



MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

**MASSACHUSETTS MEDICAL SOCIETY
COMMENTS RE: DOCKET NO. G2022-01:
PROPOSED AMENDMENTS TO 211 CMR 52.00 MANAGED CARE CONSUMER
PROTECTIONS AND ACCREDITATION OF CARRIERS
BEFORE THE DIVISION OF INSURANCE
May 18, 2022**

The Massachusetts Medical Society, representing more than 25,000 physicians, residents, and medical students, would like to thank the Division of Insurance for the opportunity to provide comments at the hearing held on May 11th, 2022. We wish to follow up and expand on our comments relative to the implementation of telehealth provisions within Chapter 260 of Acts of 2020. Additionally, the MMS is a member of the statewide tMED Coalition, which is separately submitting comments to the Division; the MMS wholly supports the comments submitted on behalf of the tMED Coalition.

**APPROPRIATENESS OF DELIVERING CARE VIA TELEHEALTH & UTILIZATION REVIEW
(52.16)**

The Medical Society strongly believes that, at its core, whether a service can be appropriately delivered via telemedicine is a clinical decision that should be determined by clinicians and is inherently dictated by professional judgment. **The MMS encourages the Division to add language in Section 52.16 consistent with MassHealth [All Provider Bulletin #327](#) affirmatively stating that that the physician or other health care provider shall make the determination as to whether a service can be appropriately provided via telehealth, including the modality.¹ Specifically, APB 327 states that “...any MassHealth-enrolled provider may deliver any medically necessary MassHealth-covered service to a MassHealth member via any telehealth modality, if: *the provider had determined that it is clinically appropriate to deliver such service via telehealth, including the telehealth modality and technology employed, including obtaining member consent...*” (emphasis added).**

Consistent with BORIM Policy 2020-01 (amended June 25, 2020), physicians are bound by the same medical standards of care whether that care is delivered in person or via telemedicine; the standard of care does not deviate based on the modality of care delivery. As was detailed in DOI Bulletin 2020-04 and reiterated in DOI Bulletin 2021-04, it is the physician offering care through telemedicine who is most apt and responsible to ensure they are able to deliver services to the same standard of care as required for in-office care and in compliance with the physician’s licensure regulations and requirements. When the appropriate standard of care cannot be met via telemedicine, physicians are already obligated to make this determination prior to delivery of

¹ See [MassHealth All Provider Bulletin 327](#), p.2, Section A. Coverage of Services Provided via Telehealth.

services and to notify the patient and advise them instead to seek appropriate in-person care. Physicians already make these determinations when triaging patients; when a patient contacts the physician practice by phone, the practices make the determination whether it is most appropriate for a patient come to the office, to speak by phone with a nurse, to have a telehealth visit, or receive care otherwise.

Additionally, the MMS would note our concern that clause (3) of section 52.16 **requires** carriers to undertake utilization review, including pre-authorization, to determine the appropriateness of telehealth as a means of delivering a health care service. This requirement goes beyond the statutory language, which is permissive and states that “[c]overage for telehealth services **may** include utilization review, including preauthorization, to determine the appropriateness of telehealth as a means of delivering a health care service...” To remedy this discrepancy, **we request that the Division strike the word “shall” and replace it with “may” in 52.16(3).**

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

DEFINITION OF A VISIT (52.02)

A medical visit fundamentally entails the application of medical judgment, which is typically identified by clinical documentation of the services rendered. Thus, a “visit” is de facto defined by existing billing and coding systems which value the services a physician provides and a patient receives, and these mechanisms can and should apply equally to telehealth visits. Telehealth is not a separate medical specialty; it is a delivery tool – a modality to provide care.

