.1016/j.acap.2018.03.010

Background - eConsult CMS CPT Codes

CPT Code	Provider	Description	Frequency	Approved clinicians	Additional details
99451	Consulting Provider/ Specialist	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time	• Cannot be seen within the past 14 days, or next 14 days • Minimum of 5 minutes spent on consult	Physicians and other qualified health care professional	New or established patient
99452	Referring or Treating Provider/ Primary Care Physician (PCP)	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 16-30 minutes	• Cannot be reported more than once per 14 days • Requires 16-30 minutes (Includes review of pertinent medical records, time preparing referral, and communicating with consultant)	Physicians and other qualified health care professional	

eConsult Recommendations - Requirements of documentation and billing

Documentation

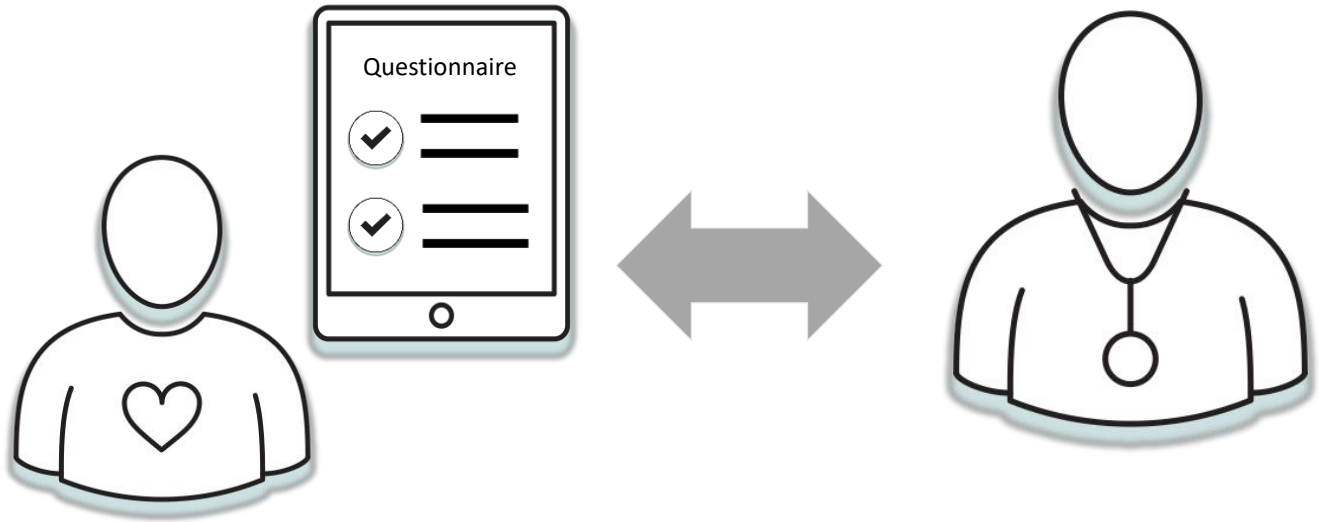
- What components are required as part of eConsult documentation?
- *AMA requires the following minimum documentation, our recommendation is to align to the AMA guidance as listed below.*
  - **Recommendation:**
    - **Referring Physician**
      - Requires documentation including the reason for request
      - Spending 16-30 minutes for review of pertinent medical records, time preparing referral, and communicating with consultant
    - **Consulting Physician**
      - Requires documentation of written or verbal request
      - Spending 5 minutes preparing and writing report

Modifiers

- Currently CMS does not require additional modifiers when submitting CPT codes.
  - **Recommendation: Do not require an additional or new modifier as eConsults can be distinguished by the CPT codes.** If a modifier is needed, it should be consistent across all codes and payers. We recommend using the GQ telehealth modifier (an asynchronous telecommunications system), already used for asynchronous telehealth services.

eVisits

Patient to Provider eVisits



asynchronous, online adaptive interview between patient and provider

(e.g., protocolized questionnaire submitted by established patient to provider)

Background - What are E-Visits?

E-Visits are defined by CMS as Patient-initiated, non-face-to face digital communications over HIPAA-complaint secure platform or portal, that require a clinical decision that otherwise typically would have been provided in the office. E-Visits are also called Online Digital Evaluation and Management Services (E/M)

- E-Visit codes originally established **2008** under Online Evaluation and Management services as codes 99444 and 98969 (both deleted 2019 and replaced with new codes). “These codes were not widely adopted by payers due to a lack of clear definitions surrounding the work”.

Background - E-Visits CMS CPT Codes (Newly published in 2020)

CPT Code	Frequency	Description	Approved clinicians
99421	Once during a 7-day period	Online digital evaluation and management service, cumulative time during the 7 days; 5-10 minutes	Physicians and other qualified healthcare professionals (QHP)
99422	Once during a 7-day period	Online digital evaluation and management service, cumulative time during the 7 days; 11-20 minutes	Physicians and other qualified healthcare professionals (QHP)
99423	Once during a 7-day period	Online digital evaluation and management service, cumulative time during the 7 days; 21 or more minutes	Physicians and other qualified healthcare professionals (QHP)
98970/G2061	Once during a 7-day period	Online digital evaluation and management service, cumulative time during the 7 days; 5-10 minutes	Qualified nonphysician health care professional*
98971/G2062	Once during a 7-day period	Online digital evaluation and management service, cumulative time during the 7 days; 11-20 minutes	Qualified nonphysician health care professional*
98972/G2063	Once during a 7-day period	Online digital evaluation and management service, cumulative time during the 7 days; 21 or more minutes	Qualified nonphysician health care professional*

3

*Licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists

Background - E-visits Service reimbursement

Coverage requirements for reimbursement

- For established patients only
- Must be patient initiated through HIPAA complaint secure platform or portal
- Codes start at minimum 5 minutes time spent – if less than 5 mins service is not reportable
- The time is cumulative within a 7-day period and is reported only once per 7 days
  - Time starts with initial review of patient's inquiry
  - Time includes:
    - Review of the initial inquiry
    - Review of patient records or data pertinent to assessment of the patient's problem
    - Interaction with clinical staff focused on the patient's problem and development of management plans
    - Physician or other QHP generation of prescriptions or ordering of tests
    - Subsequent communication with the patient through online, telephone, email, or other digitally supported communication, which does not otherwise represent a separately reported E/M service.
  - Time does not include: Staff time (only include physician/other QHP time), nonevaluative electronic communication of test results, scheduling appointments, other services that do not include E/M

E-visits Recommendations - Requirements of documentation and billing

Documentation

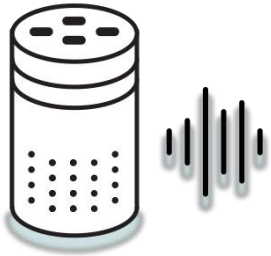
- What components are required as part of eVisit documentation?
- *CMS requires the following minimum documentation, our recommendation is to align to the CMS guidance as listed below.*
  - **Recommendation:**
    - Patient verbally consented to the services
    - Time spent
    - Modality of communication
    - Service/counseling provided, including relevant items (chief complaint, history of present illness, ROS, past/family/social history)
    - Relevant items of exam
    - Medical decision making and treatment/plan of care
    - Location of the patient and others present for the E/M service (parent or guardian), and location of the clinician

Modifiers

- Currently CMS does not require additional modifiers when submitting CPT codes.
  - **Recommendation: Do not require an additional or new modifier as eVisits can be distinguished by the CPT codes.** If a modifier is needed, it should be consistent across all codes and payers. We recommend using the GQ telehealth modifier (an asynchronous telecommunications system), already used for asynchronous telehealth services.

