



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 April 14th, 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 utilization review and telehealth standards for accreditation review.

Utilization Review

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 the requisite standard of care.

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, 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 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, etc.

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 explore and implement 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. For example, 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.

Appropriate limitations on the utilization management protocols is not only critical in telehealth, but relates to broader policy concerns relative to the use of prior authorization and other utilization management techniques. The Health Policy Commission has consistently highlighted concerns associated with prior authorizations, including barriers to care and unnecessary administrative burden, and targeted this area for reform. A recent AMA study noted that "medical practices complete an average of 40 prior authorizations per physician, per week, which consume the equivalent of two business days (16 hours) of physician and staff time. To keep up with the administrative burden, two out of five physicians employ staff members who work exclusively on tasks associated with prior authorization." It is imperative that we do not allow overuse of prior authorization to create barriers to accessing care via telehealth.



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All processes for denials, appeals, disclosure notices, reconsideration, and expedited review should be consistent with the applicable processes for care delivered in-person, including external appeals processes. To the extent that such statutorily mandated processes laid out in Chapter 176O are not applicable to MassHealth, we would encourage MassHealth to apply substantially similar processes and to the extent possible, align these processes with 176O.

Lastly, the Division's asked several questions relative to the development of medical necessity criteria for telehealth. Chapter 260 does not authorize, and the Medical Society does not believe carriers should, develop novel medical necessity criteria to apply to care delivered via telehealth; care delivered via telehealth is the same care that is being offered in-person and the same medical necessity criteria should apply. Chapter 176O already mandates provider involvement in the development of medical necessity criteria.

Out-of-Network Coverage of Telehealth Services

The Medical Society does believe the language quoted by the Division from subsection (c)¹ requires coverage and reimbursement of an out-of-network provider for telehealth services provided when a "medically necessary covered benefit is not available to an insured within the carrier's network." To the extent that c. 260 in conjunction with c. 176O of the general laws requires carriers to cover telehealth services by an out-of-network provider, we believe the same reimbursement rules should apply for coverage by out-of-network providers under these circumstances. 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.

Barriers to Reimbursement

The Division asked whether it should provide guidance clarifying what constitutes a barrier to accessing services in-person and referenced a different section of c.260 that permits a carrier to apply utilization review and prior authorization to determine whether something is covered under the plan. The Medical Society does not believe further guidance on what constitutes a barrier is necessary. Chapter 260 explicitly prohibits requiring documentation of a barrier to in-person care in order to access telehealth services. Barriers to in-person care should have no bearing on a carrier's utilization review protocols relative to the appropriateness of telehealth as a means to deliver a particular service. Further, there is no reason an insurance carrier should request documentation of the originating and distant sites, especially since the statute expressly prohibits limitations based on these factors.

¹ SECTIONS 47, 49, 51 and 53. (c) ...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.



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Credentialing

Proxy-credentialing allows a hospital or health care provider organization receiving the telemedicine services to rely on the privileging and credentialing decisions made by the hospital or entity providing the telemedicine services, provided certain requirements are met. MMS supports proxy credentialing, as it can alleviate complications and administrative burden associated with the credentialing process by allowing hospitals and other entities to facilitate access to telemedicine and comply with the Conditions of Participation without incurring the full administrative burden associated with the traditional credentialing process. This could be particularly helpful for smaller or rural hospitals.

Networks

MMS strongly supports the provisions in C.260 that an insurer cannot 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. While telemedicine is a critical means to improving access to care for many, we support provisions allowing patients to decline receiving services via telehealth to receive in-person services. Network adequacy must not be wholly reliant on telehealth providers.

We would encourage the Division to provide more concrete guidance as to what would be considered “significant reliance” on telehealth providers in the context of general prohibition on meeting network adequacy through significant reliance on telemedicine providers outside the context of the state of emergency. While we continue to believe that telehealth offers great options to patients for alternative modalities to access care, patients should continue to have access to have in-person visits with physicians who are geographically close and are available to accept patients. Telehealth should not be used to justify the adequacy of network, but instead to supplement alternative access to a network with broad in-person physician access.

Another important safeguard the legislature included was prohibiting carriers from limiting coverage to services delivered by third-party providers. This provision is important to protecting the physician-patient relationship and promoting continuity of care by prohibiting requiring patients to use a contracted 3rd party telemedicine-only provider when the patient may prefer to receive the care from their physician with whom they already have an established relationship.

Reporting

Chapter 260 requires 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 to issue a report on the use of telehealth services. The list of topics for the report is not exhaustive and we would strongly encourage the Division additionally to consider additional measures or qualitative metrics for reporting, including from the patient perspective. There is much included in the reporting, focusing heavily on utilization and health care expenditures and costs to the system, which are important to understand, but we should also be focusing on the tangible benefits in terms of expansion of access to care and improved quality of care – for example, we know anecdotally that telehealth is decreasing no show rates – particularly among Black and brown patients and thereby improving inequities in access to care, decreasing the length of stay in hospitals, preventing urgent and emergency care, improving patient compliance with care plans, and overall improving health outcomes.



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We should – to the extent possible – be focusing on and measuring these and other positive outcomes, such as: clinical outcomes, quality, and safety; access to care; patient and family experience; and clinician experience.

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.