The MMS believes the Division’s proposed definition of a visit is largely consistent with this understanding. However, we recommend two clarifying amendments to the definition of “visit” to provide clarity and consistency with Chapter 260. First, the statute defines telehealth as the use of various technologies “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.” This definition accurately encompasses the parameters of a visit. The regulatory definition of visit refers to an encounter to “treat or manage” a covered medical or behavioral health condition. This definition does not capture all of the elements covered in the definition of telehealth. **As such, we propose the Division expand the definition of visit to include, “A scheduled, urgent, or emergency encounter...to evaluate, diagnose, consult, prescribe, treat, manage, or monitor a covered medical or Behavioral Health condition of a patient.”**

Second, we recommend striking the reference to a “Health Care Professional’s office” in recognition that not all in-person encounters for patients with their providers take place in a health care professional’s office. Many services, including partial hospitalization services in the behavioral health space, and many services such as those provided by early intervention

providers, actually take place in person in the home, in pediatric development centers, or other center-based spaces. To minimize confusion, consistent with the tMED Coalition, we recommend that the words “within the health care professional’s office” be stricken and replaced by the words “in-person”.

DEFINITION OF BEHAVIORAL HEALTH (52.02)

The MMS appreciates the Division’s expansive approach to defining behavioral health by including language that affirmatively acknowledges that behavioral health services may be provided by any health care professional for whom such services are within the scope of their licensure. It is imperative to maintain this clause, as it recognizes the clinical reality that, because behavioral health services have long been so fragmented, many behavioral health services are delivered by primary care providers and other clinicians excluded from a more restrictive definition limited to licensed mental health professionals. Conversely, limiting reimbursement parity only to licensed mental health specialists ignores the practical realities of day-to-day clinical practice and also, importantly, the legislative intent. To do so would undermine the ability of many professionals, particularly those treating children and patients with developmental disabilities, to provide covered telehealth services.

Similar to our recommendation regarding the definition of a visit, and to be consistent with the scope of covered telehealth encounter, we would urge the Division to amend the first part of the definition of behavioral health services to include all covered elements, to read: “Care and services for the evaluation, diagnosis, treatment, *consultation, prescribing, monitoring,* or management of patients with mental health, developmental, or substance use disorders...”

REIMBURSEMENT OF BEHAVIORAL HEALTH SERVICES (52.16)

Clause (7) of section 52.16 ensures parity in reimbursement for behavioral health services on par with in-person services. However, the language of this section is limiting by virtue of the framing that in-network rates of reimbursement for services delivered during a telehealth visit are “no less than the rate of payment for the same behavioral health service provided during an in-person *office* visit”. As discussed previously, the use of the word “office” could inadvertently exclude in-person services that do not necessarily take place in an office, including, for example, early intervention services. **The MMS recommends striking the word “office”, such that the definition would read: “Carriers shall ensure that the in-Network rate of reimbursement for services delivered during a Telehealth Visit with Health Care Professionals of covered Behavioral Health Services when provided via interactive audio-video technology or audio-only telephone shall be no less than the rate of payment for the same Behavioral Health Service provided during an in-person Visit.”**

Additionally, it was suggested at the hearing by an insurance carrier that reimbursement parity for behavioral health services should be limited to instances where the behavioral health service is the primary diagnosis in an encounter. **We strongly disagree and believe that limiting reimbursement in such fashion would contravene the legislative language and intent. Chapter 260 did not authorize any limitations on reimbursement parity for behavioral health services.** A carrier should not be able to reduce reimbursement or otherwise not reimburse at parity for behavioral services on the premise that other health care services were also provided during the encounter. We encourage the Division to instead clarify that carriers shall be prohibited from otherwise reducing reimbursement for behavioral health services on any basis.

DEFINITION OF PRIMARY CARE (52.02)

The Medical Society continues to believe that, in all instances, the focus and determinative factor for reimbursement within the state's current framework should be the services provided as opposed to the specialty of the provider. We urge the Division to amend the definition of "primary care provider" to be consistent with the clinical reality that primary care, as it is most fundamentally understood, is not confined to those delivered by providers who an insurance carrier would deem a traditional primary care provider. Traditionally a "primary care provider" is thought of as a physician with a specialty in family medicine, internal medicine, general medicine, pediatrics, or obstetrics/gynecology. However, the current statutory definition of "primary care provider" does not specify a list of who is or is not a primary care provider, but instead focuses on the types of services provided and importantly who is coordinating and maintaining continuity of care. This definition is consistent with health system's goals to promote quality and continuity of care.