Remote Patient Monitoring

Hospital @ Home
Connected Devices + Remote Patient Monitoring



Provider – Patient or Provider
electronic media or other telecommunications technology, remote patient monitoring devices;
(e.g., apps, medical devices)

Background - What is Remote Patient Monitoring?

CMS defines Remote Patient Monitoring (RPM) as "the collection of patient physiologic data that are used to develop and manage a treatment plan, related to a chronic and/or acute health illness or condition".

- **RPM codes started being reimbursed in 2019**

In 2021, CMS clarified:

- "The medical device supplied to a patient as part of RPM services must be a medical device as defined by Section 201(h) of the Federal Food, Drug, and Cosmetic Act, that the device must be reliable and valid, and that the data must be electronically (i.e., automatically) collected and transmitted rather than self-reported".

In response to COVID-19, MassHealth published the *All Provider Bulletin 294* in May of 2020 that extended flexibilities for RPM during the public health emergency in order to divert unnecessary emergency and hospital utilization.

- Allows the facilitation of home or residence-based monitoring of members with *confirmed or suspected COVID-19* who do not require emergency department or hospital level of care but require continued close monitoring.

Background - Remote Patient Monitoring CMS CPT Codes

CPT Code	Frequency	FDA defined medical device	Description	Approved clinicians	Additional details
99453	One-time use for patient education and set-up	Yes	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), plus initial set-up and patient education on use of equipment. (Initial set-up and patient education of monitoring equipment included; do not report 99453 for monitoring of less than 16 days.)	Physicians and Non-physician practitioners (NPP)	Does not require active communication between patient and provider
99454	Once in a 30-day billing period, at least 16 days of device readings	Yes	Device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days. (Initial collection, transmission, and report/summary services to the clinician managing the patient.)	Physicians and Non-physician practitioners (NPP)	Does not require active communication between patient and provider
99457	Once in a calendar month	Yes	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified healthcare professional time in a calendar month, requiring interactive communication with the patient/caregiver during the month; first 20 minutes.	Physicians and Non-physician practitioners (NPP)	Does not require active communication between patient and provider
99458	Once in a calendar month	Yes	**Add-on code to 99457, cannot be billed alone.** Each additional 20 minutes (List separately in addition to code for primary procedure.)	Physicians and Non-physician practitioners (NPP)	Does not require active communication between patient and provider
99091	Once in a 30-day billing period	No	Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring), digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified healthcare professional, qualified by education, training, licensure/ regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days.	Physician, or other qualified health professional under the supervision of a physician	• Requires active communication between patient and provider • Cannot be in conjunction with 99457 + 99458 • Requires patient consent • Service must be initiated during in-person visit

Remote Patient Monitoring Recommendations - **Device** coverage and reimbursement

Device approval – Recommendation to use current guidelines for medical device

- According to CMS, all devices need to meet the definition of a medical device described in **section 201(h) of the Federal, Food, Drug and Cosmetic Act**. There is no language that states the device must be FDA-cleared/registered. The RPM device must digitally (i.e, automatically) upload patient physiologic data (i.e., data cannot be self-recorded or self-reported by the patient).
- **Section 201(h) of the FD&C Act (21 USC 321(h)) provides that the term "device" means:**
  - An instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is—
    1. Recognized in the official National Formulary, or the United States Pharmacopeia, or any supplement to them,
    2. Intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or
    3. Intended to affect the structure or any function of the body of man or other animals, and
  - Which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes.

Coverage – Recommendation to use current coverage requirements as durable medical equipment

- Will devices be subsidized, covered as DME, other ways?
  - **Recommendations:**
    - If it meets the criteria of a medical device, should be covered the same way medical devices would traditionally be covered (via HCPCs - 2021 CMS DME fee schedule)
    - Follow suit with Medicare's coverage of 80% DME cost with 20% patient responsibility for all RPM DME
    - New HCPCs DME code from "multi-system monitors" (ex: TytoCare, Vitls)
    - **Additional Action:** Review any missing codes for appropriate RPM DME (ex: weight scale, bp machine, pulse oximeter, otoscope, etc.)

Prior-authorizations and prescriptions – Recommendation to follow medical device auths and not create new RPM auths

- Do devices need to be prescribed by a provider or meet prior authorization requirements to be reimbursed or purchased by the insurer for the member?
  - **Recommendation:** No additional prior auth requirement and follow the medical device prior auth needs.

Remote Patient Monitoring Recommendations - **Service** requirements of documentation and billing

Documentation

- Is particular language needed to indicate that the data billed for was captured via RPM device? (e.g., location of patient or provider, duration of metric review)
  - **Recommendation:** Require same documentation standards as in-person care.

Modifiers

- Currently CMS does not require additional modifiers when submitting CPT codes
  - **Recommendation: Do not require an additional or new modifier as Remote Patient Monitoring can be distinguished by the CPT codes.** If a modifier is needed, it should be consistent across all codes and payers. We recommend using the GQ telehealth modifier (an asynchronous telecommunications system), already used for asynchronous telehealth services.

MASSACHUSETTS PSYCHIATRIC SOCIETY

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March 8, 2021

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

Dear Deputy Commissioner:

On behalf of the Massachusetts Psychiatric Society, thank you for the opportunity to participate in the listening session 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. Carrier Communications with Members (consumers)

MPS strongly supports the provisions of Chapter 260 Acts of 2020 which dictate that behavioral health visits be reimbursed at parity with in person visits. This is important in **increasing access** for much needed behavioral health (BH) treatment, not only in pandemic times, but beyond. It removes transportation cost and time barriers, child care, mobility, and other barriers and costs associated with in person treatment and can decrease structural determinants of health which lead to health disparities and inequities.

B. Carrier Contracts/Communications with Providers

MPS cautions the DOI against allowing the continued use of **substandard reimbursement rates for BH and non-quantitative treatment limits (NQTL)** which contribute to insufficient carrier networks in Massachusetts and decreased access to high quality BH 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 November, 2019 Milliman Research Report, "Addiction and Mental Health vs Physical Health; Widening Disparities in network use and provider reimbursement." (1) It is imperative that the nascent use of telehealth, an access-expanding modality, is not saddled with carrier contracts which decrease rates and increase NQTL for BH treatment. MPS supports the *t*Med Coalition's position that there should be no additional NQTL dictating 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.

C. Telecommunication Technology Platforms

MPS applauds the inclusion of **audio-only (telephone) as an acceptable modality for BH treatment** which also needs to be reimbursed at parity for in-person visits. This modality is critical for those who cannot afford computer and other smart devices or who are not familiar or competent in their use due to cognitive or emotional, or psychiatric impairment and inexperience of use. MPS also agrees with the *t*Med Coaltion and advocates that the definition of telehealth recognize, cover, and reimburse for **e-consults or interprofessional telephone/internet/electronic consultation**. Starting in 2019, CMS introduced CPT codes 99451 and 99452 that will reimburse both the referring provider (PCPs) and the consulting provider (Specialist) for performing an e-consult. The American Medical Association and American Psychiatric Association have issued guidance regarding documentation for such visits. Likewise, MPS advocates that the definition of telehealth should also include recognition, coverage, and **reimbursement for e-visits** which are patient-initiated, non-face-to face digital communications over HIPAA-complaint, secure platforms or portals that require a

clinical decision that otherwise typically would have been provided in the office. E-Visits are also called Online Digital Evaluation and Management Services (E/M). Such visits were provided with CPT codes that were published in 2020 by CMS and have documentation guidelines and coverage requirements, in addition to minimum time requirements, as well as steps for review of patient records and interaction with clinical staff and subsequent communication with patients through online portals, telephone, email or other digitally supported communication by qualified healthcare providers. The American Psychiatric Association has issued guidance regarding documentation for such visits. Both of these services have been added in recognition of the importance of integrated care. Telehealth modalities should also be adopted in the service of care coordination and integration.

