ACOG
The American College of Obstetricians and Gynecologists
Massachusetts Section

March 15, 2021

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

Dear Mr. Beagan,

We wish to thank the Division of Insurance (DOI) for holding Listening Session's to provide guidance in the implementation of Chapter 260 of the Acts of 2020, as it applies to telehealth. The Massachusetts Section of the American Congress of Obstetricians and Gynecologists (MA-ACOG) appreciates the opportunity to provide input.

Specifically, MA-ACOG is requesting that the DOI include women's health in the definition of primary care for the purposes of parity in reimbursement for telehealth services for 2 years, or until January 1, 2023.

Obstetrician/Gynecologists practice almost exclusively in women's health. This specialty offers care throughout the life cycle. As such, routine screening such as breast and cervical cancer screening, testing for sexually transmitted infections, mammograms, and bone density testing for osteoporosis are routinely ordered by the Ob/Gyn. Additionally, Ob/Gyn's provide preventive care in the form of preconception counseling, pregnancy prevention, and screening for genetic cancer syndromes. In fact, primary care internists often defer these screening tests to the Ob/Gyn physician, knowing that these are important tests in women's health.

There also exists overlap between Ob/Gyn and primary care internists. Routine visits include annual review of medical and surgical history, medications and allergies. The Ob/Gyn also oversees care related to sexual health, obstetric care, mental health screening, counseling on smoking, alcohol use, substance use, intimate partner violence, as well encouraging as balanced diet, exercise and healthy lifestyles. Ob/Gyn's are often the first physician to identify cardiovascular risk factors and chronic medical comorbidities such as hypertension, diabetes, and obesity. Our offices commonly offer vaccinations against cervical cancer, influenza, and pertussis (which includes tetanus and diphtheria).

Given the focus on women's health, women make it a priority to see their Ob/Gyn regularly, more so than their primary care. Many women identify their obstetrician-gynecologist as their main, or sometimes only, source of medical care. This means that OB-GYN's are often the first members of the medical community that women contact and more importantly the provider that maintains continuity of care for many women.

The Affordable Care Act (ACA) identified woman's health as an essential benefit, confirming its importance as a primary care service and ensuring access to woman's health as a basic right. Furthermore, the place of reproductive and sexual health as women's preventative services was reaffirmed by the Institute of Medicine (IOM). The IOM's recommendations regarding the definition of preventive services that are essential for women's health encompassed many of the services provided by OB/GYN's and other reproductive and sexual health providers. This definition was embraced by the Department of Health and Human Services when they included screenings and counseling for sexually transmitted infections—particularly HPV and HIV—as well as all FDA approved forms of contraception as preventative services essential for women's health.

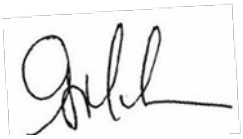
Massachusetts state law, M.G.L. c. 176O, section 1 defines "Primary Care Provider" as "a health care professional qualified to provide general medical care for common health care problems who: (i) supervises, coordinates,

prescribes, or otherwise provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii) maintains continuity of care within the scope of practice." It is clear from the scope of practice described above that OB/GYN's meet these criteria.

In conclusion, it is clear that there is precedent on both the state and the federal level for including women's health services in the definition of primary care for the purposes of telehealth reimbursement in Massachusetts. Moreover, it will increase access to quality care for our patients, reduce racial and economic disparities, improve outcomes and likely reduce long term costs.

MA-ACOG thanks you for your consideration of our request. We would be happy to answer any questions you may have. Please feel free to reach out at your convenience.

Sincerely,



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April 9, 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 representing the majority of psychiatrists, thank you for the opportunity to participate in the listening session on March 31, 2021 to discuss implementation of telehealth provisions within Chapter 260 of Acts of 2020. The Massachusetts Psychiatric Society (MPS) wishes to submit the following comments for your consideration (questions/topics below in bold).

"What falls under 'interactive audio-video technology'? What should be considered regarding the differing rates of reimbursement for those services that are not interactive audio-video technology?

Massachusetts Psychiatric Society (MPS) notes that the law states that services provided by telehealth conform to the applicable standards of care. We strongly believe that the decision about the location and modality of the treatment including in-person versus telehealth should be a clinical and patient-centered decision to be determined by clinicians and the patient, guided by the required standard of care. MPS discourages the DOI from applying old codes and standards for audio only telephone use (such as Medicare definitions cited by the MA Association of Health Plans) to the current use of audio-only, now used widely since the start of the Covid-19 pandemic. After all, the practice landscape is vastly changed from before the pandemic when CMS made their audio only codes. Similarly, we support efforts by Congress such as the "Permanency for Audio-Only Telehealth Act."

We concur with speakers on the call including the Massachusetts Medical Society who clarified the importance of recognizing that the important difference is not between audio-visual and audio-only modalities, but rather between synchronous and asynchronous modes of communication. The important consideration is not the technology used as much as the complexity of the visit and required medical decision making, which can be equally complex with either audio-only or an in-person visit. Visits by audio-only modalities such as telephone still include but are not limited to record review of past medical and family history, inquiry to the current circumstances including review of systems and social determinants of health, medication and diagnostic ordering, and plans for follow up. The payment should reflect the required and applied medical expertise and is the same no matter the modality. Asynchronous visits on the other hand such as a phone message request for a medication refill, would typically not be equivalent to the medical visit described above.

MPS also strongly agrees with concerns about structural racism occurring when services that are widely used by socio-economically disadvantaged groups, e.g., audio-only appointments, are deemed of lesser value. Individuals who only have telephone access or cannot use more advanced communications devices including smartphones, tablets, laptops, etc or who do not have broadband access, are unfairly affected by such disparate reimbursement. Indeed, unequal broadband access has been increasingly cited as a form of redlining with roots in structural racism. Paying less to providers who serve these individuals could compound the effects of structural racism by decreasing access to care.

If there are different rates of reimbursement, how should they apply?

The MPS discourages differential rates of reimbursement by telehealth modality. Many procedures previously associated with in-person office visits apply to telehealth visits, including managing waiting patients, and managing continued complexity in clinical presentations. New challenges including managing the technology difficulties that arise during the visit require greater flexibility on the part of the practitioner and patient.

The need for simplified codes is paramount. So-called surprise billing legislation requires practitioners to tell patients the expected cost of the services in advance. This depends on simplified codes and we discourage the generation of new billing codes other than the existing codes for in-person visits that are currently recognized and listed below.

99211-99215- Established Patient Evaluation & Management (E&M)

99202-99205- New Patient E&M

99241-99245 – Consultation Codes between MD and patient

90832-90853 – Behavioral Health Therapy codes

90791-90792- Psychiatric assessment codes for new patients

Will there need to be changes to existing global payment arrangements to account for telehealth?

MPS agrees with other participants' comments that global payments should be inclusive of related telehealth services including E&M which was already happening in the global payment market. In global payment models, the patient and provider decide together how to do the care as does the entity that is getting the global payment. If in person is covered, telehealth should be.

