June 18, 2020

His Excellency Charlie Baker
Governor
Commonwealth of Massachusetts
State House, Room 360
Boston, MA 02133

The Honorable Robert DeLeo
Speaker
Mass. House of Representatives
State House, Room 356
Boston, MA 02133

The Honorable Karen Spilka
President
Mass. Senate
State House, Room 332
Boston, MA 02133

Dear Governor Baker, Speaker DeLeo, and President Spilka,

On behalf of healthcare providers, human service providers, patient advocacy organizations, telehealth technology companies, and telecommunications representatives, we would like to take this opportunity to express our gratitude for the flexibilities and enhancements that have been introduced during the COVID-19 state of emergency, which have expanded access to telehealth across Massachusetts. These policy changes ensure that our residents have access to critical healthcare services while taking necessary precautions to limit exposure to COVID-19. The flexibilities have also reduced the stress and burden of traveling to appointments (including the cost of tolls and parking), allowed continued social distancing, and preserved personal protective equipment for our healthcare workforce. Telehealth has been a powerful tool to increase access to care for all residents of the commonwealth and to promote the principles of health equity and health justice. The purpose of this letter is to further expand on the benefits that have been realized and to address next steps to ensure that there are no critical gaps that remain and must be addressed as we move forward.

Telehealth utilization has grown immensely during the pandemic. According to Blue Cross Blue Shield of Massachusetts, the number of telehealth visits that it has covered increased exponentially from 5,000 visits in the six weeks prior to the pandemic to 500,000 visits in the first six weeks of the pandemic– with almost half of those visits for behavioral health services. Previously, telehealth had enjoyed limited insurer coverage and many programs still rely upon grant funding and other philanthropic efforts for payment. In addition:

- Data from the MassINC polling group indicate that nearly one-fifth of respondents had used telehealth since the COVID-19 outbreak began, with the highest utilization coming from those deemed to be at the highest risk for the virus (ages 60+).

- One Massachusetts provider indicated that its utilization rate for telehealth during the pandemic has been 83% of all visits, which is only 5% lower than when they were doing in-clinic appointments over the same time during the previous year.

- Telehealth appointments have also helped improve patient compliance with appointments. The rate of those showing up for telehealth appointments has been 89% during the emergency period versus the show rate of 80% for in-clinic-only visits during the previous year.

- Another large health system has indicated that when surveying its patients after their telehealth visits during the pandemic, 98% report being very satisfied or satisfied with their virtual visits.

Telehealth has become an integral part of ongoing treatment and care plans in Massachusetts that must be preserved.

Prior to the state of emergency in the commonwealth, the Massachusetts Telemedicine Coalition (*t*MED) strongly supported the provisions of HB991/SB612, *An Act Advancing and Expanding Access to Telemedicine Services*, filed by Rep. Tom Golden and Sen. Jason Lewis. More than half of the legislature signed on in support of this legislation, which seeks to put in place a "three-legged stool" to:

- Ensure that all payers – including MassHealth and the Group Insurance Commission (GIC) – cover telehealth services on par with in-person visits, also known as coverage parity;
- Adopt proxy credentialing similar to what is in place in the federal rural telehealth program to reduce the paperwork burden for those providers who use telehealth services; and
- Include a flexible definition of telehealth that includes coverage for both interactive services and asynchronous telehealth services – a proposal Governor Baker supported in his healthcare legislation (HB4134) filed in October 2019. Moreover, such flexibility allows a definition to evolve with technology, instead of requiring legislation to keep up with medical innovation.

The *t*MED coalition appreciates that the emergency policies enacted in recent months went far beyond what had been included in HB991/SB612. Per executive orders, as well as MassHealth and Division of Insurance (DOI) bulletins, commercial insurers, the GIC, and MassHealth must cover and reimburse telehealth services on par with in-person visits. Beyond proxy credentialing, executive actions have allowed healthcare providers to receive expedited credentialing on an emergency basis and required facilities to credential such providers within one day of receiving credentialing requests. Not only have interactive technologies been covered through the administration's policies, but the administration did not impose any limitations on audio-only telephone or live video technologies. Coverage for asynchronous (i.e. store and forward technology), however, remains one of the gaps in coverage for telehealth services.