Thank you for your consideration of these comments.

Best Regards,

Sally Reyering, MD, DFAPA
President, Massachusetts Psychiatric Society

(1) Stoddard davenport, et al, "Addiction and Mental Health vs Physical Health; Widening Disparities in network Use and provider reimbursement" 20 Novemer, 2019, Milliman research Report. https://www.milliman.com/en/insight/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-p

MAHP Feedback on MassHealth/DOI Public Listening Session February 26, 2020

Carrier Communications with Members

The new law allows a plan that provides coverage for telehealth services to include a deductible, copayment or coinsurance requirement for a health care service provided via telehealth as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-person delivery.

- How/when should carriers provide clear information to consumers about whether:
  - Deductibles apply to telehealth visits?
  - Copayments apply to telehealth visits?
  - Coinsurance applies to telehealth visits?

  MAHP Response:
  - Section 6 of MGL Chapter 176O requires EOCs to include an explanation of amounts of cost sharing, including copayments, deductibles, and coinsurance.
  - Section 23 of Chapter 176O requires plans to disclose costs, including copayments, deductibles, and coinsurance, for covered benefits via both the health plan's toll-free number and website.
  - Health plans will make this information available through these materials.

Plans are required to include "a summary description of the insured's telehealth coverage and access to telehealth services, including, but not limited to, behavioral health services, chronic disease management and primary care services via telehealth" in the EOC delivered to one insured household member. The law allows a patient to decline receiving services via telehealth in order to receive in-person services.

- How/when should present updated summary descriptions of telehealth coverage, including information that identifies that a patient may decline receiving services via telehealth in order receive in-person services, and what information should be included in the description?

  MAHP Response:
  - Section 6 of MGL Chapter 176O now requires EOCs to include a summary of the insured's telehealth coverage.
  - Health plans will update EOCs to incorporate a reference to telehealth coverage.
  - Health plans will update EOCs to state that a member may decline receiving services via telehealth in order to receive in-person services.

Carriers are also required to provide information on the network status of an identified health care provider via the carrier's toll-free telephone number and website that enables consumers to request and obtain from the carrier in real time.

- What should be reported regarding the "network status" of a health care provider?

  MAHP Response:
  - This provision of the new law was intended to protect consumers from surprise billing and is unrelated to the telehealth provisions. Therefore, we support an interpretation that health

plans are required to inform members whether a particular provider identified by the member is in or out of a plan's contracted network.

Carrier Contracts/Communications with Providers

The new law requires that a contract between a carrier and contracted health care provider shall provide coverage for health care services delivered via telehealth by a contracted health care provider if: (i) the health care services are covered by way of in-person consultation or delivery; and (ii) the health care services may be appropriately provided through the use of telehealth.

- Should there be separate provider contracts or contract amendments for telehealth?
- If so, what should be in the contracts?
- When and how should contracts be introduced/expected to be signed?

  MAHP Response:
  - It is our understanding that a majority of health plans have policy agreements in place with participating providers that provide reimbursement for covered health care services delivered via telehealth. Contract amendments are unnecessary for the implementation of health plan telehealth coverage and would impose a significant time and administrative burden on health plans and all providers.
  - MAHP supports the establishment of a reasonable time period to allow for updates to be made to telehealth coverage and payment policies in place prior to the public health emergency for contractual compliance with Chapter 260.
  - MAHP plans will communicate any changes in telehealth coverage or reimbursement that are necessitated by the requirements of Chapter 260 with participating providers in accordance with contractual provisions, which commonly require 60- or 90-day advance notice of implementation. Health plan newsletters to providers are regularly sent electronically and can incorporate details on telehealth policy changes.

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; provided however, that the determination shall be made in the same manner as if the service was delivered in-person.

- How/when should utilization review/preauthorization standards be developed?
- How/when should utilizations review/preauthorization standards be communicated?
- How/when should utilization review/pre-authorization standards be implemented?

  MAHP Response:
  - In accordance with section 12 of MGL Chapter 176O, health plans have a responsibility to ensure that members receive quality and clinically appropriate care in the right setting.
  - Not all 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)
    - In-person assessments may be essential to establishing a trusting patient-provider relationship vital to treatment in psychiatry and across all medical specialties.
- Health plans will communicate the development process for utilization review at member enrollment, in the EOC, and upon request in accordance with Sections 7 and 9 of Chapter 176O.
- Carriers are required by section 9 to provide an annual attestation of UR compliance to the DOI.

Payment Parity

Section 69 of the new law requires that the rate of payment for in-network providers of chronic disease management and primary care services are not less than the rate of payment for the same service delivered via in-person methods for two years, effective January 1, 2021 and sunsetting December 31, 2022 (per Sections 76 and 78).

Section 68 of the new law requires that rates of payment for in-network providers for telehealth services are not less than the rate of payment for the same service delivered via in-person methods.

Section 77 of the new law repeals the Section 68 telehealth payment parity mandate.

Section 78 of the new law repeals the Section 69 telehealth payment parity mandate 2 years from the effective date of this act, on January 1, 2023.

Section 79 of the new law makes Section 77 effective 90 days after termination of the governor's March 10, 2020 declaration of a state of emergency.

- What are reasonable considerations for addressing Section 77, the repeal of telehealth payment parity for services that are not BH, primary care, or chronic disease management?
- What are reasonable considerations for addressing Section 78 which impacts Section 76?
- When should clear guidance about timelines and communications be available for member, providers, and carriers?

  MAHP Response:
    - Throughout this public health crisis, Massachusetts health plans have been working to ensure that comprehensive care is available to members to meet new challenges presented by the COVID-19 pandemic. Health plans were required to reimburse providers for the provision of health care services through telehealth at the in-person reimbursement rate, an action that incentivized providers to establish virtual connections with patients and allowed health plan members to access necessary treatment without barriers during the public health emergency.
    - We support provisions in the law that allow payment parity to expire for services outside of behavioral health, primary care, and chronic care management, and that permit the rate of payment for telehealth services to vary depending on modality following the public health emergency. Our plans look forward to the opportunity to negotiate reasonable reimbursement rates for telehealth services delivery with in-network providers that reflect the services provided in order to achieve efficiencies and pass savings on to members.
    - MAHP supports the establishment of a reasonable time period to allow for updates to be made to telehealth payment policies in compliance with Chapter 260 with participating providers in accordance with contractual provisions.
    - Updates made to telehealth payment policies will be made in accordance with contractual provisions with participating providers.

Telecommunication Technology Platforms

The new law requires that health care services provided via telehealth shall conform to applicable federal and state health information privacy and security standards as well as standards for informed consent.