Behavioral health (BH) reimbursement:

MPS agrees with the DOI interpretation of the statute which makes a special rule for behavioral health such that services provided via audio-visual technology and audio telephone will be reimbursed at the same level as for an in-person visit in contradistinction with non BH services. MPS also agrees with the DOI interpretation of the statute, that there are not any provisions that limit the time that this section of the law is in effect for BH reimbursement of telehealth visits via audio-only and audio-visual telehealth modalities. MPS feel that these parts of the statute are designed to reflect the unfortunate reality that almost half of the citizens of the commonwealth with behavioral health conditions do not get treatment and 90% of individuals with substance use disorders (SUD) do not get treatment. We feel that this special consideration for BH and SUD is designed to increase access to these services which are in critical need.

Behavioral health <u>out-of-network</u> (OON) reimbursement:

If a carrier permits out-of-network health care practitioners to provide services via telehealth, should there be any guidance on their reimbursement?

Can different reimbursement rules apply to <u>out-of-network</u> health care practitioners?

Can different rules apply to different types of <u>out-of-network</u> behavioral health providers?

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

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

Best Regards,

Sally Reyering, MD, DFAPA
President, Massachusetts Psychiatric Society

Mass General Brigham

HARVARD MEDICAL SCHOOL

May 7, 2021

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

Mr. Kevin Beagan
Deputy Commissioner

Dear Mr. Beagan,

Mass General Brigham appreciates the ongoing process hosted by 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 third session hosted by The Division on March 31, 2021 explored questions critical to the ability to operationalize the telehealth expansion included in the legislation. Clear and consistent practices around billing and reimbursement are critical for equity and access in the delivery of telehealth. Mass General Brigham continues to emphasize that telehealth visits should be viewed as a co-equal substitute for in-person office visits. As such, billing and reimbursement for telehealth should follow practices and protocols for in-person visits; any differential in billing and reimbursement will have the unintended consequence of creating structural inequities between in-person and telehealth care provision. A critical reimbursement issue centers on the ability to bill for and be reimbursed for audio-only services in the same manner as that for audio-visual and/or in-person visits. Those lacking broadband access, the elderly and those without smart technology are those that benefit the most from audio-only telehealth visits; differentiating billing and reimbursement for audio-only telehealth provision will discourage the use of audio-only telehealth and disenfranchise the vulnerable populations that rely on it.

Interactive Audio-Video Technology

We support the definition established by Chapter 260 (“‘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.”).

We encourage the Division to also consider flexibilities for patients requiring ASL or other accommodative technologies and to include language that speaks to requirements that accommodate patients and their individual needs.

Bundling/Global Payments

Mass General Brigham maintains that telehealth visits are equal to and substitutive for in-person visits. Global payments are designed to cover patients' care inclusive of all types of visits. There is no need to change global payment structures or add billing on top of the global payments for telehealth services, as they are an appropriate delivery modality within the episode of care.

Out of Network (OON) Billing and Reimbursement

In keeping with the premise that telehealth is equal to in-person care, Mass General Brigham recommends that any OON allowances for in-person settings should be extended to telehealth settings. Behavioral health presents a particular equity issue with regard to OON billing. Historically, network adequacy for behavioral health providers has been limited and constraining; many patients must seek behavioral health care outside of their network. Telehealth has proven to be an effective and often preferred method for the provision of therapy and other behavioral health services and the pathways to receiving such care through telehealth need to accommodate the reality of out-of-network care provision while adhering to state and federal requirements to protect patient's in certain circumstance from balance billing. Patients who need to go out of network for services that are not available in-network, should be able to use telehealth to access those services and have the same protections and costs that would be afforded if in-person out of network care was selected.

Reimbursement for Telehealth

GT Modifier for distinguishing telehealth provision: Mass General Brigham urges The Division to adopt the use of the GT modifier that is universally accepted and has been used by Medicare for over a decade, rather than the Division inventing additional codes or allowing each insurer to require the use of plan specific codes. Use of this well understood GT modifier will eliminate the need for new CPT codes which would only serve to complicate billing and reimbursement.

Another key issue is how to establish that a service rendered is covered under the criteria of primary care, chronic disease management or behavioral health. We feel that this determination should be based on the service provided rather than the specialty training of the provider, because many different provider types deliver these services regardless of their specialty training. If The Division or other oversight agencies would like to collect specific data on the type of telehealth provision, or to determine that a service provided was eligible for reimbursement coverage, then we recommend that an additional modifier be added for tracking, such as attesting that a specific encounter met the primary care or behavioral health definition for coverage, or that an audio-only modality was used because the patient had social determinants of health or other limitations that prevented delivery over video. If such an attestation or additional modifier is added, it is imperative that it is standard across all payers so that providers do not have the administrative burden of multiple, different per-payer requirements, new CPT codes or other mechanisms.

CPT Codes: In order to meet the spirit of the statute wherein telehealth, inclusive of audio-visual and audio only, is aligned with service provision in-person, we strongly suggest you use the same codes as in person in alignment with Medicare billing and reimbursement. Consistent with this guiding principle, that the current

E&M structure accurately captures the degree of work by the provider, we offer that physicians (MD/DO) and Advanced Practice Providers (such as NP,PA) should bill either by time or medical complexity using established E&M codes, and non-E&M providers (such as physical therapists, speech and language pathologists and others) should bill for hospital-based services. Examples of these E&M codes include:

99211-99215- Established Patient E&M

99202-99205- New Patient E&M

99241-99245 – Consultation Codes between MD and patient

90832-90853 – Behavioral Health Therapy codes

90791-90792- Psychiatric assessment codes for new patients

Mass General Brigham appreciates the collaborative and transparent process that The Division of Insurance 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 The Division 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 yours,

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MAHP Final Feedback on March 31 DOI Session #3 to Discuss Implementation of Telehealth Provisions within Chapter 260 of Acts of 2020

1. **What are the rules for reimbursement?**

SECTIONS 47, 49, 51 and 53. (a)…"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.

Interactive Audio-Video and Other Telehealth Modalities

- What falls under "interactive audio-video technology"?
  - In accordance with the statute, health care services delivered via telehealth will be covered if:
    - the health care services are a **covered benefit**, and
    - the health care services may be appropriately provided through the use of telehealth.
      - Services rendered must be **clinically appropriate, medically necessary** covered services and not require an in-person assessment and/or treatment.
  - Telehealth includes covered health care services when furnished by interactive audio-video technology, or an interactive telecommunications system.
  - **According to Medicare, *Interactive telecommunications system* means multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. Both the patient and the provider must be present and participating throughout the communication. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system.**
  - **Interactive audio-video technology does not encompass the other telehealth modalities explicitly listed within the new definition of telehealth in addition to interactive audio-video technology: remote patient monitoring, audio-only telephone, or online adaptive interviews synchronous interactive communications between a member and an in-network provider.**

SECTIONS 47, 49, 51 and 53. (e)The rate of payment for telehealth services provided via interactive audio-video technology may be greater than the rate of payment for the same service delivered by other telehealth modalities.

