March 12, 2021 – 10:00 – 11:30
Session #2 to Discuss Implementation of Telehealth Provisions within Chapter 260 of Acts of 2020

Proposed Discussion about

A. What constitutes a telehealth visit?
B. Definitions of Services

A. What constitutes a telehealth visit?

SECTIONS 47, 49, 51 and 53.
(a) For the purposes of this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:-
"Behavioral health services", care and services for the evaluation, diagnosis, treatment or management of patients with mental health, developmental or substance use disorders.
"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.

(b) An individual policy of accident and sickness insurance issued under section 108 that provides hospital expense and surgical expense insurance and any group blanket or general policy of accident and sickness insurance issued under section 110 that provides hospital expense and surgical expense insurance that is issued or renewed within or without the commonwealth shall provide coverage for health care services delivered via telehealth by a contracted health care provider if: (i) the health care services are covered by way of in-person consultation or delivery; and (ii) the health care services may be appropriately provided through the use of telehealth; provided, however, that an insurer shall not meet network adequacy through significant reliance on telehealth providers and shall not be considered to have an adequate network if patients are not able to access appropriate in-person services in a timely manner upon request. Coverage shall not be limited to services delivered by third-party providers.

(h) Health care services provided via telehealth shall conform to the standards of care applicable to the telehealth provider's profession and specialty. Such services shall also conform to applicable federal and state health information privacy and security standards as well as standards for informed consent.

QUESTIONS

- Is there a way to define a "visit" 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?
  - Are there certain features/items/criteria that need to be met for an encounter to be considered a "visit" whether in office or provided via telehealth?
  - Is there a range of activities that should be expected in every "visit"?
  - Would a 2-minute call for a prescription refill be considered a "visit"?
  - Are there certain things that need to be documented?
  - Are the items identified in Bulletin 2020-04 relevant or should be updated?
- What services should not be considered to be appropriately provided through telehealth
  - Are there standards that clearly define what is or is not appropriate?
  - Do these standards change and how should DOI guidance change with standards
  - Should different standards apply to differing professions and specialties?
  - Should this be standard across all health plans?
  - Should individual plan medical directors develop standards in a manner similar to the ways that they develop medical necessity criteria?

B. Definitions of services

SECTION 55. Section 1 of chapter 176O of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the definition of “Behavioral health manager” the following definition:-

“Behavioral health services”, care and services for the evaluation, diagnosis, treatment or management of patients with mental health, developmental or substance use disorders.

This term is used to subsequently define a range of services that will be paid when provided via telehealth on par with when the same services are provided in an office.

There is a requirement that insurance carriers include coverage of behavioral health services in M.G.L. c. 176G, section 4M(g) that “(g) [behavioral health b]enefits authorized pursuant to this section shall consist of a range of inpatient, intermediate, and outpatient services…[and f]or the purposes of this section, …[o]utpatient services may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office, or home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of his license.”

i) For the purposes of this section, ''licensed mental health professional'' shall mean a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist, a licensed alcohol and drug counselor I, as defined in section 1 of chapter 111J, or a licensed marriage and family therapist within the lawful scope of practice for such therapist.

QUESTIONS

- Should any elements of the definition need further clarification?
- Does section 55 apply to any network provider who provides the notes services or only those providers that are identified as licensed mental health professionals?

B. Definitions of services

SECTION 56. Said section 1 of said chapter 176O, as so appearing, is hereby further amended by inserting after the definition of "Case management" the following definition:-
"Chronic disease management", care and services for the management of chronic conditions, as defined by the federal Centers for Medicare and Medicaid Services, that include, but are not limited to, diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke, cancer and coronary artery disease.

This term is used to subsequently define a range of services that will be paid when provided via telehealth on par with when the same services are provided in an office during the period defined within Chapter 260 of the Acts of 2020.

CMS also has a website that lists chronic conditions for 2021 - https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/CC_Main - and it appears intends to update this website on an annual basis.

CMS has produced a booklet to describe chronic care management - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf. This booklet identifies practitioner eligibility and billing for chronic care management.

QUESTIONS

- Should the list of chronic conditions identified on the CMS website for 2021 be the list of chronic conditions to be used for compliance with Section 56?
    - If no, is there a more appropriate list identified in other CMS materials?
    - If yes, the terms used on the CMS website do not exactly match the terms in Section 56. Are there any further clarifications that the DOI should make so that the two lists are as compatible as possible?
    - If yes, should there be a process that allows carriers to update their systems to allow for new chronic diseases as they may be added by CMS in the future.
- Should the information listed in the booklet to describe chronic care management apply to "chronic disease management" as defined in Section 56?
    - The CMS guide identifies practitioners who provide chronic disease management; should this list apply in Massachusetts as the appropriate list of practitioners to provide chronic disease management according to Section 56?
    - The CMS guide identifies chronic disease management by CPT service codes; should these services and codes identify what is to be considered chronic disease management according to Section 56?

B. Definitions of services

SECTION 57. Said section 1 of said chapter 176O, as so appearing, is hereby further amended by inserting after the definition of "Primary care provider" the following definition:-
"Primary care services", services delivered by a primary care provider.

This term is used to subsequently define a range of services that will be paid when provided via telehealth on par with when the same services are provided in an office during the period defined within Chapter 260 of the Acts of 2020.

Existing law provides under M.G.L. c. 176O, section 1 that a "primary care provider" is defined 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." Under M.G.L. c. 176O, the term "primary care provider" is used in section 15 when referring to the designation of a primary care provider.

QUESTIONS

- Who should be considered a primary care provider?
- Is there a clear way to distinguish between primary and non-primary care?
- Should this only apply to a designated primary care provider?
- Should the provider be one with whom the patient has a regular primary care relationship where there is "continuity of care within the scope of practice"?
- Are there certain types of providers that should be considered primary care providers?
- Are there certain types of providers that should not be considered primary care providers?