As the commonwealth moves forward with a phased reopening, the *t*MED Coalition urges our state elected leaders to make the preservation of these critical policies a top priority. Telehealth has now been adopted by providers and used by patients across the state, in addition to addressing some gaps in coverage that had not been previously recognized. There is significant anxiety among providers and patients alike that there will be a rescinding of these policies, creating clinical, operational, and financial challenges for providers and inhibiting the use of telehealth as a much needed modality for service delivery. Preserving telehealth will also allow healthcare providers to continue to limit exposure to COVID-19, promote continued social distancing, prepare for the upcoming flu season, and preserve personal protective equipment for the healthcare workforce. For these reasons, we recommend keeping in place the governor's March 15 Executive Order Expanding Access to Telehealth Services, the associated MassHealth All-Provider Bulletins, and DOI 2020-04 Bulletin, and expand upon them to preserve the following key provisions:

1. **Continued coverage and reimbursement parity across all payers on par with in-person visits – including commercial payers, GIC and MassHealth – for all providers that can provide services through telehealth.** Healthcare providers did not fully embrace telehealth prior to the pandemic since reimbursement did not cover the costs of providing care. We encourage you to model future legislation and regulation off of the governor's telehealth executive order in addition to DOI Bulletin 2020-04, MassHealth All-Provider Bulletins #289 & #291, and Managed Care Entity Bulletins #21 & #22. Coverage parity with subsequent reimbursement on par with in-person visits supports initiation fees, overhead costs, liability costs, the information technology infrastructure (including monthly fees for telehealth platforms), support for healthcare providers and patients, in addition to the scheduling and logistics for telehealth appointments. For healthcare providers, the front-desk, back-desk, and medical assistant workload in prepping patients for the visit has been the same during the COVID-19 pandemic – it's all just being done remotely. Additionally, we would recommend striking the current telehealth reimbursement language for commercial insurers in Chapter 175, section 47BB as recommended in both the *t*MED legislation (HB991/SB612) and Governor Baker's legislation (HB4134) that allows coverage only through insurer-approved telehealth networks.

   Moreover, many providers in the commonwealth offer comprehensive care models where a single encounter with a provider could include services delivered by several different specialties – many of which are not currently reimbursable. Without reimbursement on par with in-person visits inclusive of facility fees as noted by both MassHealth and DOI, patients who access telehealth instead of in-person visits could lose access to these comprehensive services.

2. **Continued coverage and reimbursement parity for audio-only telephone visits for all payers on par with in-person visits critical to supporting our state's at-risk populations.** The governor's March 15 executive order, MassHealth All-Provider Bulletins 289 and 294, and DOI Bulletin 2020-04 permit telephonic utilization for telehealth services. For low-income populations, communities of color, families with young children, and older adult populations, the ability to access care by audio-only telephone has proven to be critically important since many do not have access to adequate internet connections or fluency in the use of interactive audio-video technologies. Throughout the month of May, one physician group indicated that more than 70% of its visits on a weekly basis have been conducted through audio-only telephone. The audio-only telephone services have helped to ensure that the hardest hit communities – including both rural and urban areas – in the COVID-19 pandemic have stayed connected to vital services. The *t*MED Coalition has identified the ability to access audio-only telephone visits as an essential resource to maintain after the COVID-19 emergency to ensure access to healthcare for all communities – including diverse populations, persons with complex behavioral health and/or chronic health conditions, and to address systemic health inequities and disparities. Additionally, some patients opt for audio-only telephone visits because they do not have access to private space within the home or workplace that is conducive to confidential participation in a video visit. Nothing about the public health emergency ending will resolve these access issues, and the emergency has shown that these are valued services that patients are using.

3. **Coverage and reimbursement parity for asynchronous technologies across all payers.** The current policies do not offer a comprehensive definition of telehealth, leaving out asynchronous technologies, which provide critical, cost-effective patient care. Asynchronous technologies or store-and-forward telehealth describes platforms where patients or providers collect relevant

medical information (e.g., images of a skin condition) and then send that information to a specialist physician for remote diagnosis or triage at a later time. Because patients and providers do not need to sync-up schedules, this allows for a cost-effective and time-efficient process for all involved. Moreover, for certain specialties, such as dermatology, store-and-forward technologies are considered standard-of-care in-part because of the higher diagnostic accuracy and higher image resolution.

In Massachusetts, a network of community health centers has been using a store-and-forward system to improve dermatology access. However, these health centers have not been able to offer this service to all patients due to lack of reimbursement – both from MassHealth and commercial payers. Instead, they have relied upon temporary grants. Store & forward communications technologies are covered by Medicare in the Physician Payment Fee Schedule, including the codes for the coverage of remote evaluation of pre-recorded patient information (Healthcare Common Procedure Coding System (HCPCS) Code G2010), in addition to other interprofessional consultation codes (Current Procedural Terminology (CPT) codes 99451 and 99452). Hospitals, health systems, specialists, home- and community-based providers, and the U.S. Departments of Defense and Veterans Affairs already have trained and deployed clinicians and IT staff to use asynchronous technologies to deliver accessible and high-quality care to their patients.