Other Telehealth Modalities: Remote Patient Monitoring

- **Remote patient monitoring is the monitoring and review of patient health data via interactive communication between an established patient and a provider related to a chronic and/or acute health illness or condition**.
- A remote patient monitoring device must meet the **FDA's definition of a medical device** as described in section 201(h) of the Federal, Food, Drug and Cosmetic Act.
- 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).
- RPM is an Evaluation and Management (E/M) service. RPM can only be billed by physicians and other qualified health care professionals who are eligible to bill for E/M services.

Other Telehealth Modalities: Audio-Only Telephone

Other Telehealth Modalities: Online Adaptive Interviews

- Can each type of the other telehealth services have differing rates of reimbursement?
  - **The language of the law clearly permits each telehealth modality to be reimbursed at a rate less than the rate of payment for the same service delivered via in-person, other than interactive audio-video technology.**
  - **to be paid.** The flexibility afforded by the new law allows for reimbursement which reflects the lower value of interactions which do not represent a "visit" or live interactive communication between a patient and provider.
  - Asynchronous store-and-forward applications use technology to collect and transmit data for the use of remote patient monitoring and chronic care management. The electronic transmission of documents, images, or clinical data to a distant site for review at a later time do not require the simultaneous presence (virtual or otherwise) of a patient or provider and therefore do not comprise a synchronous, interactive audio-visual communication between a patient and a provider and are not representative of a traditional covered in-person office visit or outpatient service.

- What should be considered regarding the differing rates of reimbursement for those services that are not interactive audio-video technology?
  - **Medicare distinguishes health care services delivered via interactive audio-video technology from health care services delivered by audio-only telephone or other asynchronous store-and-forward applications such as remote patient monitoring for both coding and reimbursement purposes.**
  - **Coding and documentation of the specific modality to distinguish the different types of telehealth services delivery modalities (e.g. audio-only, RPM etc.) from "standard" synchronous audio-video interaction is necessary.**

- Can there be different rates of reimbursement within a category, for example for different types of online adaptive interviews?
  - **Plans do not currently reimburse in-network providers for online adaptive interviews.**
  - **We are unaware of any covered health care service that can be appropriately provided via this modality.**

Bundling

SECTIONS 47, 49, 51 and 53.
(f) **Coverage that reimburses a provider with a global payment, as defined in section 1 of chapter 6D, shall account for the provision of telehealth services to set the global payment amount.**

M.G.L. c. 6D, section 1:
''Global payment'', a payment arrangement where spending targets are established for a comprehensive set of health care services for the care that a defined population of patients may receive in a specified period of time.

QUESTIONS

- Will there need to be changes to existing global payment arrangements to account for telehealth?
  - **Health plans will work with contracted providers reimbursed with a global payment to account for covered telehealth service delivery.**

Behavioral Health Services

SECTIONS 47, 49, 51 and 53.
(e) T**he rate of payment for telehealth services provided via interactive audio-video technology may be greater than the rate of payment for the same service delivered by other telehealth modalities.**

(g) Insurance companies organized under this chapter shall ensure that **the rate of payment for in-network providers of behavioral health services delivered via interactive audio-video technology and audio-only telephone shall be no less than the rate of payment for the same behavioral health service delivered via in-person methods**; provided, that this subsection shall apply to providers of behavioral health services covered as required under subclause (i) of clause (4) of the second sentence of subsection (a) of section 6 of chapter 176O.

QUESTIONS

- It appears that there are not any provisions that limit the time that this section of the law is in effect. Is there anyone that has a different reading of these sections?
  - **We agree the payment parity requirement for in-network providers of behavioral health services delivered via interactive audio-video technology and audio-only telephone does not sunset in Chapter 260.**

- Within subsection (d), it is noted that "[t]he rate of payment for telehealth services provided via interactive audio-video technology may be greater than the rate of payment for the same service delivered by other telehealth modalities." In subsection (g), it is noted that "behavioral health services delivered via interactive audio-visual technology **and audio telephone** (emphasis added) shall not be less than the rate of payment for the same behavioral health service delivered via in-person methods." Is there anyone with a different reading of this section?
  - **We agree that the statutory provisions require that behavioral health services provided via audio-visual technology and audio telephone be reimbursed at the same level as for an in-person visit. Behavioral health services must be delivered by a licensed mental health professional** who provides behavioral health outpatient services provided by a licensed hospital, a mental health or substance abuse clinic licensed by DPH, a public community mental health center, a professional office, or home-based services delivered via telehealth as defined in MGL Chapter 176G, Section 4M(g). **Behavioral health services rendered must be clinically appropriate, medically necessary covered services and not require an in-person assessment and/or treatment.**

- The statute applies to in-network providers within those health plans that are regulated under M.G.L. c. 32A, 118E, 175, 176A, 176B, 176G and 176I. If a carrier permits out-of-network health care practitioners to provide services via telehealth, should there be any guidance on their reimbursement? Can different reimbursement rules apply to out-of-network health care practitioners? Can different rules apply to different types of out-of-network behavioral health providers?
  - **The new law does not require health plans to reimburse health care services delivered via telehealth by an out-of-network provider, therefore these provisions do not apply to OON**

providers and no further DOI regulation is necessary. Different coverage and reimbursement rules may apply to OON providers and amongst different types of OON BH providers.

Chronic Disease Management and Primary Care Services

SECTIONS 47, 49, 51 and 53.
(e) **The rate of payment for telehealth services provided via interactive audio-video technology may be greater than the rate of payment for the same service delivered by other telehealth modalities.**

SECTION 69.
…**the rate of payment for in-network providers of chronic disease management**, as defined in section 1 of chapter 176O of the General Laws, **and primary care services**, as defined in said section 1 of said chapter 176O, **delivered via telehealth** pursuant to section 30 of said chapter 32A, section 79 of said chapter 118E, section 47MM of said chapter 175, section 38 of said chapter 176A, section 25 of said chapter 176B, section 33 of said chapter 176G and section 13 of said chapter 176I **are not less than the rate of payment for the same service delivered via in-person methods.**

SECTION 76. **Section**s 63 and **69** are **hereby repealed**.

SECTION 78. **Section 76 shall take effect 2 years from the effective date of this act.**

QUESTIONS

- The statute had an emergency preamble making the law effective when signed into law by the Governor on January 1, 2021. This would appear to mean that section 76 repeals section 69 on January 1, 2023 and that provisions of section 69 are in effect only through December 31, 2022. Is there anyone that has a different reading of these sections?
  - **MAHP agrees that statutory payment parity provisions included in Section 69 of Chapter 260 sunset on January 1, 2023.**

- Within subsection (e), reimbursement for interactive audio-video technology may be greater than the rate of payment for the same service delivered by other telehealth modalities. Section 69 requires that services delivered via telehealth shall not be less than the rate of payment for the same service delivered via in-person methods. It appears that the statute does not have the same language included in the section for behavioral health and that only audio-visual technology will be reimbursed at the same level as for an in-person visit, while for non-behavioral health services only audio-visual technology is required to be reimbursed at the same level as for an in-network visit. Is there anyone with a different reading of this section?

