



MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

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 12th, 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 defining a telehealth “visit” and definitions of behavioral health, chronic disease management, and primary care services.

Defining a “Visit” & Telehealth “Appropriateness”

The Medical Society does not believe the Division or MassHealth should be further defining a medical telehealth “visit” in regulatory guidance any more so than a visit currently regulated for in-office care. Telehealth is not a separate medical specialty; it is a delivery tool – a modality to provide care. As with care provided in-person, there are existing billing and coding systems in place to quantify the services a physician provides and a patient receives, and these mechanisms can and should apply equally to telehealth visits. We understand and appreciate the Division’s perspective in seeking clarification and a bright line for patients so that they may understand their financial responsibility for any encounter with their physician that could be considered a visit. We share in that goal of transparency and are striving for a system of fair reimbursement for care where our patients are informed about all co-payments or cost-sharing responsibilities.

A medical visit fundamentally entails the application of medical judgment, which is typically identified by clinical documentation of the services rendered. 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 accurately encompasses the parameters of a visit. As such, MMS does not support the creation of additional criteria to define a visit, for example requiring a minimum time for an encounter or requiring that an encounter be pre-scheduled to constitute visit. Billing and coding systems already account for time, complexity, and medical judgment; many patient-provider interactions are urgent and unexpected and while these encounters are not scheduled, they often involve evaluation, assessment, and treatment that involves the application of complex medical judgment and thus would constitute a visit. The Medical Society further cautions against setting reimbursement rates solely based on the modality, which is not indicative of medical complexity; rather the contents of the clinical encounter and complexity of the medical-decision making should drive reimbursement.

Consistent with our comments above, as to whether a 2-minute phone call would be considered a “visit”, this would not likely meet the current standards for billing a visit. However, patient refill requests often trigger an assessment as to whether the medication requires dosage adjustment, review of laboratory values, vital signs, etc. This type of evaluation necessarily entails medical judgment and constitutes a visit, so the determining factor should be the need for clinical judgment. This is important clinical care and that can and should be covered. Patient notification of this type of circumstance would be appropriate.

Relative to the questions pertaining to documentation requirements, we have seen significant variation in documentation requirements across payers during this pandemic, which has proven very burdensome from an administrative perspective. There is tremendous value in, to the extent possible, consistency



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across payors in line with the documentation guidance noted in MassHealth All Provider Bulletin 289¹, which requires documentation consistent with all applicable health records standards that apply to care delivered in-person.

The Medical Society understands that the topic of appropriateness will be further addressed in a later listening session. For now, we would like to note that in conformity 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, 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, programmatic regulations, and performance specifications related to the service. When the appropriate standard of care cannot be met via telemedicine, physicians are already obligated to make this determination prior to delivery of 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 calls, practices make the determination to come in, to talk with a nurse, to have a telehealth visit, etc.

The Medical Society strongly believes that whether care can be appropriately delivered via telehealth is a clinical decision that should be made by the physician. Because the standard of care inherently dictates the appropriateness of telehealth to provide care, we do not believe this warrants further guidance from the Division or from individual plans' medical directors. As it stands, carriers can apply existing medical necessity criteria, as they would apply to care delivered in-office.

Definitions of Behavioral Health, Chronic Disease Management, and Primary Care Services

Behavioral Health

Chapter 260 provides a broad definition of behavioral health services and, importantly, does not limit coverage or reimbursement of those services by the type of provider offering them. If the legislature had intended to limit parity in reimbursement for behavioral health services to services provided by licensed mental health professionals, they would have explicitly done so or otherwise cross-referenced the statutory definition. As such, the Medical Society does not believe that coverage, and therefore parity in reimbursement, for behavioral health services should be restricted to the provision of services by specific provider types, as this would be contrary to the legislative intent. The definition of

¹ MH All Provider Bulletin 289:

Providers delivering services via telehealth must meet all health records standards required by the applicable licensing body as well as any applicable regulatory and program specifications required by MassHealth. This includes storage, access, and disposal of records.

In addition to complying with all applicable MassHealth regulations pertaining to documentation of services, providers must include a notation in the medical record that indicates that the service was provided via telehealth, the technology used, and the physical location of the distant and the originating sites.

The provider must also include the CPT code for the service rendered via telehealth in the patient's medical record. MassHealth may audit provider records for compliance with all regulatory requirements, including record keeping and documentation requirements, and may apply appropriate sanctions to providers who fail to comply.



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behavioral health in Ch. 260 includes three separate types of health care: mental health, developmental and substance use disorders. Each clinical subcategory in this definition could be treated by a different type of physician, including psychiatrists, developmental pediatricians, addiction medicine physicians, and primary care physicians. A limited approach to defining behavioral health based solely upon the type of clinician providing the care would necessarily limit patients' access to services, which the legislature intended to be covered through the expansive behavioral health definition.

In addition, the collaborative care model supports integrated behavioral health care within the primary care setting. This is important to keep in mind as, as primary care providers are key to promoting and improving access to behavioral health care. For too long, the health care system has carved out mental and behavioral health care. Mental health care is health care. Massachusetts should be striving toward a more integrated system of mental health care delivery so Massachusetts residents can access the care they need and deserve. The Division and MassHealth have a tremendous opportunity with implementation guidance to promote the integration of mental health care into overall health care by clarifying that primary care physicians and other physicians providing behavioral health services are covered under the behavioral health sections of Ch. 260.

Chronic Disease Management

The Medical Society does not believe the chronic conditions identified by Centers for Medicare and Medicaid Services (CMS) is sufficiently inclusive of the breadth and types of chronic conditions that can and should be allowed to be managed effectively through telehealth. 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 very adult-centric and excludes some of the most common pediatric chronic conditions, such as cystic fibrosis, attention deficit disorder, or obesity, which would detrimentally impact pediatric patients.

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. Instead of devising an exclusive list of eligible conditions, the Division should consider crafting a definition of chronic disease that is applicable to 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 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 strongly urges the Division to reject the incredibly narrow interpretation offered by some, 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



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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, excluding 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 critical care that can be delivered through telemedicine from reimbursement parity and undermine efforts to promote access to that very care in a coordinated, cost-efficient manner.

Primary Care Services

The Medical Society urges the Division to consider approaching guidance relative to primary care services similarly to the approach for behavioral health. That is, the focus and determinative factor for reimbursement should be the services provided as opposed to the specialty of the provider. Traditionally a “primary care provider” is thought of as those physicians with a specialty in family medicine, internal medicine, general medicine, pediatrics, or obstetrics/gynecology – these are specialists who provide what are conventionally thought of as primary care services. 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 is consistent with health system goals to promote quality and continuity of care. As such, parity in reimbursement for services should not be limited to single designated “primary care provider.”

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, MS is primarily managed by neurologists. 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. We recognize the complexity of this approach and the challenges it may pose as the Division seeks a clean, bright-line way to designate primary care services for purposes of the statutorily mandated parity in reimbursement for primary care services. As the Division grapples with this, we urge you to avoid narrow designations of a single, “primary care provider”, which do not reflect the realities of clinical practice, and instead consider a broader approach that recognizes relationships between patients and physicians that promote quality and continuity of care.



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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.