MASSACHUSETTS PSYCHIATRIC SOCIETY

PO Box 549154
Waltham MA 02454-9154
(781) 237-8100 FAX (781) 464-4896
email: mps@mms.org

April 26, 2021

Kevin Patrick Beagan
Deputy Commissioner, Health Care Access Bureau
Massachusetts Division of Insurance
1000 Washington Street
Boston, MA 02118

Dear Deputy Commissioner:

On behalf of the Massachusetts Psychiatric Society, thank you for the opportunity to participate in the listening session on April 14, 2021 to discuss implementation of telehealth provisions within Chapter 260 of Acts of 2020. The Massachusetts Psychiatric Society (MPS) wishes to submit the following comments for your consideration:

A. <u>Utilization Review (UR)</u>

Massachusetts Psychiatric Society (MPS) notes that Section 54 subsection c of Chapter 260 of Acts of 2020 clearly states that "An organization may undertake utilization review, including preauthorization, to determine the appropriateness of telehealth as a means of delivering a health care service; **provided, however, that the determination shall be made in the same manner as if the service was delivered in person."** (emphasis added). MPS supports the position expressed by the *t*Med Coalition, Massachusetts Medical Society, Massachusetts General Brigham and others on the call, that there should be no additional **non-quantitative treatment limits (NQTL)** such as prior authorization dictating the appropriateness of telehealth as a modality or the platform used for telehealth. We strongly believe that the decision about the location and modality of the treatment including in-person versus telehealth should be a clinical and person-centered decision that should be determined together by clinicians and the patient, and is inherently dictated by the required standard of care. Creating different rules for the use of different telehealth rules vs. in-person treatment risks the unintended consequence of limiting access by limit use of telehealth. The utilization review process for telehealth needs to be exactly the same as that for in-person visits. UR is already overly burdensome and a separate process to determine the appropriateness of telehealth for a clinical encounter will increase administrative burden to providers which can increase cost and create delays in care delivery which can increase ED and urgent care utilization and decrease access to otherwise timely care.

Massachusetts is ranked 44th out of the 50 states in outpatient provider reimbursement rates and in the bottom half of the 50 states in other non-quantitative treatment limits (NQTL) on behavioral health according to the Milliman Research Report, "Addiction and Mental Health vs Physical Health; Widening Disparities in Network Use and Provider Reimbursement," (1) from 11/19/2019. This extremely high rate of use of NQTL in MA should not exacerbated by new NQTL such as the use of prior authorization for the use of telehealth.

B. Regarding Out of Network (OON)

MPS strongly advocates any insurance carrier's existing OON provisions should be the same for telehealth. There should be no difference in OON service provisions for in-person care and telehealth. The MA DOI and national organizations, e.g., the American Psychiatric Association, have data that demonstrate the severe inadequacy of current insurance-based behavioral health networks. There are multiple legitimate reasons why patients seek and clinicians provide out-of-network care, including access, geography, specific expertise, existing provider relationships, and others. Restricting or eliminating benefits for out-of-network care delivered via telehealth will only greatly exacerbate the existing inadequacy of these networks and therefore access to care.

C. Billing/Location

MPS also strongly believes that behavioral health care provided on telehealth should be billed and guided by current Procedural Terminology (CPT) codes. Adding new billing criteria based on location of care provision (office or telehealth) or modality (audio visual or audio only) or provider status (an in-network or out-of-network) is anathema to the significant improvement to the CPT codes which are in universal use. CPT codes were developed by the American Medical Association (AMA) and universally adopted by the Center for Medicare and Medicaid Services (CMS) and insurance carriers. For the first time in 30 years, starting Jan. 1, 2021 CPT codes have incorporated streamlined documentation requirements for Evaluation and management (E/M) with a renewed emphasis on medical decision making instead of requiring a myriad of separate component parts of a visit. (See link #2 below and attached) The new proposed E/M CPT code changes were based on public comment with the goal of decreasing unnecessary documentation. In essence, the billing codes have less emphasis on a score for components of the documentation and have more emphasis on the degree of medical decision making and hence accurately reflect the actual practice of medicine. We also agree with comments made during the call that any determinations of location of telehealth as relevant to state licensure should be determined by the Board of Registration in Medicine and not DOI.

Thank you for considering these comments and for hosting the listening sessions. We are happy to answer any questions you may have about these comments.

Best Regards,

Sally Reyering, MD, DFAPA
President, Massachusetts Psychiatric Society

1 (http://www.milliman.com/insight/2017/Addiction-and-mental-health-vs_-physical-health-Analyzing-disparities-in-network-use-and-provider-reimbursement-rates/)
2 https://www.ama-assn.org/system/files/2020-04/e-m-office-visit-changes.pdf