  - **We agree with the Division that the language included in subsection (e) permits the rate of payment for in-network providers of chronic disease management services and primary care services delivered via interactive audio-video technology to be greater than the rate of payment for chronic disease management services and primary care services delivered via other telehealth modalities.**

  - **Therefore, only primary care services delivered via interactive audio-video technology must be reimbursed at the rate of payment for the same service delivered via in-person methods.**

- **Primary care services delivered via other telehealth modalities such as audio-only telephone, remote patient monitoring, and online adaptive interviews are not required to be reimbursed at the in-person rate for the service.**
- **Chronic disease management services, as reimbursable by CMS, do not have a corresponding in-person equivalent and should therefore be reimbursed in accordance with payment policies.**

All Other Services

SECTIONS 47, 49, 51 and 53.
(e) **The rate of payment for telehealth services provided via interactive audio-video technology may be greater than the rate of payment for the same service delivered by other telehealth modalities.**

SECTION 68.
…**rates of payment for in-network providers for telehealth services** provided pursuant to section 30 of said chapter 32A, section 79 of said chapter 118E, section 47MM of said chapter 175, section 38 of said chapter 176A, section 25 of said chapter 176B, section 33 of said chapter 176G and section 13 of said chapter 176I **are not less than the rate of payment for the same service delivered via in-person methods**.

SECTION 77. **Section 68 is hereby repealed**.

SECTION 79. **Section 77 shall take effect 90 days after termination of the governor's March 10, 2020 declaration of a state of emergency**.

QUESTIONS

- It appears section 77 repeals section 68 on the 90th day after termination of the Governor's March 10, 2020 declaration of a state of emergency. Is there anyone that has a different reading of these sections?
  - **We have interpreted the statute to terminate broad telehealth payment parity on the 90th day after termination of the Governor's March 10, 2020 declaration of a state of emergency.**

- Within subsection (e) of SECTIONS 47, 49, 51 and 53, "the rate of payment for telehealth services provided via interactive audio-video technology may be greater than the rate of payment for the same service delivered by other telehealth modalities." Section 68 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." It appears that the statute does not have the same language included in the section for behavioral health and that only audio-visual technology will be reimbursed at the same level as for an in-person visit. Non-behavioral health using audio-visual technology could be reimbursed at a lower level. Is there anyone with a different reading of this section?
  - **We agree that the statutory language requires that only covered services delivered via interactive audio-video technology be reimbursed at a rate no less than an in-person visit.**
  - **We agree that all non-behavioral health services delivered via other modalities, including audio-only telephone, remote patient monitoring, and online adaptive interviews may be reimbursed at a lower level than an in-person visit.**

Billing

DOI Bulletin 2020-04, **Reimbursement for Health Service Provided via Telehealth**

When submitting claims for reimbursement, Carriers may request that providers include a code that signifies that the service is being provided via telehealth for purpose of tracking the number of health services that are being provided via telehealth. The collection of such code should not alter a provider's rate of reimbursement below any contractually agreed rate of reimbursement.

QUESTIONS

- Should the same guidance continue for the purpose of tracking telehealth visits? Are there other ways that carriers should use to track the number of services being provided via telehealth?
- Are there codes that could be used to distinguish among the different types of telehealth?
- Should there be separate codes for audio-visual technology than for all other types of telehealth? Should there be separate codes for each type of telehealth?

Interactive Audio-Visual CPT Codes

- Plans will reimburse covered health care services delivered via telehealth **when the services are billed using appropriate in-person CPT codes and modifiers, which identify the different telehealth services delivery modalities.**

Audio-Only CPT Codes

Plans must now cover telehealth delivered by audio-only telephone, but may reimburse at a rate less than the in-person for all services except behavioral health services.

- **Plans will reimburse covered health care services for the purposes of telehealth utilizing CPT codes listed by Medicare, with use of the appropriate modifier to identify the modality, whether audio-visual or audio-only.**
- **MAHP plans do not have concerns with continuing to reimburse the telephone assessment and management CPT codes for audio-only telehealth (98966, 98967, 98968, 99441, 99442, and 99443) for so long as allowable by Medicare.**

Remote Patient Monitoring

- CPT codes 99091, 99453, 99454, 99457, and 99458 are used for remote patient monitoring. CPT codes 99453 and 99454 are for the remote collection of physiologic data and include reimbursement for the device.

The Massachusetts Medical Society, representing more than 25,000 physicians, residents, and medical students, would like to thank the Division of Insurance and MassHealth for the productive listening session held on March 31st, 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 billing and reimbursement.

Reimbursement: Differential Reimbursement

Chapter 260 explicitly allows that the rate of payment for telehealth services provided via interactive audio-video technology *may* be greater than the rate of payment for the same service delivered by other telehealth modalities. However, the Medical Society strongly urges against differentiating between interactive audio-visual technology and audio-only technologies and would instead recommend approaching differential reimbursement as it applies to synchronous v. asynchronous technologies. In terms of these synchronous technologies, MMS encourages the Division and MassHealth not to focus solely on the specific technology when thinking about reimbursement rates. Instead, when thinking about reimbursement rates for care delivered through telehealth the Division and payors across the spectrum should be focused on more salient considerations, including the medical complexity and medical judgment involved, the overall time spent on the patient encounter, and the services provided. Telehealth visits that are audio-only v. audio-visual may still require the same expertise, the same follow up, order entries, etc. that an in-person visit requires and should be compensated similarly.

Moreover, in crafting reimbursement models, we must be careful not to create bright-line distinctions that may codify policies that perpetuate racial disparities and other forms of discrimination into our payment system, further exacerbating inequities in access to care for patients. Distinguishing real-time audio-only would increase disparities in care and be discriminatory in the case of patients – particularly elderly, differently-abled, and patients of color or those with low-incomes – who only have telephone access or are not able to use more advanced communications devices including smartphones, tablets, laptops, etc. or who do not have broadband access.

Beyond considerations regarding these synchronous telehealth encounters, we acknowledge the challenges inherent in creating ways to price certain novel asynchronous telehealth encounters, including online adaptive interviews, and appreciate the level of flexibility required to determine the value and payment associated with care provided through these modalities. Medicare covered telehealth services include many services that are normally furnished in-person. These codes include E/M codes as well as eligible CPT codes listed in the CPT manual. Additionally, Medicare reimburses several non-face-to-face services that can be used to assess and manage a beneficiary's conditions. These services include care management, remote patient monitoring, and communication technology-based services, e.g., remote evaluation of patient images/video and virtual check-ins.