Importantly, the Center for Health Information and Analysis (CHIA) has undertaken efforts to define primary care for purposes of establishing a baseline understanding of primary care spend in the Commonwealth. Notably, CHIA defined primary care based both on provider taxonomy as well as the service provided. As outlined in the Data Specification Manual, CHIA explicitly identifies obstetric visits, including routine obstetric care, as well as OB/GYN evaluation and management services, as primary care spending.² Reproductive health and family planning are cornerstones of primary care for women and people who may become pregnant, and our regulations should recognize that just as CHIA has.

Moreover, under M.G.L c. 1760, many who are considered specialists outside of "primary care" would meet the current statutory definition of primary care provider because of the nature of the services provided to patients. For example, multiple sclerosis (MS) is a common neurologic issue that is managed longitudinally with regular visits to maintain control of the disease. While a patient with MS likely has a designated "primary care provider" for insurance purposes, primary care for a patient with MS is primarily managed by a neurologist. The neurologist would be responsible for supervising, coordinating, and prescribing, and otherwise providing health care services – fitting the statutory definition of a primary care provider. With the definition as currently drafted in the proposed regulation, carriers are implementing narrow interpretations of "primary care provider" that do not reflect the realities of clinical practice. We instead urge you to broaden the approach to defining 'primary care' in order to recognize relationships between patients and physicians that promote quality and continuity of care.

DEFINITION OF CHRONIC DISEASE MANAGEMENT (52.02)

The MMS appreciates the flexibility inherent in the proposed regulatory language authorizing the Commissioner of the Division of Insurance to further define Chronic Disease Management. We strongly urge the Division to issue sub-regulatory guidance building upon the list of chronic conditions identified by the Centers for Medicare and Medicaid Services (CMS). The CMS list is not sufficiently inclusive of the breadth and types of chronic conditions requiring the sort of disease management giving rise to the need for telehealth reimbursement parity in the first place. The CMS list of chronic conditions is not and was not intended to be a comprehensive list of chronic conditions, but rather an example of certain conditions for which CMS tracks relevant utilization and spending data for purposes of the Medicare program. As such, the CMS list is

² Center for Health Information and Analysis, Data Specification Manual, 957 CMR 2.00: Payer Reporting of Primary Care and Behavioral Health Expenses, August 10, 2021.

very adult-centric and excludes some of the most common pediatric chronic conditions, such as cystic fibrosis, attention deficit disorder, or obesity, which would ultimately detrimentally impact pediatric patients in need of appropriate telehealth services.

The Division should consider issuing guidance allowing for a broader, more inclusive spectrum of chronic diseases to ensure that patients can access appropriate care management, including through telehealth. A more inclusive approach would not require carriers to cover any illness or disease beyond what is already required to be covered through a different modality. As an alternative to devising an exclusive list of eligible conditions, the Division should consider crafting a definition of chronic disease that is appreciative of clinical practice and reflects the plethora of diseases that impact patients on a chronic basis. Most groups, including several carriers in Massachusetts, do not define chronic conditions based on a list, but rather through a descriptive approach. For example, the American Medical Association, the Centers for Disease Control and Prevention, and Tufts Health Plan generally define chronic diseases as conditions that last one year or more and require ongoing medical attention, or limit activities of daily living, or both. The need for chronic disease management is so pervasive, as it is noted on one plan's website that "six in ten adults in the US have a chronic disease and four in ten adults have two or more," referencing the CDC/National Center for Chronic Disease Prevention and Health Promotion.

The Medical Society continues to reiterate our opposition to alternative approaches to this matter that have been suggested by other advocates, including the narrow interpretation which would limit reimbursement parity for chronic disease management to 4 CPT management codes identified in Medicare's Chronic Care Management (CCM) program. There is a difference between providing Chronic Care Management as defined by Medicare and managing chronic conditions. They are not the same and should not be treated as such. The CMS Chronic Care Management program is intended for Medicare patients that have two chronic conditions expected to last at least 12 months or until the death of the patient and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. This program is intended for Medicare patients and has resulted in very limited uptake among providers, making it ill-suited for application to commercial and Medicaid populations in Massachusetts. The legislature was certainly not intending to limit parity in reimbursement for chronic disease management to this specific Medicare program, which would exclude the vast majority of patients who suffer from chronic illness.

