April 14, 2021 – 10:00 – 11:30

Session #4 to Discuss Implementation of Telehealth Provisions within Chapter 260 of Acts of 2020

Proposed Discussion about

Planned topics: (1) utilization review for telehealth and

(2) telehealth standards to be added to managed care accreditation reviews

A. What are the rules for managed care?

a. Utilization review

SECTIONS 47, 49, 51 and 53.

(c) An organization may undertake utilization review, including preauthorization, to determine the appropriateness of telehealth as a means of delivering a health care service; provided, however, that the determination shall be made in the same manner as if the service was delivered in person. An organization shall not be required to reimburse a health care provider for a health care service that is not a covered benefit under the plan or reimburse a health care provider not contracted under the plan except as provided for under subclause (i) of clause (4) of the second sentence of subsection (a) of section 6 of chapter 176O.

M.G.L. c. 176O, section 12

Section 12. (a) Utilization review conducted by a carrier or a utilization review organization shall be conducted under a written plan, under the supervision of a physician and staffed by appropriately trained and qualified personnel and shall include a documented process to: (i) review and evaluate its effectiveness; (ii) ensure the consistent application of utilization review criteria; and (iii) ensure the timeliness of utilization review determinations.

A carrier or utilization review organization shall adopt utilization review criteria and conduct all utilization review activities under said criteria. The criteria shall be, to the maximum extent feasible, scientifically derived and evidence-based, and developed with the input of participating physicians, consistent with the development of medical necessity criteria under section 16. Utilization review criteria shall be applied consistently by a carrier or a utilization review organization and made easily accessible and up-to-date on a carrier or utilization review organization's website and upon request to the general public; provided, however, that a carrier shall not be required to disclose licensed, proprietary criteria purchased by a carrier or utilization review organization on its website, but shall disclose such licensed, proprietary criteria relevant to particular treatments and services to insureds, prospective insureds and health care providers upon request. If a carrier or utilization review organization intends either to implement a new preauthorization requirement or restriction or amend an existing requirement or restriction, the carrier or utilization review organization shall ensure that the new or amended requirement or restriction shall not be implemented unless the carrier's or utilization review organization's website has been updated to reflect the new or amended requirement or restriction.

Adverse determinations rendered by a program of utilization review or other denials of requests for health services, shall be made by a person licensed in the appropriate specialty related to such health service and, if applicable, by a provider in the same licensure category as the ordering provider.

(b) A carrier or utilization review organization shall make an initial determination regarding a proposed admission, procedure or service that requires such a determination within two working days of obtaining all necessary information. For purposes of this section, ''necessary information'' shall include the results of any face-to-face clinical evaluation or second opinion that may be required.

In the case of a determination to approve an admission, procedure or service, the carrier or utilization review organization shall notify the provider rendering the service by telephone within 24 hours, and shall provide written or electronic confirmation of the telephone notification to the insured and the provider within two working days thereafter. In the case of an adverse determination, the carrier or utilization review organization shall notify the provider rendering the service by telephone within 24 hours, and shall provide written or electronic confirmation of the telephone notification to the insured and the provider within one working day thereafter.

…

(d) The written notification of an adverse determination shall include a substantive clinical justification therefor that is consistent with generally accepted principles of professional medical practice, and shall, at a minimum: (1) identify the specific information upon which the adverse determination was based; (2) discuss the insured's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria; (3) specify any alternative treatment option offered by the carrier, if any; and (4) reference and include applicable clinical practice guidelines and review criteria.

(e) A carrier or utilization review organization shall give a provider treating an insured an opportunity to seek reconsideration of an adverse determination from a clinical peer reviewer in any case involving an initial determination or a concurrent review determination. Said reconsideration process shall occur within one working day of the receipt of the request and shall be conducted between the provider rendering the service

and the clinical peer reviewer or a clinical peer designated by the clinical peer reviewer if said reviewer cannot be available within one working day. If the adverse determination is not reversed by the reconsideration process, the insured, or the provider on behalf of the insured, may pursue the grievance process established pursuant to sections 13 and 14. The reconsideration process allowed herein shall not be a prerequisite to the formal internal grievance process or an expedited appeal required by section 13.

(f) Upon request by an insured or insured's treating health care provider, a carrier or utilization review organization shall make a determination regarding whether a proposed admission, procedure or service is medically necessary within 7 working days of obtaining all necessary information, except that a carrier or utilization review organization may choose not to perform such a review if the carrier or utilization review organization determines that the admission, procedure or service will be covered. Nothing in this subsection shall:— (i) require a treating health care provider to obtain information regarding whether a proposed admission, procedure or service is medically necessary on behalf of an insured; (ii) restrict the ability of a carrier or utilization review organization to deny a claim for an admission, procedure or service if the admission, procedure or service was not medically necessary, based on information provided at the time of claim; or (iii) shall restrict the ability of a carrier or utilization review organization to deny a claim for an admission, procedure or service if other terms and conditions of coverage are not met at the time of service or time of claim

QUESTIONS

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

M.G.L. c. 176O, section 16

Section 16. (a) The physician treating an insured, shall, consistent with generally accepted principles of professional medical practice and in consultation with the insured, make all clinical decisions regarding medical treatment to be provided to the insured, including the provision of durable medical equipment and hospital lengths of stay. Nothing in this section shall be construed as altering, affecting or modifying either the obligations of any third party or the terms and conditions of any agreement or contract between either the treating physician or the insured and any third party.