Additionally, remote patient monitoring – another form of asynchronous care – is currently covered for COVID-19 patients in the MassHealth program through All-Provider Bulletin 294 (and is recommended for broad coverage as defined by Governor Baker's bill, HB4134), in addition to other application-based triage services. These technologies should be included in the state's definition of telehealth – and be covered by payers – if we wish to truly realize the full potential of telehealth to assist healthcare providers and improve patient care.

4. **Proxy credentialing for providers who use telehealth services.** Healthcare providers have continued to use emergency credentialing provisions during the state of emergency to facilitate the credentialing of providers at medical facilities through the executive order adopted on March 17. To support telehealth on a permanent basis, the *t*MED coalition requests that the administration and legislature align Massachusetts rules with federal standards that currently allow appropriate clinicians to utilize proxy credentialing when providing telehealth services within their current licensure and scope of practice standards. Medicare has adopted a streamlined and more efficient provider credentialing process to allow these caregivers to provide telehealth services in rural areas. Specifically, the federal rules eliminate duplicative paperwork and reviews at each site at which the provider seeks to offer care through telehealth. Proxy credentialing is also approved by the Joint Commission, the leading national accreditation and certification body for healthcare facilities. Contrary to these federal rules, Massachusetts requires a provider to go through an extensive credentialing process at each site of care, which requires detailed documentation of Primary Source Verification of each clinician's education, skills, trainings, and more. This adds to the overall cost and internal resources for each facility at which the provider is seeking to provide remote telehealth services and disproportionately affects rural facilities. The *t*MED Coalition recommends that any permanent policies that are adopted direct the respective boards of registration to promulgate regulations allowing licensed clinicians to obtain proxy credentialing for telehealth services consistent with the federal Medicare Conditions of Participation for telehealth in the rural telehealth program.

5. **Reduce barriers associated with prior authorization.** The *t*MED Coalition also recommends that any permanent policies put forward on telehealth follow the Division of Insurance Bulletin 2020-04, which states that "Carriers are directed not to impose any prior authorization barriers to obtain medically necessary health services via telehealth that would not apply to receipt of those same services on an in-person basis." The coalition believes that this policy ensures that there are not undue barriers placed on telehealth services solely because the service is being provided via telehealth.

6. **Comprehensive & clear definition of telehealth.** As you consider what the definition of telehealth is, we would encourage you to ensure that the definition recognizes telehealth as a modality that includes synchronous, asynchronous, and audio-only telephone technologies; and that telehealth allows the broadest possible view of a patient's health and wellness and the services to support their health, including but not limited to the evaluation, diagnosis, consultation, prescribing, and treatment of a patient's medical, oral, mental health, and substance use disorder conditions. Additionally, we would discourage you from selecting certain services and codes to be covered. A broad definition of telehealth and a comprehensive service delivery model that uses telemedicine across the care continuum from acute care to outpatient care will assist the healthcare system in removing barriers to access and allow for flexibility in how services can be provided to address social determinants of health. This includes coverage for services such as physical therapy, occupational therapy, and speech language therapy.

7. **Enhanced consumer protections.** Any regulations or legislation that are adopted should also include enhanced consumer protections that preserve a patient's choice of modality by which to receive services. The *t*MED Coalition recommends that:
    - **i)** Insurers should meet network adequacy requirements without a significant reliance only on telehealth providers, and should be considered to have an adequate provider network only if patients can access both telehealth and in-person services in a timely manner.
    - **ii)** Protections are put into place so that a patient may decline receiving telehealth services in order to access in-person services and shall not incur increased financial burdens for doing so.
    - **iii)** Providers who use telehealth should be able to offer information to patients about follow-up care and services that are available in their communities through a website identifying such information. Such a requirement would ensure that providers who may not necessarily be in Massachusetts but are Massachusetts-licensed to provide care to patients located in Massachusetts, can appropriately direct patients to timely, local follow-up treatment.
    - **iv)** Deductibles, copayments, or coinsurance requirements for telehealth services should not exceed the deductibles, copayments or coinsurances applicable for in-person services. Throughout the COVID-19 pandemic, some insurers have waived cost-sharing requirements for telehealth services.
    - **v)** A healthcare provider shall not be required to document barriers to an in-person visit prior to utilizing telehealth, and the type of setting where telehealth is utilized should not be restricted or limited.

