MASSACHUSETTS PSYCHIATRIC SOCIETY

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

April 9, 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 representing the majority of psychiatrists, thank you for the opportunity to participate in the listening session on March 31, 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 (questions/topics below in bold).

"What falls under 'interactive audio-video technology'? What should be considered regarding the differing rates of reimbursement for those services that are not interactive audio-video technology?

Massachusetts Psychiatric Society (MPS) notes that the law states that services provided by telehealth conform to the applicable standards of care. We strongly believe that the decision about the location and modality of the treatment including in-person versus telehealth should be a clinical and patient-centered decision to be determined by clinicians and the patient, guided by the required standard of care. MPS discourages the DOI from applying old codes and standards for audio only telephone use (such as Medicare definitions cited by the MA Association of Health Plans) to the current use of audio-only, now used widely since the start of the Covid-19 pandemic. After all, the practice landscape is vastly changed from before the pandemic when CMS made their audio only codes. Similarly, we support efforts by Congress such as the "Permanency for Audio-Only Telehealth Act."

We concur with speakers on the call including the Massachusetts Medical Society who clarified the importance of recognizing that the important difference is not between audio-visual and audio-only modalities, but rather between synchronous and asynchronous modes of communication. The important consideration is not the technology used as much as the complexity of the visit and required medical decision making, which can be equally complex with either audio-only or an in-person visit. Visits by audio-only modalities such as telephone still include but are not limited to record review of past medical and family history, inquiry to the current circumstances including review of systems and social determinants of health, medication and diagnostic ordering, and plans for follow up. The payment should reflect the required and applied medical expertise and is the same no matter the modality. Asynchronous visits on the other hand such as a phone message request for a medication refill, would typically not be equivalent to the medical visit described above.

MPS also strongly agrees with concerns about structural racism occurring when services that are widely used by socio-economically disadvantaged groups, e.g., audio-only appointments, are deemed of lesser value. Individuals who only have telephone access or cannot use more advanced communications devices including smartphones, tablets, laptops, etc or who do not have broadband access, are unfairly affected by such disparate reimbursement. Indeed, unequal broadband access has been increasingly cited as a form of redlining with roots in structural racism. Paying less to providers who serve these individuals could compound the effects of structural racism by decreasing access to care.

If there are different rates of reimbursement, how should they apply?

The MPS discourages differential rates of reimbursement by telehealth modality. Many procedures previously associated with in-person office visits apply to telehealth visits, including managing waiting patients, and managing continued complexity in clinical presentations. New challenges including managing the technology difficulties that arise during the visit require greater flexibility on the part of the practitioner and patient.

The need for simplified codes is paramount. So-called surprise billing legislation requires practitioners to tell patients the expected cost of the services in advance. This depends on simplified codes and we discourage the generation of new billing codes other than the existing codes for in-person visits that are currently recognized and listed below.

99211-99215- Established Patient Evaluation & Management (E&M)

99202-99205- New Patient E&M

99241-99245 – Consultation Codes between MD and patient

90832-90853 – Behavioral Health Therapy codes

90791-90792- Psychiatric assessment codes for new patients

Will there need to be changes to existing global payment arrangements to account for telehealth?

MPS agrees with other participants' comments that global payments should be inclusive of related telehealth services including E&M which was already happening in the global payment market. In global payment models, the patient and provider decide together how to do the care as does the entity that is getting the global payment. If in person is covered, telehealth should be.

Behavioral health (BH) reimbursement:

MPS agrees with the DOI interpretation of the statute which makes a special rule for behavioral health such that services provided via audio-visual technology and audio telephone will be reimbursed at the same level as for an in-person visit in contradistinction with non BH services. MPS also agrees with the DOI interpretation of the statute, that there are not any provisions that limit the time that this section of the law is in effect for BH reimbursement of telehealth visits via audio-only and audio-visual telehealth modalities. MPS feel that these parts of the statute are designed to reflect the unfortunate reality that almost half of the citizens of the commonwealth with behavioral health conditions do not get treatment and 90% of individuals with substance use disorders (SUD) do not get treatment. We feel that this special consideration for BH and SUD is designed to increase access to these services which are in critical need.

Behavioral health <u>out-of-network</u> (OON) reimbursement:

If a carrier permits out-of-network health care practitioners to provide services via telehealth, should there be any guidance on their reimbursement?

Can different reimbursement rules apply to <u>out-of-network</u> health care practitioners?

Can different rules apply to different types of <u>out-of-network</u> behavioral health providers?

MPS feels strongly that if an insurance carrier already has OON provisions, these 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.

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