We believe reimbursement for asynchronous telehealth encounters for newer capabilities should be based on data analysis, including literature assessments, and collaboration between the physician and provider community and carriers, and as such we strongly encourage the Division to issue guidance allowing sufficient time to review the relevant data and work collaboratively to address these novel payment issues.

In the first session, we noted that 90 days after the lifting the public health emergency would not be sufficient time to adjust to changing reimbursement rates (when the parity requirement expires). Since the onset of the COVID-19 pandemic, physician offices have rapidly and completely redesigned care delivery, working to develop protocols and stand-up systems, workflows, and staffing for telehealth services. MMS is part of the *t*MED Coalition, which is advocating in the legislature this budget cycle for an additional glidepath of 180-days after the public health emergency is lifted to provide more time to prepare for this transition. The reality is, even 180 days will not be enough – in practice, it will be incredibly challenging to unwind or readjust our newly established care delivery models, which embrace telehealth, based on potentially dramatic changes in reimbursement. This will be detrimental both for patients and for physician practices.

Lastly, we would like to underscore to the Division concerns we have heard from the physician and provider community relative to some carrier's approach to telehealth payment wherein reimbursement rates for services delivered via telehealth are considered a payment policy that is unilaterally imposed with contracted providers. Instead, we would urge the Division to issue guidance clarifying that payment for services delivered via telehealth is not a policy that payors can unilaterally impose, but instead that rates for services delivered via telehealth should be negotiated on a contractual basis and through the same processes that apply to rate negotiation for services delivered in person.

Reimbursement: Global Payments

Care delivered via telehealth is comparable in quality and cost to care delivered in-person. While there may be some contract changes that are necessary, we do not anticipate the need for any guidance or intervention from the Division or MassHealth relative to any changes to global payment arrangements to account for telehealth. We would expect the Carriers to provide the necessary and timely advanced notice as agreed to in existing contracts and to negotiate the telehealth rates as they do in-person rates.

Reimbursement: Behavioral Health, Chronic Disease Management, Primary Care & All Other Services

MMS understands and agrees with the DOI interpretation that behavioral health services delivered through both interactive audio-visual and audio-only must be reimbursed at parity in perpetuity. The COVID-19 pandemic not only disrupted access to in-person health care, but it also simultaneously intensified behavioral health needs at a magnitude that still may not be fully appreciated, while exposing the existing crisis in access to behavioral health care. According to the Massachusetts Health Policy Commission (HPC), utilization data showed that over 70% of visits for BH were performed via telehealth in April 2020, with this percentage remaining near 70% through September 2020. Permanent reimbursement parity for any physician or clinician providing behavioral health services, including through both interactive audio-visual visits and audio-only visits, will be critical to promoting greater access to care, including improving no show rates, and closing gaps in equity.

Based on the remaining statutory framework, we understand that *all* services delivered through telehealth, regardless of the technology and therefore including audio-only, must be reimbursed on par with in-person services for 90 days after the state of emergency is lifted. Beyond that, primary care services and chronic disease management services must be reimbursed at parity for 2 years from the date of enactment (until Dec 31, 2022), again regardless of the form of technology. MMS agrees that the provision allowing differential reimbursement for care delivered through interactive audio-visual technology does not have a time limit and applies in perpetuity *once the relevant statutory requirements*

for parity in reimbursement expire. Therefore, once these two parity requirements expire, ostensibly starting 1/1/23, all services outside of behavioral health services (and so including chronic disease management services and primary care services) can be reimbursed at varying levels, and interactive audio-visual visits can be reimbursed at a greater rate than other technologies. Here again, we strongly encourage the Division to issue rules or guidance that does not distinguish between interactive audio-visual technologies and audio-only technologies for these purposes to avoid policies that codify inequities in access to care, seeking instead to have these modalities reimbursed comparably and at a sustainable rate for the organization. While the legislature importantly recognized the equitable imperative of parity for audio-only coverage in the context of behavioral health services, we would stress that the same approach should apply equally to other services – including primary care and chronic disease management – which can be just as effectively delivered through audio-only synchronous modalities. Again, any decision that use audio-only is appropriate for a given service is a clinical decision made by the physician with good medical judgment and patient awareness of this being a visit. Lastly, we wish to underscore that "differential construct" only applies to reimbursement, and the DOI should ensure that all covered services that can appropriately be provided via telemedicine should be covered regardless of audio-visual or audio-only modality.

With regard to how this reimbursement framework should apply to out-of-network providers, MMS believes that our existing statutory rules governing out-of-network providers should apply. In subsection (c) of all the telehealth provisions, the law explicitly refers to the application of requirements under clause 4 of section 6 of chapter 176O. So for example, when there are network adequacy issues or a particular service is not available to a member through an in-network provider, clause 4 of section 6 of chapter 176O requires carriers cover the service from out-of-network provider and the patient will not be responsible to pay more than the amount which would be required for service if it were available from a provider within the carrier's network. In this case, and to the extent that 176O requires carriers to cover services by an OON provider, we believe the same reimbursement rules should apply for coverage by OON providers under these circumstances. It should be treated the same as if the care were provided on an in-person basis and subject to negotiation between the physician and the plan with all required notice provided to the patient.

Billing

When it comes to billing, MMS does not believe we need to be creating a new coding structure for telehealth. Services provided through telehealth visits are the same services we are providing to our patients in an office-setting, but through a different delivery mechanism; physicians are held to the same standard of care regardless of the modality. Instead of looking to add codes for telehealth, we encourage the Division to require health plans to utilize the full panoply of existing CPT, office-based Evaluation & Management (E&M), and other codes (e.g. recently developed codes applicable to asynchronous telehealth encounters, including, but not limited to, online adaptive interviews and remote patient monitoring) used for health care services; the same codes used for in-office care should be applied for care delivered via telehealth with a modifier to indicate delivery through telehealth.[1]

[1] The Medical Society has included, for your reference, an accompanying excel document with applicable codes. These codes include but are not limited to telehealth codes, e.g. 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 and patient monitoring codes

We strongly urge the Division not to use outdated CMS codes and standards for audio-only telephone visits that were in use prior to the pandemic (and as listed in listening session 3 and cited by some health plans during that listening session). Other existing CPT codes with appropriate telehealth modifiers have been widely used since the start of the Covid-19 pandemic and are more apt and reflective of services rendered (see attached excel spreadsheet). The practice landscape is vastly changed from before the pandemic, when CMS/Medicare older telephone-only codes were used. We support efforts in Congress to make permanent the newly developed audio-only codes.

We appreciate the claims guidance DOI provided in Bulletin 2020-04 and agree that same guidance allowing carriers to request a code modifier should continue for the purpose of tracking telehealth visits. Most critically, we would encourage – to the extent possible – that all code modifiers be consistent across all carriers, including MassHealth, to reduce administrative burden. To the extent that it is useful to connote the interactive audio/visual technology, which the statute has carved out for higher reimbursement, with a distinct E and M code or universal modifier for telehealth delivered through interactive A/V makes sense.