- Any further clarification issued by the Division of Insurance should reference the federal standards for privacy of personal health information under the HIPAA Privacy Rule and 42 CFR 2, an HHS regulation that protects the confidentiality of substance use disorder patient records, and incorporate state rules around the security of personal information.
- The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") limits the types of telehealth technologies that covered health care providers may use to provide telehealth services to patients. Those technologies are subject to HIPAA's strict privacy and security requirements, and often business associate agreements are required with the vendors providing the audio, video, or other technology for the telehealth service. Violations can lead to significant penalties.
- In response to the novel coronavirus nationwide public health emergency, the U.S. Department of Health and Human Services Office for Civil Rights has temporarily waived enforcement of penalties for using non-HIPAA compliant telehealth technologies when providing telehealth services related to potential COVID-19 exposure or for any other medical condition. The Notice permits covered health care providers to use any non-public facing remote communication product, such as popular applications that allow for video chats, including Apple Face Time, Facebook Messenger video chat, Google Hangouts video, or Skype, without risk that OCR may impose a penalty for noncompliance with HIPAA related to the good faith provision of telehealth during the emergency period. Providers are encouraged to notify patients of the potential privacy risks and to enable all available encryption and privacy modes when using such applications. Under the Notice, OCR states that providers should not use public facing video communication applications, such as Facebook Live, Twitch, and TikTok.
- Despite these temporary flexibilities, MAHP supports imposing comprehensive privacy requirements on telehealth communications as soon as possible.

Mass General Brigham

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Massachusetts Division of Insurance
1000 Washington St, #810
Boston, MA 02118

Mr. Kevin Beagan
Deputy Commissioner

March 23, 2021

Dear Mr. Beagan,

Mass General Brigham commends the Division of Insurance (The Division) and MassHealth for their open and transparent process related to the development of regulation for the telehealth provisions included in Chapter 260 of the Acts of 2020.

The COVID-19 pandemic resulted in a sudden, unexpected proof-of-concept opportunity for telehealth expansion. As a result, these listening sessions and associated comment periods provide a unique opportunity to shape a longer-term to telehealth systems that improve patient outcomes, provide access to those currently underserved by the brick-and-mortar health care system, and foment creativity and innovation in the provision of medical and behavioral health care. Mass General Brigham recognizes that all expansion in telehealth requires appropriate technology usage, documentation and compliance requirements to guard against potential fraud, waste and abuse. We are encouraged that The Division and MassHealth are seeking comment on the regulatory environment necessary to ensure telehealth is outcome-driven, safe, and clinically appropriate.

In February 2020, prior to the pandemic, telehealth accounted for only 0.2% of all ambulatory visits across the Mass General Brigham system. By April, at the height of the pandemic, virtual appointments skyrocketed to 62% of all ambulatory visits. In just five short months, Mass General Brigham clinicians have documented more than one million completed telehealth virtual visits, both over the phone and through video. Of note, an important enabler in this rapid scaling was the audio-only virtual visit --- a new type of scheduled visit subject to the same expectations as an in-person visit, generally reserved for patients who are unable to conduct video visits due to factors such as lack of adequate videoconference technology or broadband service or low digital literacy, and distinct from brief telephone calls which have long been a practice in medicine. When the PHE suspended in-person care for most patients, virtual care was able to restore access to many at-risk patients, like a backup generator during a power failure. This was a remarkable safety net for many patients with chronic conditions including, hypertension, Chronic Artery Disease, Stroke, and Cancer, as well as, those with milder symptoms of COVID. Remote physiologic monitoring enabled patients to be discharged sooner and be tracked for stability from home or subacute facilities.

Many beneficiaries of the emergent telehealth expansion are our most vulnerable populations: the elderly, low-income populations, and those experiencing mental illness. As the state of Massachusetts has stabilized throughout the COVID crisis, telehealth virtual visits have plateaued at ~25% of all ambulatory visits – largely substitutive to in-person visits. (Mass General Brigham believes this level of telehealth service is the natural plateau and will have continued usage into the future if the regulatory and payment structures are built to support it.)

As follow up to the Division and MassHealth Listening Session that occurred on February 26, 2021, Mass General Brigham welcomes the opportunity to provide the following comments on the topics that were addressed in that session, intended as constructive input.

Carrier Contracts with Providers

Mass General Brigham supports the notion that delivery of contracted telehealth services should not require separate and additional contracts between carriers and providers. Instead, telehealth should be treated as a modality within the overall contract and service delivery framework. Requiring separate contracts would lead to unnecessary administrative burden for carriers and providers, fragmentation between in person and telehealth modalities, and greater likelihood of patient confusion and surprise billing due to a telehealth visit with a non-telehealth contracted provider. Furthermore, this streamlined contracting approach should apply to both audio-video and audio-only telehealth visits that are determined to be clinically appropriate by patients and their healthcare practitioners.

Development of Utilization Management Requirements

Mass General Brigham strongly urges the Division and MassHealth to consider first and foremost the needs of patients when developing parameters for utilization management for telehealth services. Despite concerns raised about clinical appropriateness and overutilization of telehealth services, the overwhelming majority of services delivered through telehealth are routine, appropriate, and substitutive to care that would have otherwise been rendered in person. Mass General Brigham urges the Division and MassHealth to avoid implementing a two-tiered system that risks impeding the continued adoption of the promising telehealth modality and inhibits patient choice in healthcare delivery. Furthermore, Mass General Brigham strongly discourages the establishment of a differential process for audio-only visits, which would only compound the complexity and create additional barriers for patients. The need to provide and value in-person, audio-visual, and audio-only visits is particularly important for vulnerable patients or patients lacking broadband access, including those receiving services, such as behavioral health, which require streamlined and immediate access to prevent outcomes like overdose and emergency department boarding.

Timeliness of Communication

Mass General Brigham requests that the Division and MassHealth establish processes and protocols for clear and timely communication with patients and providers about decisions pertaining to service categories whose reimbursement protections are set to end 90 days following the end of the public health emergency. Furthermore, the establishment of differential standards for audio-visual and audio-only, which Mass General Brigham strongly discourages, must be communicated in a clear and timely manner. In cases where payers may change reimbursement and other standards that affect patient access to services, these changes must be communicated in a timely fashion in order to ensure clear and accurate communication to patients ahead of any scheduled telehealth visits for services whose reimbursement may be changing within the timeframe of their scheduled visit and mitigate any negative patient impacts of those policies.

Privacy, Platforms, and Other Standards

Mass General Brigham agrees that patient privacy must be protected whilst receiving telehealth services and supports the notion that the Division and MassHealth can play an important role in sharing information with carriers and providers about HIPAA approved platforms. Furthermore, Mass General Brigham urges the Division and MassHealth to allow patients the greatest possible access to appropriate primary care, behavioral health, and specialty providers without being subjected to unnecessary barriers based on location.

Mass General Brigham appreciates the collaborative and transparent process that the Division and MassHealth have embarked upon to promulgate regulations related to the telehealth provisions included in Chapter 260 of the Acts of 2020. We look forward to upcoming telehealth listening sessions and other opportunities for collaboration with DOI and MassHealth on telehealth and other matters. Should there be any questions regarding this comment letter please contact Kelly Driscoll, Director Government Payer Policy, kdriscoll12@partners.org.