(b) A carrier shall be required to pay for health care services ordered by a treating physician or a primary care provider if: (1) the services are a covered benefit under the insured's health benefit plan; and (2) the services are medically necessary. A carrier may develop guidelines to be used in applying the standard of medical necessity, as defined in this subsection. Any such medical necessity guidelines utilized by a carrier in making coverage determinations shall be: (i) developed with input from practicing physicians and participating providers in the carrier's or utilization review organization's service area; (ii) developed under the standards adopted by national accreditation organizations; (iii) updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and (iv) evidence-based, if practicable. In applying such guidelines, a carrier shall consider the individual health care needs of the insured. Any such medical necessity guidelines criteria shall be applied consistently by a carrier or a utilization review organization and made easily accessible and up-to-date on a carrier or utilization review organization's website to insureds, prospective insureds and health care providers consistent with subsection (a) of section 12. If a carrier or utilization review organization intends either to implement a new medical necessity guideline or amend an existing requirement or restriction, the carrier or utilization review organization shall ensure that the new or amended requirement or restriction shall not be implemented unless the carrier's or utilization review organization's website has been updated to reflect the new or amended requirement or restriction.

(c) With respect to an insured enrolled in a health benefit plan under which the carrier or utilization review organization only provides administrative services, the obligations of a carrier or utilization review organization created by this section and related to payment shall be limited to recommending to the third party payor that coverage should be authorized.

QUESTIONS

- Are there things the Division should consider regarding the development of the relevant medical necessity criteria when applied to telehealth?
    - Should certain providers be involved in the process of developing criteria?
    - Are there any standards developed or adopted by national accreditation organizations?
- Are there things the Division should consider regarding the information being available on websites or otherwise being available to insureds?

A. What are the rules for managed care?

b. Out-of-network

SECTIONS 47, 49, 51 and 53.

(c) An organization may undertake utilization review, including preauthorization, to determine the appropriateness of telehealth as a means of delivering a health care service; provided, however, that the determination shall be made in the same manner as if the service was delivered in person. An organization shall not be required to reimburse a health care provider for a health care service that is not a covered benefit under the plan or reimburse a health care provider not contracted under the plan except as provided for under subclause (i) of clause (4) of the second sentence of subsection (a) of section 6 of chapter 176O.

M.G.L. c. 176O, section 6(a)(4)(i)

(4) the locations where, and the manner in which, health care services and other benefits may be obtained, including: (i) an explanation that whenever a proposed admission, procedure or service that is a medically necessary covered benefit is not available to an insured within the carrier's network, the carrier shall cover the out-of-network admission, procedure or service and the insured will not be responsible to pay more than the amount which would be required for similar admissions, procedures or services offered within the carrier's network

QUESTIONS

- Does this section allow for an out of-network provider to provide telehealth services when a "medically necessary covered benefit is not available to an insured within the carrier's network?
- Are there are expectations regarding utilization review for this service?
- Are there any expectations regarding coding and reimbursement?

A. What are the rules for reimbursement?

c. Barriers

SECTIONS 47, 49, 51 and 53.
(d) A health care provider shall not be required to document a barrier to an in-person visit nor shall the type of setting where telehealth services are provided be limited for health care services provided via telehealth; provided, however, that a patient may decline receiving services via telehealth in order to receive in-person services.

QUESTIONS

Are there things the Division should consider addressing regarding this section:

- Should the Division clarify what constitutes a barrier, especially since a different section permits a carrier to apply utilization review and prior authorization to determine whether something is covered under the plan?
- Should the Division clarify anything regarding documentation of a setting of a telehealth visit:
    - Is there any reason to document that the provider or patient are physically in the state of Massachusetts?
    - Is there any reason to document where the patient may be located for information purposes (e.g., in an inpatient facility, at home, at work, etc.)?
    - Is there any reason to document where the provider may be located for information purposes (e.g., in a facility outpatient office, doctor office or other location)?

B. Accreditation

SECTION 59. Subsection (b) of said section 2 of said chapter 176O, as so appearing, is hereby amended by adding the following paragraph:-

To establish minimum standards for the accreditation of carriers related to access to behavioral health services, chronic disease management and primary care services via telehealth, the division shall consult with the health policy commission and the center for health information and analysis.

QUESTIONS

What minimum standards should apply regarding access to telehealth services:

- Should there be standards about the number of providers available for synchronous and asynchronous telehealth visits for behavioral health, chronic disease management and primary care services?
- Should there be standards about ability to access telehealth services from persons other than a patient's customary primary care, behavioral health, or chronic care provider in case of emergency or the provider is otherwise unavailable?
- Should there be standards availability of telehealth outside customary working hours?
- Should there be standards about scheduling telehealth visits?
- Should there be standards about disclosure of information about telehealth?
- Should there be standards about expectations that provider communications with patients about telehealth visits?