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

Massachusetts League
of Community Health Centers

June 15, 2021

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

RE: Comments on Session #3: Implementation of Telehealth Provisions within Chapter 260 of Acts of 2020

Dear Mr. Beagan,

We wish to thank the Division of Insurance (DOI) for holding Listening Sessions to provide guidance in the implementation of Chapter 260 of the Acts of 2020, as it applies to telehealth. The Massachusetts League of Community Health Centers (the League) appreciates the opportunity to provide input on DOI's Session 3 questions and highlight (1) the importance of the audio only modality for our patients, and (2) our community health center's unique billing codes.

The League is Massachusetts' Primary Care Association, representing and serving the state's 52 community health center organizations, which operate out of over 314 practice sites throughout the state. Annually, community health centers provide high quality health care for more than one million state residents of all ages, representing a wide range of racial and ethnic backgrounds, and they serve 96% of the state's zip codes. Health center patients have been disparately impacted by the COVID-19 pandemic. We serve as the largest safety net provider network for primary care in the Commonwealth, with virtually all health centers also providing significant co-located and/or integrated behavioral health services. By mission (and law, in the case of Federally-Qualified Health Centers (FQHCs)), health centers serve all who walk through their doors, regardless of ability to pay. As a result, the patient population at health centers looks very different than that of other providers: 15% uninsured, 49% Medicaid, 10% Medicare. Reimbursement for these services varies depending on coverage type.

Our patients are racial and ethnic minorities who are also front line and essential workers, new immigrants, those living in congregate housing, the farmworkers who pick our fresh food, and the those experiencing homelessness or other forms of housing insecurity. The need to address the systemic issues, including racism, that led to our communities experiencing such a scale of tragedy and illness has never been more urgent. As you know, due to their payer and service mix, health centers experience severe and chronic underfunding for the high-quality care they provide. The result is a fragile primary care safety net and inadequate access to identified, needed services for our most vulnerable residents, including medical, behavioral health, dental, vision, pharmacy and substance use disorder care; as well as enabling (non-clinical) and other support services, which often focus on social determinants of health. We believe that a strong, integrated approach to

primary care that addresses the whole person and, in many cases the whole family, is critical to improving health and reducing costs.

Advancing and expanding telehealth services, coverage, and access in Massachusetts has been a longstanding priority for community health centers. However, throughout the COVID -19 pandemic, the ability to deliver and be reimbursed for care provided via telehealth has become paramount to health access for our patients and communities, and to the financial viability of health centers. The League is a member of the tMEd Coalition, and we have joined with the more than 35 members of that coalition in providing detailed recommendations around the telehealth provisions in previous testimony. However, below are several provisions of particular importance to community health centers regarding billing and reimbursement.

We appreciate the opportunity to provide written comments in follow up to the thoughtful discussion around the rules for reimbursement and how providers will bill for telehealth services.

Importance of Audio-Only Modality for Health Center Patients:

Throughout the pandemic the use of audio-only services has been essential to access to care for our patients and in fact increased access significantly. First, the use of audio-only has substantially reduced our no-show rates, which are currently lower than usual across all visit modalities (audio-only, video, and in-person). Patients were able to save travel time and no longer needed to take time off work, get childcare, arrange transportation. Health centers are even able to convert no-shows into visits by calling and conducting audio-only visits with patients who missed an in-person appointment. Secondly, survey data indicates that there are many situations where patients prefer phone over video. Results from an ongoing survey conducted in 16 health centers over the course of the pandemic show that the majority of health center patients have done visits predominately over the phone; with 85% of visits conducted via phone and 15% via video. And, there is an indication that patients do prefer audio over video depending on the purpose of the visit.

Health center patient's reliance on audio-only is not surprising given the digital divide, which the Mass League has been working to bridge through our work on equity and access. Many low-income patients lack the devices, internet access or digital literacy necessary to conduct video visits. Patients that live in rural parts of Massachusetts suffer from spotty broadband, and even patients in urban and suburban areas, do not always have access to broadband that best allows for use of video technologies. Yet, even among patients who can participate in video visits, many prefer not to because of other concerns, such as privacy, data usage, and preferred language. As an example, some patients are not comfortable showing their home environment. Furthermore, our health centers have said that patients with limited data plans often do not want to use their data on a video visit. Finally, a video visit, like an in-person visit, typically requires multiple steps such as clicking links, downloading mobile apps, troubleshooting connection issues, and waiting in a virtual waiting room. Even when these steps are relatively easy for patients to navigate, automated instructions and communications are seldom available in multiple languages. This technology can be challenging for many, especially non-English speakers, compared to audio-only visits that you can passively receive as you go about your day without the need for any instruction.

The League believes that the law is clear that audio only is a modality for all telehealth encounters. Audio-only has been an essential modality for health center patients and has helped to avoid exacerbating disparities in their access to care. Pursuant to Chapter 260, Section 3, section

30(a) 47(a), 49(a), 51(a) and 53 (a), audio-only is unambiguously listed in the definition of telehealth services, and therefore should be reimbursed at the same rate as other modalities.

> "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.

Reimbursement for Behavioral Health:

The League agrees with DOI's interpretation that the provisions in sections 47, 49, 51 and 53 of Chapter 260 in subsections (g) require that the rate of payment for in-network providers of behavioral health services delivered via interactive audio-video technology and audio-only telephone be not less than the rate of payment for the same behavioral health service delivered via in-person methods in perpetuity. As per the above, this policy advancement will be of great value to health center patients, and we welcome its inclusion.

Chronic Disease Management and Primary Care – Audio only:

The League disagrees that only audio-visual primary care and chronic disease management should be reimbursed at parity with in-person visits. For the next two years (until December 31, 2022), all forms of telehealth (including audio-only telephone) for primary care services and chronic disease management are clearly required to be reimbursed at the same level as in-person visit per the provision of sections 69, 76 and 78:

> "[T}he rate of payment for in-network providers of chronic disease management, as defined in section 1 of chapter 176O of the General Laws, and primary care services, as defined in said section 1 of said chapter 176O, delivered via telehealth pursuant to section 30 of said chapter 32A, section 79 of said chapter 118E, section 47MM of said chapter 175, section 38 of said chapter 176A, section 25 of said chapter 176B, section 33 of said chapter 176G and section 13 of said chapter 176I are not less than the rate of payment for the same service delivered via in-person methods." Section 69.

The League advocated strongly for reimbursement parity for audio-only telehealth services, including for chronic disease management and primary care in order to avoid exacerbation of the racial inequalities caused by COVID. We are grateful that the legislature created this two-year time period, until December 31, 2022, to provide Massachusetts healthcare consumers, especially those who are most vulnerable to the health and economic effects of COVID-19, including communities of color, with needed stability during these difficult times and consistent, reliable access to care, including via all telehealth modalities. The League also advocated for this longer time period to give state policymakers the opportunity to study the effects of telehealth coverage, including how audio-only has improved access and health outcomes and how elimination of parity for certain modalities might disproportionately harm certain racial and ethnic groups and other historically disadvantaged people.