Sincerely,

Lee H. Schwamm, MD, FAHA, FANA
Vice President, Virtual Care- Mass General Brigham
Director, Center for Telehealth- Mass General Hospital

MASSACHUSETTS ALLERGY AND ASTHMA SOCIETY
A Professional Association of Board Certified Allergy, Asthma and Immunology Specialists

www.massallergysociety.org

Post Office Box 342
North Uxbridge, MA 01538

March 9, 2021

Kevin Beagan
Deputy Commissioner
Division of Insurance
Commonwealth of Massachusetts
1000 Washington St #810, Boston, Massachusetts 02118

Dear Deputy Commissioner Beagan,

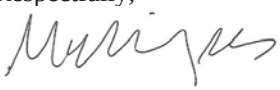
There are approximately 200 allergists to provide care to the 7 million residents in the Commonwealth of Massachusetts. Said differently, there is one allergist in Massachusetts for every 35,000 residents. Allergists provide care across the life spectrum and for conditions that are rising in frequency including life threatening food allergies, asthma, medication allergies and immune deficiencies. More recently, our specialty has been called upon to evaluate thousands of patients who have had reactions to the Covid 19 mRNA vaccines in order to quickly determine the safety for their second dose. This acute, critical need has strained our capacity ever more. Like many other specialties, the Covid 19 pandemic raised the tension our on practices over the past year, but also allowed novel practice modifications as well.

Parity in reimbursement of virtual visits has allowed allergists in Massachusetts to continue providing care to our patients and, more importantly, to extend access to individuals and families we would otherwise not have reached. From Boston to Berkshire County, video and telephone visits have enhanced access for allergy services, and allowed us to markedly improve equity in provision of our care. Virtual visits have significantly improved socioeconomic access to experts in managing allergic diseases.
Here are some ways that video and telephone visits directly enhance access to and equity in care:

1. Because there are so few allergists, patients often have to travel hours to be seen in person. This is eliminated with virtual visits.
2. Virtual visits allow patients to access care with less time required off from work and school for appointments. This improves continuity of care through fewer missed appointments and increases equity for people with trouble getting time off of work for doctor visits.
3. Many patients in Massachusetts do not have access to transportation, precluding them entirely from accessing our in-person care. Virtual visits help us reduce those barriers to our care as almost everyone in the Commonwealth has a telephone, smart phone, or online access.
4. Urgent and same-day visit access has been dramatically increased with virtual visits. This has been critical during the pandemic particularly for many of our patients with asthma and immune deficiencies. Through virtual, same day visits we have been able to save unnecessary and costly urgent care and ER visits for our patients.
5. Improved protection for our patients with immune deficiencies who now do not need to sit in crowded waiting rooms resulting in multiple potential exposures that could make them very sick. For these patients in particular, virtual visits have completely changed their lives.
6. Ability to increase our volume quickly and unexpectedly to address the urgent issues surrounding COVID vaccine allergy and reactions. Allergists/Immunologists are **vaccine experts**. We understand the immunologic mechanisms of vaccine efficacy and are the key experts in understanding, categorizing, treating and preventing adverse reactions to vaccines. We have worked unending hours over these last months to make certain that we maximize the numbers of people who can safely get immunized to Covid 19 in Massachusetts. We have only been able to see this volume of patients and address this public health crisis by leveraging virtual visits. To optimize vaccine success and achieve widespread protective immunity, allergists must be allowed to continue virtual visits.

The vital benefits of virtual visits to increase access and address equity in care cannot be understated and should not be undone. Doing so would unravel the gains we have made in caring for our patients. We ask you to continue parity in reimbursement for telephone and video visits to continue the novel health care delivery that technology easily allows and that our patients deserve.

Respectfully,



Michelle E. Conroy, MD

MASSACHUSETTS ALLERGY AND ASTHMA SOCIETY
A Professional Association of Board Certified Allergy, Asthma and Immunology Specialists

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President, Massachusetts Allergy and Asthma Society

The *t*MED Coalition, representing more than 35 healthcare provider organizations, consumer advocates, technology organizations and telecommunication associations, would like to thank the Division of Insurance and MassHealth for the productive listening session held on February 26th, 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 carrier contracts and communications with providers and members, as well as telehealth technology platforms.

At the outset, we would like to reiterate that, as the Division and MassHealth consider changes to policies to implement the provisions of CH. 260, we would respectfully ask that both agencies consider adopting uniform policies, as far as is practicable, including equitable policies that promote access to care for all patients. Additionally, we would urge both the Division and MassHealth to adopt timelines for any policies to be implemented contemporaneously. Coordinated, streamlined changes among the Division and MassHealth will reduce confusion for providers who will be implementing and tracking such policies.

Finally, we would also like to encourage both agencies to consider flexibility throughout the implementation process. The state has thoughtfully afforded innovative, flexible tools that have allowed health care providers to treat patients at a distance, prevent disease, and preserve supplies of personal protective equipment for our patients during this unprecedented public health emergency. Since the future course of the pandemic, while trending in a positive direction, is still unknown and social distancing is still paramount as we administer vaccines, we would encourage you to continue, to the extent possible, to afford providers with flexibilities that have been allowed under the public health emergency for the use of telehealth, in conjunction with telehealth flexibilities offered by the federal government during the course of the Public Health Emergency (PHE), which will, most likely, extend federally through the end of 2021. Alignment across payers, as much as practicable, will reduce confusion and redundancy for our providers. We would additionally appreciate it if carriers would encourage plan sponsors to take steps that are consistent with the provisions of the guidance that DOI and MassHealth put forth to implement Chapter 260.

A. Carrier Communications with Members

It is critically important that members understand their coverage and any patient liability (deductibles, copayments, coinsurance) for telehealth services as well as any differences in coverage or cost between telehealth visits and in person visits. The *t*MED Coalition was pleased to generally be in alignment with carriers that information relative to deductibles, co-payments, and coinsurance should be communicated with members at the same time and manner as such cost-sharing mechanisms for in-office care through existing means. For example, this information must be clearly displayed in a carrier's evidence of coverage documentation, as required under M.G.L. 176O Section 6, which may need to be amended to include telehealth services.

In addition, there should be clarity for members regarding any differences between coverage for in-office services and telehealth services, as well as the ability for patients to obtain cost estimates that reflect any cost differentials between the two modalities. As such, it may thus be necessary to further amend M.G.L. 176O in Section 23 to require carriers to include clear cost estimates for telehealth services. Lastly, the network status of a health care provider should be clearly reflected in the provider directory and should not be affected by whether the patient is being seen via telehealth or in-office. Treating communication relative to cost-sharing mechanisms for services delivered via telemedicine and in-office the same ensures that care delivered via telemedicine is viewed and treated as commensurate with care delivered in-office.

Regarding an appropriate timeline, the Coalition believes that any relevant information related to cost-sharing should be communicated to members as soon as practicable, recognizing it may take time for carriers to codify any related policy changes.

Many carriers have waived co-payment requirements for telehealth services for patients during the pandemic and some are still waiving such requirements for all telehealth care or COVID-related care until the end of the PHE. The variation in co-payments for telehealth services may lead to confusion for patients. Therefore, it is appropriate that carriers provide patients with the most-updated, timely information regarding any co-payment requirements as soon as practicable. Alternatively, the Division may wish to consider waiving co-payments for all telehealth services until 90 days after the conclusion of the public health emergency. In this way, providers will be able to adjust to any changes in the payment system and carriers will have adequate time to communicate such information to their members.

