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.