Reimbursement - All Other Services:

After the close of the state public health emergency and subsequent glidepath, the League encourages DOI to prioritize reimbursement on par with in-person visits to the greatest extent feasible for those services that are not primary care, chronic disease management or behavioral health services – for all modalities so as to maintain access to services for all patients especially during this "catch-up" period where we are continuing to recover from the impacts of delayed care during the pandemic.

Billing - Unique G and T Billing Codes:

Thirty-three Massachusetts Federally Qualified Health Centers (FQHCs) use unique G and T billing for MassHealth, which trigger an all-inclusive bundled payment: G Codes for psychiatry and T Codes for medical visits (both outlined in more detail under the MassHealth health center pricing regulation: 101 CMR 304).

Depending on the unique service and the provider delivering the service, either of these codes might be utilized in the provision of substance use treatment. Health centers have been successful utilizing these codes to bill for services via telehealth, including video and audio-only services and look forward to continuing to do so.

We ask that all FQHC specific codes in 101 CMR 304 be included in the list of codes that may be provided via telehealth modality to MassHealth patients beyond the public health emergency, in accordance with Chapter 260 These include:

- G codes for psychiatry: G0469 and G0470
- T codes for medical: T1015 (including T1015-TH and T1015-HQ)
- FQHC Preventive care/EPSDT codes: 99381-99385; 99391-99395
- FQHC Code for after-hours care: 99050

We appreciate the opportunity to provide comment on this proposed rule. Should you have any questions about our comments, please feel free to contact Kathryn Cohen, Director of Public Policy and Government Affairs at 617-515-8066 or kcohen@massleaguge.org or Liz Sanchez, Director of Policy and Health Access, at 617-460-1145 or lsanchez@massleague.org.

Sincerely,

Kathryn Cohen
Director of Government Affairs and Public Policy
Massachusetts League of Community Health Centers

The *t*MED Coalition, representing more than 45 healthcare provider organizations, consumer advocates, technology organizations and telecommunication associations, would like to thank the Division of Insurance (DOI) and MassHealth for the productive listening session held on March 31, 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 what the rules are for reimbursement and how providers should bill for telehealth services.

A. What are the rules for reimbursement?

a. Interactive audio-video and other telehealth modalities

The *t*MED Coalition appreciates the questions from the Division of Insurance regarding standardizations of definitions for telehealth. We would like to draw your attention to the definitions that were put forth by the American Telemedicine Association (ATA) in its "Standardize Telehealth Terminology and Policy Language for States on Medical Practice, updated as of 9/21/2020:

> "Asynchronous" means an exchange of information regarding a patient that does not occur in real time, including the secure collection and transmission of a patient's medical information, clinical data, clinical images, laboratory results, or a self-reported medical history.
>
> "Synchronous" means an exchange of information regarding a patient occurring in real time. (This includes interactive audio-visual technology and audio-only telephone).
>
> "Remote patient monitoring" means the remote monitoring of a patient's vital signs, biometric data, or other objective or subjective data by a device which transmits such data electronically to a healthcare practitioner.

In addition, Medicare, 42 CFR Section 410.78 defines "interactive telecommunications systems" as "multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner."

Given the coverage and reimbursement for audio-only telephone services, we believe that the law is clear that the healthcare provider and patient must be able to at least hear and talk to

each other for a telehealth encounter (with or without an assistive device or accommodation for disability).

A. What are the rules for reimbursement?

b. Bundling

It is important to recognize that "bundling" and "global payments" are two different payment approaches and we want to make sure that the two are not conflated. Bundled episodes are a payment approach in which a single payment is made to cover the cost of services delivered by multiple providers over a defined period of time to treat a given episode of care (e.g., a knee replacement surgery, or a year's worth of diabetes care). Global payments, which are specifically referenced in Ch. 260, are a single payment made to a provider organization to cover the cost of a pre-defined set of services delivered to a patient (e.g., an amount paid per member per month to cover the cost of all of a patient's health care needs). In many cases, the provider organization is responsible for reimbursing other providers for care they deliver to the patient. Both providers and payers will make the changes that are necessary to existing global payment arrangements to account for telehealth.

A. What are the rules for reimbursement?

c. Behavioral health

The *t*MED Coalition agrees with the DOI's interpretation that the provisions in subsection (g) of Sections 47, 49, 51 and 53 of Chapter 260 require that the rate of payment for in-network providers of behavioral health services delivered via interactive audio-video technology and audio-only telephone not be less than the rate of payment for the same behavioral health service delivered via in-person methods in perpetuity.

The Division of Insurance also asked: It appears that the statute makes a special rule for behavioral health such that services provided via audio-visual technology and audio telephone will be reimbursed at the same level as for an in-person visit, while for non-behavioral health services only audio-visual technology is required to be reimbursed at the same level as for an in-person visit. Is there anyone with a different reading of this section?

The *t*MED Coalition disagrees that there is a "special rule" for telehealth. Specifically, we note that 90 days after the end of the public health emergency, but for the next two years (until December 31, 2022), all forms of telehealth (including audio-only telephone) for primary care services and chronic disease management are required to be reimbursed at the same level as for an in-person visit per the provision of Sections 69, 76 and 78.

d. Chronic Disease Management and Primary Care Services

The *t*MED Coalition agrees with the DOI regarding the effective dates for the provisions affecting the reimbursement of primary care and chronic disease management services, including the interpretations that, 90 days after the end of the public health emergency, but for the next two years (until December

31, 2022), all forms of telehealth (including audio-only telephone) for primary care services and chronic disease management are required to be reimbursed at the same level as for an in-person visit per the provision of Sections 69, 76 and 78, and the emergency preamble included in the law.

As noted above, we disagree that there is a "special rule" for behavioral telehealth. Section 69 provides a "special rule" for the reimbursement of primary care and chronic disease management services. Specifically, 90 days after the end of the public health emergency, but for the next two years (until December 31, 2022), all forms of telehealth (as defined in the law in all of the reference payer statutes, with no exceptions, including audio-only telephone) for primary care services and chronic disease management are required to be reimbursed at the same level as an in-person visit per the provision of Sections 69, 76 and 78. The provisions of subsection (d) of the commercial payer statutes would be effective after December 31, 2022. The *t*MED Coalition would especially encourage the implementation of Section 69, which clearly requires rate and coverage parity; we advocated before the legislature for this extension of parity for all modalities, specifically audio-only, to avoid exacerbation of the racial inequities caused by COVID-19 and are grateful that the Legislature responded through Section 69.