Finally, the *t*MED Coalition strongly encourages the development of any written communications or materials for consumers to available in multiple languages and reviewed with an equity lens. Written information on websites is often not accessible to many communities due to language, cultural, disability, and education barriers.

B. Carrier Contracts/Communications with Providers

The *t*MED Coalition uniformly believes in the central tenet that telehealth services must be treated on-par with in-office visits and, therefore, should not require a separate contract or contract amendments. We are again pleased that the carriers who commented regarding these questions are in agreement that requiring providers to execute separate contracts would be administratively burdensome for carriers and for providers and unnecessary for those who are already participating providers for in-office services. Instead of requiring separate contracts, each carrier could embed telehealth as a term as defined in the law within existing contracts or changes could be made through policy amendments to be even more timely. Any contractual or policy amendments must be consistent with any regulatory requirements or guidance issued by the Division around coverage, definitions, prior authorization, patient liability, and technology. Further, providers should be given adequate, mutually agreed upon notice to any such amendments.

Utilization review standards should be carefully developed, based on supporting data and with the input of affected providers and patient representatives. We agree with comments from the carriers at the listening session that it is of paramount importance that members get quality care in the appropriate

setting and that not all care may appropriate for telemedicine; however, we strongly believe that 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 required standard of care. Telemedicine has the power to improve access to health care by removing physical and logistical barriers for patients. We 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 preauthorization requirements simply based on the modality. We believe this will have a chilling effect on the ability of many patients to access timely and effective care and on the ability of providers to offer telehealth.

Moreover, we interpret the relevant statutory language[1] to mean that the determination as to whether any utilization review is required should be made based on whether it is required for the same service when delivered in-office. For example, a consult with a dermatologist does not require a prior authorization when provided in the office; likewise, it should not require a prior authorization when delivered by telehealth. By contrast, if speech therapy requires a prior authorization for an in-office visit, it can also be required for telehealth. The important factor to consider is the *service* being delivered, not the modality through which it is delivered. This interpretation is consistent with the policy outlined by the Division in Bulletin 2020-04 which clearly states that "[c]arriers are directed not to impose any prior authorization barriers to obtain medically necessary health services via telehealth that would not apply to the receipt of those same services on an in-person basis." This policy implicitly acknowledges that requiring prior authorizations beyond what is required for the same care delivered in-office is unnecessary and can serve as a hindrance to patients' ability to access medically necessary care.

Again, the determination of which modality is most appropriate should be decided by the treating clinician and the patient, not by the carrier. The provider community has significant concerns that requiring prior authorization for telehealth services when it is not required for in-office visits will significantly affect a patient's ability to access medically necessary services in a timely fashion. In addition, due to social distancing measures, immunocompromised patients, behavioral health diagnoses, childcare issues, transportation challenges, bad weather, disabilities, etc., many patients prefer the option to connect with a clinician via telehealth and compliance is greater.

As to the timing of the development and implementation of utilization management and prior authorization standards, we strongly urge delay to allow sufficient time to gather and review relevant data, including any proposed guidelines that have been developed regarding the appropriateness of the use of telehealth, to thoughtfully inform such standards. Specifically, we recommend that the Division continue to apply the provisions included in Bulletin 2020-04 regarding prior authorization until after Health Policy Commission (HPC) submits its interim report on the use of telehealth services in the Commonwealth and the effect of telehealth on health care access and system cost, due in January 2022 as mandated in section 67 of chapter 260 of the acts of 2020. Additionally, on the federal level, the

[1] E.g. Newly inserted Section 47MM(c) of Chapter 175 of the General Laws: 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**; provided, however, that the determination shall be made in the same manner as if the service was delivered in-person** (emphasis added).

Office of the Inspector General (OIG) at the U.S. Department of Health and Human Services – in recognizing the promise that telehealth and other digital health technologies have for improving care coordination and health outcomes – is conducting significant oversight work assessing telehealth services during the public health emergency. With anticipated completion later this year, these reviews will provide objective findings and recommendations that can further inform stakeholders considering appropriate telehealth flexibilities and utilization review standards. The reports from both the HPC and OIG can help ensure the potential benefits of telehealth are realized for patients and providers and should be considered when developing utilization review and prior authorization standards.

With regards to considerations relative the sunsetting of the various reimbursement parity provisions, physicians and other affected health care clinicians need as much transparency and advanced notice as possible before parity provisions expire to ensure sufficient time to meaningfully negotiate reimbursement rates with carriers. It was suggested at the listening session that the Division and MassHealth, along with relevant licensure boards, should communicate with physicians and other clinicians regarding the lifting of the state declaration of emergency, which will trigger the 90-day period after which overall parity in reimbursement for all telehealth services is no longer statutorily mandated.

Upon further reflection, we would recommend that the Administration consider giving at least 90 days-notice as to the recission of the declaration of emergency to give healthcare providers an adequate timeline for a "glide-path" or "runway" regarding changes in reimbursement for telehealth services so they modify their billing systems, adjust patient scheduling, and provide sufficient notice to patients with regards to any changes that providers may make regarding their continued ability to offer telehealth services. We believe that 90 days, as outlined in the legislation, is insufficient time and to the extent possible, additional time should be afforded to avoid disruption of patient care. Physicians and other health care providers regularly schedule patients greater than 90 days in advance; it is critical that patients and clinicians understand important information at the time of scheduling or very soon thereafter. Moreover, carriers should be communicating directly with their contracted clinicians, in addition to any guidance or bulletin that may be issued by a state agency. Any negotiated changes in reimbursement needs to be appropriately reflected in the provider manual and payment systems should be programmed in advance to accurately reflect updated billing and coding for services delivered via telemedicine. To the extent possible, billing and coding should be streamlined across payors, with common modifiers for telehealth adopted uniformly across all payers.

Finally, the *t*MED coverage would respectfully request that payers provide information regarding patients' telehealth coverage benefits electronically from the carriers in a consistent format. For example, specialist visit coverage, including potential patient liability, should be sent in a consistent manner across all carriers, so providers know exactly what the coverage is for their patients and can upload this data into their electronic health record (EHR). Currently, there is no consistency in how telehealth coverage is reported on a 271 eligibility response. Some carriers report this in a specified loop, while others include it in free text, which is difficult to impossible to extract and upload in the EHR using batch eligibility. The uniform provision of this information across carriers would be extremely helpful to providers in easing administrative burdens.

C. Telecommunication Technology Platforms

The *t*MED Coalition appreciates the broad statutory flexibility in the definition of telehealth to allow for the inclusion of existing and new, innovative technologies as key to facilitating access to care via telemedicine, including asynchronous technologies. This definition also allows for future technologies to be encompassed within the statutory definition of telehealth without requirement for further refinement or expansion contingent upon legislative approval. We recommend that the Division and MassHealth adopt a similarly adaptable frame when assessing the utilization and coverage of new and emerging telehealth technologies. The use of technology platforms should remain flexible so long as the technology meets the clinical needs for the services provided, maintains sufficient patient privacy protections (e.g. HIPAA-compliant), and follows necessary provisions of informed consent.