Instead, we believe the plain text of the law evinces a legislative intent to connote a broader interpretation of chronic disease management. Specifically, the definition in Chapter 260 of "chronic disease management" includes the "care and services for the management of chronic conditions" and lists out many examples of the types of care that should be covered at parity under the law. The legislature sought to promote greater care management and access to services for patients suffering from chronic disease, which has an outsized impact on health care costs. It is important to facilitate access to these services through telehealth by ensuring reimbursement parity. A narrow interpretation would exclude important care that can be delivered through telemedicine from receiving reimbursement parity, and it would undermine efforts to promote coordinated, cost-efficient access to that very care.

REIMBURSEMENT FOR ASYNCHRONOUS TELEHEALTH CARE (52.16)

The legislature intentionally defined telehealth broadly to include coverage for care delivered through asynchronous telehealth modalities. Carrier policies reviewed by the MMS to date have

referenced asynchronous care and offered guidance on how to bill for such services but have not identified how such services will otherwise be covered and reimbursed.

Clause (9) of 52.16 indicates that the rate of payment for services delivered during telehealth visits when provided via synchronous interactive audio-video technology or audio-only telephone may be greater than the rate of payment for the same service delivered by other telehealth modalities. However, these regulations do not offer guidance regarding which “other telehealth modalities” would fall under this category. Additionally, in sections 52.05(3)(q)(6) and (4)(m)(6), as well as 51.16(12)(f), the Division directs carriers to identify billing and other codes they will use to reimburse providers, including “when telehealth may be used for follow-ups that may be considered less than an office-visit...” This language is confusing and unclear. As described above, a visit is already defined by existing billing and coding systems that codify the services a physician provides and a patient receives, and these mechanisms can and should apply equally to telehealth visits. We presume that the intention of this clause was to capture certain follow-up services delivered through asynchronous modalities, such as online adaptive interviews or remote patient monitoring. If the Division is indeed referencing follow-up care delivered through asynchronous modalities, we recommend striking the confusing language in the above-referenced sections and instead clarifying the intent in sections 52.05(3)(q)(5) and (4)(m)(5), as well as 52.16(12)(e). Specifically, section 52.16(12)(e) directs carriers to issue a statement of how the carrier intends to reimburse providers for behavioral services, primary care services, chronic disease management services, and “all other services.” Here, in 52.16(12)(e)(iv) we would encourage the Division to expand on the notion of “all other services” to specifically reference care delivered through asynchronous modalities.

Additionally, we would encourage the Division to define asynchronous using the prevailing definition put forth by the American Telemedicine Association (ATA) in its “Standardized 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.”

Lastly, consistent with the tMED Coalition, we would note that many asynchronous codes do not have an in-person equivalent and therefore may not be considered the “same service.” These services, however, are undoubtedly intended to be covered under Chapter 260 and therefore require further definition under these regulations to eliminate confusion and provide clarity for the provider community. 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 in addition to the codes that CMS has permitted as brief communication technology-based service (CTBS) check-ins: G2012 and G2010, for example. The legislature very intentionally used the word “consulting” in the definition of telehealth and explicitly referred to remote patient monitoring and online adaptive interviews, evidencing its clear intent that these services be covered. Some carriers to date have indicated they will not be covering certain such services, which we believe to be in direct contravention to the plain language and intent of Chapter 260. As such, we request clarification to the regulations regarding the coverage requirements for these eVisit, eConsult and CTBS codes.

BILLING & CODING GUIDANCE

Section 52.16(12)(f) directs carriers to identify billing codes, location codes or other codes that the carrier intends to use to reimburse providers for telehealth services. We strongly urge the Division to go one step further in issuing guidance relative to which codes and modifiers should be used in billing and coding. If possible, we recommend issuing billing and coding guidance consistent with MassHealth All Provider Bulletin 327, so as to promote consistency across all carriers, including MassHealth, which is critical to reducing administrative burden. 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. 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.