We believe the intent behind this two-year time period was to provide Massachusetts healthcare consumers, especially those who are most vulnerable to the health and economic effects of COVID-19 including communities of color, with needed stability during these difficult times. These patients must know that they will have consistent, reliable access to care via all telehealth modalities. We advocated for this longer time period to give state policymakers the opportunity to study the effects of telehealth coverage, including how audio-only has improved access and health outcomes and how elimination of parity for certain modalities might disproportionately harm certain racial and ethnic groups and other historically disadvantaged people

The *t*MED Coalition encourages an interpretation of this statute focused on health access as the pandemic has displaced 20 million workers, affected up to 40% of families, and disproportionately affected Black Americans, Hispanic patients, and communities with high social vulnerability (Blumenthal et al, N Engl J Med 2020; 383:1483-1488). Around the time of the pandemic, the CDC reported that 7.3% of persons delayed medical care and 4.8% simply did not get care (https://www.cdc.gov/nchs/covid19/rands/reduced-access-to-care.htm). With large numbers of persons without broadband access and without interactive audio-video technologies in rural and inner city areas, we recommend an interpretation of the statute that enables access to both audio-only and interactive audio-video technologies (https://policylab.chop.edu/blog/broadband-internet-access-education-child-health-differences-disparities-part-1).

A. What are the rules for reimbursement?

e. All Other Services

The *t*MED Coalition agrees with the DOI's interpretation that Section 68 – requiring reimbursement rates for in-network telehealth services be not less than the rate of payment for the same service delivered via in-person methods – is repealed on the 90th day after the termination of the governor's March 10, 2020 state of emergency declaration.

For those in-network telehealth services that are NOT primary care, chronic disease management or behavioral health services, on the 90th day after the termination of the state of emergency, the rate of payment for telehealth services provided by interactive audio-video technology may be greater than the rate of payment for the same service delivered by other telehealth modalities. Additionally, for those services that are not primary care, chronic disease management and behavioral health, there is no statutory requirement to reimburse any services at the same level as for in-person visits. However, the *t*MED Coalition would encourage the Division to prioritize reimbursement on par with in-person visits to the greatest extent feasible and for all modalities in order to maintain access to services for patients.

B. Billing

The *t*MED Coalition agrees with the Division that, as was noted in DOI bulletin 2020-04, for the purposes of recording the number of health services that are being provided via telehealth, carriers may continue to request that providers include a specific telehealth code (place of service code or telehealth modifier) when providers submit claims for reimbursement.

The *t*MED Coalition recognizes that there are a common set of modifiers to identify telehealth claims. For example, for Medicare telehealth claims: GT indicates that the services took place via an interactive audio and video telecommunications system; G0 (zero) is used to identify telehealth services to diagnose and treat stroke; and GQ is used for asynchronous telehealth services. The use of modifier 95 indicates that a service was a synchronous telehealth service administered via real-time interactive audio and video telecommunications system. Throughout the pandemic, MassHealth also required that providers include the Place of Service (POS) Code 02 when submitting a claim for services delivered via telehealth. The *t*MED Coalition thus recommends continuing to utilize this set of modifiers and to not allow carriers to only accept one modifier over another. For example, carriers must accept both the GT and 95 modifiers for synchronous, interactive audio and video services and not only accept one or the other. This will ensure that administrative burdens on providers are reduced by not needing to match only accepted modifiers by select carriers.

In addition, the *t*MED Coalition recommends use of a modifier to track audio-only telephone services. Should the DOI and MassHealth be interested, we would be happy to work with our billing and coding staff to recommend how best to identify audio-only telephone visits.

BA. Billing

The *t*MED Coalition believes that the codes that DOI listed, while a good start, are not the entire list of codes that should be considered for coding telehealth services. Rather than developing a new list of codes, something that would need to be continually updated on a periodic basis, the *t*MED Coalition strongly recommends that the same codes for in-person services be used but that the appropriate modifier indicating a telehealth encounter be added to that code. This should be inclusive of all codes currently recognized by CMS and carriers to include CPT codes (e.g., E&M codes), HCPCS codes (e.g., G codes), audio only telephone (e.g., 98966, 98967, 98968, 99441, 99442, 99443), and virtual check-in codes (e.g., G2012, G2010). The *t*MED Coalition urges the DOI and MassHealth to also include the codes

that were submitted by the Massachusetts Medical Society in the appendix to its comments in response to this listening session.

In addition, it's important to stress that there are other recognized codes by both CMS and carriers that do not have an equivalent in-person code. These services fall under the asynchronous, online adaptive interview and remote patient monitoring categories. Online adaptive interviews are more commonly defined as eConsults and include the recognized codes of 99451 and 99452 as well as eVisits and include the recognized codes of 99421, 99422, 99423, 98970/G2061, 98971/G2062, 98972/G2063. Some of the codes that don't have in-person equivalents include:

eConsult codes

- 99451: interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, including a written report of the patient's treating/requesting physician or other qualified health professional, 5 minutes or more of medical consultative time

- 99452: interprofessional telephone/internet/electronic health record referral service provided by a treating / requesting physician or other qualified health professional, 30 minutes

eVisits codes / Online Digital Evaluation & Management

- CPT 99421: online digital E/M service for an established patient for up to 7 days cumulative time during the 7 days; 5 to 10 minutes

- CPT 99422: same as above, 11 to 20 minutes

- CPT 99423: same as above 21 or more minutes

- 98970/G2061: Qualified Non-physician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes

- 98971/G2062: Qualified Non-physician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes

- 98972/G2063: Qualified Non-physician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days: 21 or more minutes

Remote Physiological Monitoring (RPM) codes

- 99453: initial setup and patient education on the use of equipment

- 99454: FDA-approved device supply, recording, and transmission of data

- 99457: remote physiologic monitoring treatment management services are provided when clinical staff/physicians/other QHPs use the results of the remote physiologic monitoring to manage a patient under a specific treatment plan

- 99458: remote physiologic monitoring treatment management services for additional 20 minutes

- 99091: collection and interpretation of physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health professional

Brief Communication Technology- Based Check-ins

- G2012: virtual check-ins: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

- G2010 review of images or video: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.

In summary, 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 regulations 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 Association for Occupational Therapy
- Atrius Health
- New England Cable & Telecommunications Association
- Association for Behavioral Healthcare
- National Association of Social Workers – Massachusetts Chapter
- Massachusetts Psychiatric Society
- Massachusetts Early Intervention Consortium
- Digital Diagnostics
- Zipnosis
- Perspectives Health Services
- Bayada Pediatrics
- American Heart Association / American Stroke Association
- Planned Parenthood Advocacy Fund of Massachusetts
- Mass. Family Planning Association
- BL Healthcare
- Phillips
- Maven Project
- Upstream USA
- Cambridge Health Alliance
- Heywood Healthcare
- Franciscan Children's Hospital
- American Physical Therapy Association – Massachusetts
- Community Care Cooperative
- Fertility Within Reach
- Virtudent
- Resolve New England
- Massachusetts Association of Mental Health
- AMD Global Telemedicine
- hims | hers
- Asian Women for Health