C. Credentialling

SECTION 65. Notwithstanding any general or special law to the contrary, the department of public health and the office of consumer affairs and business regulation shall allow their applicable licensees to obtain proxy credentialing and privileging for telehealth services with other health care providers as defined in section 1 of chapter 111 of the General Laws or facilities that comply with the federal Centers for Medicare & Medicaid Services' conditions of participation for telehealth services.

It appears that CMS Conditions of participation for telehealth services are outlined in CMS-3227F - https://www.namss.org/Portals/0/Regulatory/Final%20Rule%20on%20Telemedicine%20Credentialing%20and%20Privileging.pdf?ver=2013-11-15-144725-367

QUESTIONS

- Is there anything that the Division should relay to the Department of Public Health and the Office of Consumer Affairs and Business Regulation about this item?
- Is the noted CMS document the correct and most recent document?
- Does this impact any providers ability to provide and bill for telehealth services within insured health or MassHealth coverage?

D. Networks

SECTION 66. For the purposes of section 30 of chapter 32A, section 79 of chapter 118E, section 47MM of chapter 175, section 38 of chapter 176A, section 25 of chapter 176B, section 33 of chapter 176G and section 13 of chapter 176I of the General Laws, network adequacy may be met through significant reliance on telehealth providers until the termination of the governor's March 10, 2020 declaration of a state of emergency.

QUESTIONS

- Is there anything the Division should do to address this item?
- Is there general agreement that following the termination of the Governor's declaration of a state of emergency that network adequacy will be based on distribution of providers who able to provide face-to-face office visits for covered health services.

E. Reporting

SECTION 67. Notwithstanding any general or special law to the contrary, the health policy commission, in consultation with the center for health information and analysis, the executive office of health and human services and the division of insurance shall report on the use of telehealth services in the commonwealth and the effect of telehealth on health care access and system cost. The report shall include, but not be limited to:

(i) the number of telehealth services provided by type of service, provider and provider organization and payer;

(ii) an analysis of the use of telehealth services by patient demographics, geographic region and type of service;

(iii) total health care expenditures on telehealth services by type of service and type of telecommunication technology used;

(iv) an analysis of the impact of payer coverage and payment rate of telehealth services on patient access to and cost of care by patient demographics, geographic region and type of service;

(v) any barriers to increased use of telehealth services, including cost and availability of technology infrastructure for health care providers and patients with limited access to technology, including access to broadband internet and cellular telephone service, cost and availability of technology infrastructure for patients, equity in access for low-income patients, patient choice of providers offering telehealth services, provider reimbursement amounts and method of payment and other payer, patient or provider financial incentives that may reduce the availability of telehealth services;

(vi) an assessment of the appropriate scope of coverage requirements for telehealth services provided through various synchronous or asynchronous audio, video, electronic media and other telecommunications technology; provided, however, that the assessment shall consider the effect of coverage requirements on access to quality care, with special consideration for populations with limited access to technology, and the effect of coverage requirements on increasing health care expenditures and appropriate utilization;

(vii) the estimated impact of the use and coverage of telehealth services on health care utilization and total health care expenditures in the commonwealth;

(viii) the estimated aggregate savings or additional costs of telehealth coverage and rate requirement on total health care expenditures, including the impact on insurance premiums, and on health care access in the commonwealth;

(ix) recommendations on the appropriate reimbursement rates for services provided via telehealth, including facility fees, compared to comparable in-person services, in order to maximize health care access and public health outcomes and limit health care cost growth;

(x) recommendations on ways to expand the use of and services provided through telehealth services, including, but not limited to, the safe and appropriate provision of telehealth services by health care professionals licensed and residing in other states; and

(xi) an analysis of any impact of pre-authorization or other utilization management tools on access to care via telehealth and recommendations for appropriate limitations on those tools to ensure access to care; provided, however, that data on the use of telehealth services and related effect on access and cost shall differentiate between telehealth services used while the governor's March 10, 2020 declaration of a state of emergency was in effect and telehealth services used after the termination of the governor's March 10, 2020 declaration of a state of emergency.

The report, along with a suggested plan to implement its recommendations in order to maximize access, quality of care and cost savings, shall be submitted to the joint committee on health care financing and the house and senate committees on ways and means not later than 2 years from the effective date of this act; provided, however, that not later than 1 year from the effective date of this act, the commission shall present an interim estimate of the fiscal impact of telehealth use in the commonwealth.

QUESTIONS

The HPC report is a one-time report covering many aspects of the implementation of telehealth

- Should there be periodic information collected and reported by carriers to the Division of Insurance and the MassHealth Program on a regular basis?
- What types of information should be collected and reported publicly:
    - Use of telehealth by georgraphic region?
    - Utilization by type of service category?
    - Utilization for behavioral health, primary care, chronic care, and other?
    - Utilization that tracks synchronous and asynchronous utilization?