8. **Flexibilities to provide care across state lines.** Through the COVID-19 emergency, the Baker administration has adopted a number of executive orders that facilitated the care of patients via telehealth across state lines. These include: the March 17 executive order expanding access to

physician services; the March 17 executive order extending the registrations of certain licensed healthcare professionals; the April 3 executive order maximizing healthcare provider availability; and the Board of Registration in Nursing Licensure Policy 10-03, which expedited the processing of reciprocal license applications for nurses in the event of a declared public health emergency. On a permanent basis, the *t*MED coalition urges the administration and the legislature to consider the adoption of the interstate medical licensure compact and other compacts, including the nurse licensure compact, the physical therapy license compact, and other licensure reciprocity agreements. This would eliminate the need for executive orders in the future, recognizing that healthcare practice is national in scope and facilitating provider healthcare practice across state lines. States should make every effort to facilitate the licensure of providers whenever possible.

9. **Reducing the administrative burden for the practice of telehealth**. The *t*MED coalition recommends that any additional policies issued on a permanent basis for telehealth streamline and make uniform payer policies regarding coverage, billing, and coding, especially at the state level. This would benefit both patients and healthcare providers and increase efficiencies in the healthcare system. Such policies could include the development of appropriate processes for providers to validate cost-sharing for patients prior to telehealth services.

10. **Face-to-face encounter requirements & standards of care.** We would encourage the Board of Registration in Medicine to make permanent Policy 2020-01: Interim Policy on Telehealth in the Commonwealth, which states that the practice of medicine shall not require a face-to-face encounter between the physician and the patient prior to healthcare delivery via telehealth and that the standard of care applicable to the physician is the same whether the patient is seen in-person or through telehealth. Providers have demonstrated that they can effectively welcome new patients into their practices and establish new patient relationships via telehealth. This is especially essential at this time in making sure that care needs are met and in assisting patients to access care, including those who are experiencing transitions in health insurance. Further, we ask policymakers to consider expanding this policy to other licensure boards, including but not limited to, oral health provider, and behavioral health providers.

11. **Addressing the digital divide**. The *t*MED Coalition has heard loudly and clearly from members during the COVID-19 pandemic that residents in low-income urban, diverse, and rural communities must have the option of audio-only telephone as part of the telehealth continuum, and that ongoing efforts are needed to address the digital divide to maximize the use of telehealth. In addition, the digital equity gap is also experienced by many other patient cohorts, including those with technology literacy needs, complex behavioral health and chronic conditions, and linguistic access needs, including the ability to access multi-lingual patient portals. Whether due to limited availability or limited financial means to access broadband or cable services or through data limitations on smartphone plans or reliance upon telephonic technologies alone, the COVID-19 pandemic has laid bare the health disparities that make up the digital divide. Access to computers/tablets, to smartphones, and to viable and affordable broadband internet and/or data plans varies widely. We look forward to working with you to address these disparities through increased access to technology on a widespread basis in local communities – similar to the provision of tablets to nursing home residents through the work of the Attorney General's office. One issue that providers might consider is the ability to screen patients for their ability to access and use telehealth services. Additionally, while providers are working on these issues on an institutional basis, we look forward to working on issues to

address language challenges for those with limited English proficiency who seek to use telehealth services.

We look forward to continuing our work with you to advance and expand access to telehealth services in the commonwealth.

Sincerely,

*t*MED – the Massachusetts Telemedicine Coalition

cc: Marylou Sudders, COVID-19 Response Command Center

*t*MED Supporting Organizations

Massachusetts Medical Society
Every physician matters, each patient counts.

COBTH Conference of Boston Teaching Hospitals

MHA Massachusetts Health & Hospital Association

Massachusetts Council of MCH Community Hospitals

Hospice & Palliative Care Federation of Massachusetts

Health Care For All

AMD Global Telemedicine

ONL Organization of Nurse Leaders
Advancing a culture of health.

HealthPoint Plus Foundation

Massachusetts Association of Behavioral Health Systems

Massachusetts Academy of Family Physicians
Strong Medicine for Massachusetts

CMSNE

NECTA

ABH

NASW National Association of Social Workers Massachusetts Chapter

Seven Hills Foundation

Atrius Health

MAJT, Inc.

Massachusetts Psychiatric Society

3Derm

zipnosis

Perspectives Health Services, LLC

BAYADA Pediatrics
A specialty of BAYADA Home Health Care

American Heart Association | American Stroke Association
life is why

Massachusetts League of Community Health Centers

Planned Parenthood Act. No matter what.

BL Healthcare

Mass. Family Planning Association

PHILIPS

MAVEN PROJECT

upstream USA

Franciscan Children's
So every kid can.

APTA Massachusetts

COMMUNITY CARE COOPERATIVE