PROVIDER DIRECTORY PROVISIONS

The Massachusetts Medical Society is a leading member of the Massachusetts Collaborative, a voluntary, open organization of more than 35 payers, providers, and trade associations dedicated to reducing complex and cumbersome health care administrative processes in Massachusetts. Blue Cross Blue Shield of Massachusetts, the Massachusetts Association of Health Plans, and the Massachusetts Health & Hospital Association are also core leading members of the Collaborative.

As a member of the of the Provider Directories Task Force created under Chapter 124 of the Acts of 2019 and representative of physicians responsible for delivering health care services, the MMS is committed to ensuring and providing accurate and up to date information for consumers. To that end, we have been working voluntarily to support Healthcare Administrative Services (HCAS) and the Council for Affordable Quality Healthcare (CAQH) to stand up a centralized portal for providers to enter directory information once for all participating health plans.

Due to the considerable technological and educational needs, workflow adjustments, and maintenance needs associated with this extensive ongoing work, we support the **Collaborative's testimony requesting that the Division of Insurance establish an effective date of the proposed amendments to 211 CMR 52.15 to be one year from promulgation of the regulations to ensure that all parties have sufficient time to implement the new requirements. This added time will help ensure accuracy and enable a reliable process. We further support** several specific provisions where the MassCollaborative requests clarification or suggest revising the requirements:

The inclusion of “only accepting new patients covered by the Carrier under limited circumstances” (referenced in 52.15 (2)(g)(3)). The reference to “limited circumstances” is confusing as it may have different meanings to each party, and therefore may not be helpful to the consumer. It is preferred that the directories identify whether the provider is or is not accepting new patients, but not include “limited circumstances”. We recommend striking this provision.

The inclusion of office locations where providers do not see patients. (Referenced in 52.15(2)(f)(4)) – office locations where providers do not see patients is not a required field to be displayed. We are concerned if such information were to be displayed, it could cause significant consumer confusion and would be fluid and result in inaccurate information. Since displaying the information would be confusing to consumers, we see no reason the information should be collected, and we therefore recommend striking this provision.

The inclusion of provider email addresses (referenced in 52.15(2)(i) and (4)(g)) – this poses issues with HIPAA compliance as email is not a secure method of communication, would violate the provider appointment process, and could potentially create breaches if protected health information is exchanged. We recommend striking references to provider email addresses.

The inclusion of cultural groups (referenced in 52.15(2)(m) and (3)(j)) – we are seeking clarity around the definition of “cultural groups.” Consistent reporting of this field would be helpful for providers, payers, and consumers since it could mean different things to different people.

The inclusion of language fluency (referenced in 52.15(2)(j)) – We recommend this be changed to “languages spoken” as fluency is a subjective assessment and may or may not reflect a provider’s ability to speak languages.

The inclusion of intellectual vs. physical disabilities (referenced in 52.15(2)(k)) – providers are often unaware of such granularity and instead are informed by office staff whether their offices meet ADA accessibility standards. We recommend this be changed to “ADA accessibility.”

Lastly, for administrative simplicity the MMS urges consistency between the federal No Surprises Act (NSA) and the state regulations with regard to health plans updating their information. As of January 2022, the NSA requires that changes to provider directory requirements for both Health Plans and Providers and Health Care Facilities. It requires health plans to verify all provider directory data every 90 days, and to process updates within two business days of receiving updated information. Since health plans must update provider information within 2 business days of receiving updates from a provider, the MMS recommends adoption of the same standard. Therefore, we would recommend 52.15 (16) be updated as follows: Carriers shall contact Providers every 90 days, or as directed by the Commissioner, to remind Providers to check and verify their profiles so that Carriers can certify that the Provider’s information is correct. As part of such reminders, Carriers shall educate Providers about the importance of making Provider changes as soon as Provider changes occur so that Carriers may make the appropriate Provider directory updates within 2 business days as required under the NSA.

Thank you for the opportunity and your consideration of these comments. We look forward to continuing the conversation and are happy to meet to answer any questions or discuss any issues further. If you have questions or concerns, please feel free to reach out to Leda Anderson, MMS Legislative Counsel, at landerson@mms.org.