One flexibility that the Division and MassHealth may want to consider through the end of the PHE is with regards to the use of technology platforms that are not HIPAA compliant. Prior to the PHE, a health care provider generally would have to enter into a business associate agreement with a telehealth vendor supplying a HIPAA-compliant telehealth platform. Such an agreement would ensure that the provider and vendor have controls in place to prevent unauthorized access to protected health information (PHI) and a responsibility to notify patients of any breaches of PHI. The HHS Office for Civil Rights (OCR) announced at the start of the pandemic that it will exercise enforcement discretion and not impose penalties for non-compliance with HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the PHE. This enforcement discretion has allowed providers to temporarily use applications such as Apple FaceTime, Facebook Messenger, or Google Hangouts to provide telehealth services. As OCR will continue to exercise discretionary -enforcement during the PHE and to support uniformity in the utilization of technology platforms for providers, the *t*MED Coalition would recommend that continued temporary use of applications such as Apple FaceTime, Facebook Messenger, or Google hangouts be permitted to continue through the conclusion of the PHE (and 90 days thereafter), despite provisions in Ch. 260 that direct that telehealth services conform to applicable federal and state health information privacy and security standards.

As to the questions regarding licensure, we believe these issues are best addressed with the appropriate state licensing boards. At present, the prevailing interpretation of the law dictates that licensure is dependent on the physical location where the patient is receiving care. The BORIM policy allowing the establishment of a physician-patient relationship via telemedicine is understood to mean that a Massachusetts physician treating a patient in Massachusetts should have a Massachusetts license, regardless of where the physician is physically located. Requiring additional state medical licenses for MA-licensed physicians who are physically located out-of-state at the time of the visit treating MA patients creates an unduly burdensome licensure requirement that will ultimately undermine access to care for patients and disrupt continuity of care.

With regards to the comprehensive, yet flexible, definition of telehealth in the new law, the *t*MED coalition believes that the definition afforded by the legislature intentionally broadens the use of what has been covered and reimbursed by carriers during the PHE to include systems that have already been in use for a year. Agency guidance during the PHE did not explicitly recognize the use of asynchronous technologies, including store & forward technologies where providers and patients interact on their own timeline. Patient data, such as an image or x-ray in an electronic health record, are captured and

"stored" at the originating site and then "forwarded" to a specialist for remote review at a different site at a later time. For some specialties, these "store and forward" systems are standard of care in triaging patients in providing diagnostic accuracy and cost effectiveness. The tMED Coalition would note that this coverage and reimbursement needs to be explicitly mentioned in any imminent guidance to be provided by DOI and MassHealth as it is now law.

Commercial carriers were not required to cover or reimburse for remote patient monitoring during the PHE, while MassHealth has wisely recognized the importance of coverage and reimbursement for remote patient monitoring services. Because remote patient monitoring was included in chapter 260, the Division and MassHealth should consider issuing flexible guidance to define remote patient monitoring (RPM) devices. According to CMS, all devices need to meet the definition of a medical device described in section 201(h) of the Federal, Food, Drug and Cosmetic Act. There is no language that states the device must be FDA-cleared/registered. The RPM device must be capable of digitally uploading patient physiologic data acquired directly by the device (i.e., data cannot be self-recorded or self-reported by the patient). Here is the definition from the FDA definition of a device:

Section 201(h) of the FD&C Act (21 USC 321(h)) provides that the term "device" means:

- An instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is—

    1. Recognized in the official National Formulary, or the United States Pharmacopeia, or any supplement to them,

    2. Intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or

    3. Intended to affect the structure or any function of the body of man or other animals, and

- Which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes.

One question that has emerged is will RPM devices be subsidized and covered as durable medical equipment (DME), or reimbursed and covered in other ways? The *t*MED Coalition recommends that if an RPM device meets the criteria of a medical device, it should be covered the same way medical devices would traditionally be covered, commensurate with Medicare's coverage of 80% DME cost with 20% patient responsibility for all RPM DME. The Division and MassHealth should also recognize, cover, and reimburse for new Healthcare Common Procedure Coding System (HCPCS) DME codes for "multi-system monitors". The *t*MED Coalition would additionally recommend that: DOI and MassHealth review any missing codes for appropriate RPM DME (including but not limited to those for weight scales, blood pressure machines, pulse oximeters, otoscopes, glucometers, etc.); require the same documentation standards for remote patient monitoring as for in-office care; and establish consistent, uniform coding modifiers for RPM across all payers, including utilizing the GQ telehealth modifier for asynchronous telecommunication systems.

Under Chapter 260, MassHealth and commercial carriers are required to cover and reimburse for audio-only services, which was previously mandated under Governor's COVID-19 Order #4, which has since been rescinded. Audio-only coverage has been extremely helpful for those who do not have access to broadband services that support interactive audio-video technology. It is important to preserve payment parity between audio-only versus video visits among patients who cannot conduct video visits to avoid perpetuating inequities in access and coverage for patients. Online adaptive interviews are similarly helpful and accessible to patients, but this area is ripe for clarification as there has not been prior explicit recognition and state guidance regarding this modality. Furthermore, the *t*MED Coalition believes that "application-based services" or mHealth (mobile health) should also be included in the definition of telehealth. Examples of such applications include the provision of health care services and personal health data via mobile devices. Applications are downloaded to mobile devices and can be used for patient self-care management, tracking medication usage or drug-to-drug interactions, performing calculations used in clinical practice, and as medical device data systems.

It is important the definition of telehealth recognize, cover, and reimburse for e-consults or interprofessional telephone/internet/electronic consultation. Facilitating interprofessional, peer-to-peer consultations promotes high quality clinical care, especially in complex cases. We urge the Division to consider addressing the potential for patient liability in cost-sharing related to these interprofessional consults, as it may create undue barriers for patients and unnecessary administrative complexities. The AMA defines these consults as an "assessment and management service in which a patient's treating (e.g., attending or primary) physician/other qualified health care professional (QHP) requests the opinion and/or treatment advice of a consultant with specific specialty expertise to assist the treating physician/QHP in the diagnosis and/or management of the patient's problem without the need for the patient's face-to-face contact with the consultant." Starting in 2019, CMS introduced CPT codes 99451 and 99452 that will reimburse both the referring provider (PCPs) and the consulting provider (Specialist) for performing an eConsult. Additional recommendations regarding coding and billing for these codes will be provided by the Coalition following the March 31st listening session.

Finally, the *t*MED Coalition recommends that the definition of telehealth also include recognition, coverage, and reimbursement for e-visits which are patient-initiated, non-face-to face digital communications over HIPAA-complaint, secure platforms or portals that require a clinical decision that otherwise typically would have been provided in the office. E-Visits are also called Online Digital Evaluation and Management Services (E/M). Such visits were provided with CPT codes that were published in 2020 by CMS and have documentation guidelines and coverage requirements, in addition to minimum time requirements, as well as steps for review of patient records and interaction with clinical staff and subsequent communication with patients through online portals, telephone, email or other digitally supported communication by qualified healthcare providers. Additional recommendations regarding coding and billing for these codes will be provided by the Coalition following the March 31st listening session.

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 Adam Delmolino, Director, Virtual Care

& Clinical Affairs at the Massachusetts Health & Hospital Association (MHA) at (617) 642-4968 or adelmolino@mhalink.org or 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 Occupational Therapy Association
Atrius Health
New England Cable & Telecommunications Association
Association for Behavioral Healthcare
National Association of Social Workers – Massachusetts Chapter
Massachusetts Psychiatric Society
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

MAHP Feedback on MassHealth/DOI Public Listening Session February 26, 2020

Carrier Communications with Members

The new law allows a plan that provides coverage for telehealth services to include a deductible, copayment or coinsurance requirement for a health care service provided via telehealth as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-person delivery.

- How/when should carriers provide clear information to consumers about whether:
  - Deductibles apply to telehealth visits?
  - Copayments apply to telehealth visits?
  - Coinsurance applies to telehealth visits?

  MAHP Response:
  - Section 6 of MGL Chapter 176O requires EOCs to include an explanation of amounts of cost sharing, including copayments, deductibles, and coinsurance.
  - Section 23 of Chapter 176O requires plans to disclose costs, including copayments, deductibles, and coinsurance, for covered benefits via both the health plan's toll-free number and website.
  - Health plans will make this information available through these materials.

Plans are required to include "a summary description of the insured's telehealth coverage and access to telehealth services, including, but not limited to, behavioral health services, chronic disease management and primary care services via telehealth" in the EOC delivered to one insured household member. The law allows a patient to decline receiving services via telehealth in order to receive in-person services.

- How/when should present updated summary descriptions of telehealth coverage, including information that identifies that a patient may decline receiving services via telehealth in order receive in-person services, and what information should be included in the description?

  MAHP Response:
  - Section 6 of MGL Chapter 176O now requires EOCs to include a summary of the insured's telehealth coverage.
  - Health plans will update EOCs to incorporate a reference to telehealth coverage.
  - Health plans will update EOCs to state that a member may decline receiving services via telehealth in order to receive in-person services.

Carriers are also required to provide information on the network status of an identified health care provider via the carrier's toll-free telephone number and website that enables consumers to request and obtain from the carrier in real time.

- What should be reported regarding the "network status" of a health care provider?

  MAHP Response:
  - This provision of the new law was intended to protect consumers from surprise billing and is unrelated to the telehealth provisions. Therefore, we support an interpretation that health

plans are required to inform members whether a particular provider identified by the member is in or out of a plan's contracted network.

Carrier Contracts/Communications with Providers

The new law requires that a contract between a carrier and contracted health care provider shall provide coverage for health care services delivered via telehealth by a contracted health care provider if: (i) the health care services are covered by way of in-person consultation or delivery; and (ii) the health care services may be appropriately provided through the use of telehealth.

- Should there be separate provider contracts or contract amendments for telehealth?
- If so, what should be in the contracts?
- When and how should contracts be introduced/expected to be signed?

  MAHP Response:
  - It is our understanding that a majority of health plans have policy agreements in place with participating providers that provide reimbursement for covered health care services delivered via telehealth. Contract amendments are unnecessary for the implementation of health plan telehealth coverage and would impose a significant time and administrative burden on health plans and all providers.
  - MAHP supports the establishment of a reasonable time period to allow for updates to be made to telehealth coverage and payment policies in place prior to the public health emergency for contractual compliance with Chapter 260.
  - MAHP plans will communicate any changes in telehealth coverage or reimbursement that are necessitated by the requirements of Chapter 260 with participating providers in accordance with contractual provisions, which commonly require 60- or 90-day advance notice of implementation. Health plan newsletters to providers are regularly sent electronically and can incorporate details on telehealth policy changes.

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; provided however, that the determination shall be made in the same manner as if the service was delivered in-person.

- How/when should utilization review/preauthorization standards be developed?
- How/when should utilizations review/preauthorization standards be communicated?
- How/when should utilization review/pre-authorization standards be implemented?

  MAHP Response:
  - In accordance with section 12 of MGL Chapter 176O, health plans have a responsibility to ensure that members receive quality and clinically appropriate care in the right setting.
  - Not all 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)
    - In-person assessments may be essential to establishing a trusting patient-provider relationship vital to treatment in psychiatry and across all medical specialties.
- Health plans will communicate the development process for utilization review at member enrollment, in the EOC, and upon request in accordance with Sections 7 and 9 of Chapter 176O.
- Carriers are required by section 9 to provide an annual attestation of UR compliance to the DOI.

Payment Parity

Section 69 of the new law requires that the rate of payment for in-network providers of chronic disease management and primary care services are not less than the rate of payment for the same service delivered via in-person methods for two years, effective January 1, 2021 and sunsetting December 31, 2022 (per Sections 76 and 78).

Section 68 of the new law requires that rates of payment for in-network providers for telehealth services are not less than the rate of payment for the same service delivered via in-person methods.

Section 77 of the new law repeals the Section 68 telehealth payment parity mandate.

Section 78 of the new law repeals the Section 69 telehealth payment parity mandate 2 years from the effective date of this act, on January 1, 2023.

Section 79 of the new law makes Section 77 effective 90 days after termination of the governor's March 10, 2020 declaration of a state of emergency.

- What are reasonable considerations for addressing Section 77, the repeal of telehealth payment parity for services that are not BH, primary care, or chronic disease management?
- What are reasonable considerations for addressing Section 78 which impacts Section 76?
- When should clear guidance about timelines and communications be available for member, providers, and carriers?

  MAHP Response:
    - Throughout this public health crisis, Massachusetts health plans have been working to ensure that comprehensive care is available to members to meet new challenges presented by the COVID-19 pandemic. Health plans were required to reimburse providers for the provision of health care services through telehealth at the in-person reimbursement rate, an action that incentivized providers to establish virtual connections with patients and allowed health plan members to access necessary treatment without barriers during the public health emergency.
    - We support provisions in the law that allow payment parity to expire for services outside of behavioral health, primary care, and chronic care management, and that permit the rate of payment for telehealth services to vary depending on modality following the public health emergency. Our plans look forward to the opportunity to negotiate reasonable reimbursement rates for telehealth services delivery with in-network providers that reflect the services provided in order to achieve efficiencies and pass savings on to members.
    - MAHP supports the establishment of a reasonable time period to allow for updates to be made to telehealth payment policies in compliance with Chapter 260 with participating providers in accordance with contractual provisions.
    - Updates made to telehealth payment policies will be made in accordance with contractual provisions with participating providers.

Telecommunication Technology Platforms

The new law requires that health care services provided via telehealth shall conform to applicable federal and state health information privacy and security standards as well as standards for informed consent.

- Any further clarification issued by the Division of Insurance should reference the federal standards for privacy of personal health information under the HIPAA Privacy Rule and 42 CFR 2, an HHS regulation that protects the confidentiality of substance use disorder patient records, and incorporate state rules around the security of personal information.
- The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") limits the types of telehealth technologies that covered health care providers may use to provide telehealth services to patients. Those technologies are subject to HIPAA's strict privacy and security requirements, and often business associate agreements are required with the vendors providing the audio, video, or other technology for the telehealth service. Violations can lead to significant penalties.
- In response to the novel coronavirus nationwide public health emergency, the U.S. Department of Health and Human Services Office for Civil Rights has temporarily waived enforcement of penalties for using non-HIPAA compliant telehealth technologies when providing telehealth services related to potential COVID-19 exposure or for any other medical condition. The Notice permits covered health care providers to use any non-public facing remote communication product, such as popular applications that allow for video chats, including Apple Face Time, Facebook Messenger video chat, Google Hangouts video, or Skype, without risk that OCR may impose a penalty for noncompliance with HIPAA related to the good faith provision of telehealth during the emergency period. Providers are encouraged to notify patients of the potential privacy risks and to enable all available encryption and privacy modes when using such applications. Under the Notice, OCR states that providers should not use public facing video communication applications, such as Facebook Live, Twitch, and TikTok.
- Despite these temporary flexibilities, MAHP supports imposing comprehensive privacy requirements on telehealth communications as soon as possible.