



MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

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Dear Conferee:

Thank you for your leadership and for your participation in the conference committee. On behalf of the Massachusetts Medical Society, representing over 25,000 member physicians, residents, and medical students, I write to provide comments and constructive feedback relative to the major health care provisions under consideration by this conference committee as you work to reconcile differences between House bill 4916 and Senate bill 2796.

Telehealth

Telehealth is a critical means to improve access to care for patients, both during COVID and beyond. Establishing a framework for coverage and reimbursement that reduces barriers to its adoption and use by both patients and physicians is necessary in responding to the current pandemic and in addressing broader issues in healthcare access and equity. The medical community's unprecedented experiences caring for patients during the COVID-19 crisis have shaped our policy approach to telehealth, underscoring the vital role telehealth plays in providing continuity of access to the safest form of medical care and stability in the health care system, which now faces unparalleled uncertainty.

As such, the Medical Society urges the committee to adopt the more comprehensive approach to telehealth outlined in S.2796, instead of the approach in H.4916 requiring coverage only for primary care, behavioral health, and chronic disease management services. Comprehensive coverage of all medically necessary care that is a covered service, including synchronous and asynchronous technologies without limitation on origination site or distant site, best promotes patient safety and access to care. Patients who purchase insurance that covers a medical service should be provided coverage for that service through any appropriate modality of care. Coverage for audio-only services is also very important and will help to bridge the digital equity divide, especially in the context of behavioral health which has seen telehealth account for over 50% of visits for some common conditions.¹ Parity in reimbursement, on par with rates for in-person services, is essential given the crucial role telehealth is playing in keeping patients safe and in maintaining access to care. Accordingly, to ensure continuity of care, such parity should be maintained for at least two years, as provided in S.2796, in order to minimize disruption and provide predictability for coverage and reimbursement when the public health emergency ends.

MMS opposes restrictions on prescribing via telehealth included in H.4916, which complicate access to care and are inconsistent with policy adopted by the Board of Registration in Medicine (BORIM) that explicitly states that the practice of medicine shall not require a face-to-face encounter between the physician and the patient prior to health care delivery via telemedicine and requires an equivalent standard of care for services delivered via telemedicine as those delivered in person. Similarly, MMS strongly opposes authorizing carriers to use utilization

management, including prior authorization, to determine whether a health care service can be appropriately delivered via telehealth. 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 required standard of care. Instead, MMS acknowledges allowing prior authorization for services delivered via telemedicine only where a prior authorization is allowed for that same service when delivered in person.

Lastly, MMS supports inclusion of all provisions that allow physicians, through BORIM (H.4916, section 16), and other clinicians licensed through the Department of Public Health and the Office of Consumer Affairs and Business Regulation (S.2796, section 68) to obtain proxy credentialing under regulations adopted consistent with the -federal Centers for Medicare & Medicaid Services' conditions of participation for telehealth services.

Out-of-Network Billing

While the Medical Society continues to seek a comprehensive solution to ensure that patients never receive a surprise out-of-network bill, we have serious concerns about the long-term policy approach taken in S.2796 and instead prefer the short-term approach to protect patients in H.4916. In this time of economic uncertainty, when physician practices continue to struggle with up to 70% reductions in patient volume over the past several months, and when acute care hospitals in Massachusetts are projected to lose \$6 billion by Labor Day, MMS is wary of legislation that would, if adopted, set a precedent that will weaken the marketplace by threatening physicians' ability to negotiate fair contracts with insurers and by prompting physician consolidation or practice closures, which undermines patient access to care.

MMS supports the House's interim approach to out-of-network billing, which would reimburse out-of-network emergency services at the greater of 115% of the average allowed amount or 135% of Medicare rates. Inclusion of the average allowed amount in the rate calculation ensures that physicians are reimbursed for emergency services based upon rates negotiated in Massachusetts between physicians and insurers, rather than being based solely upon a percentage of the Medicare reimbursement rate. A one-year interim approach would protect patients from unexpected out-of-network charges and allow for a thoughtful discussion of an appropriate, long-term solution that factors in the impact of COVID-19 on the health care system and health care economy. Importantly, the MMS feels strongly that a key element in any long-term approach is an independent dispute resolution (IDR) process. A fair system cannot be created without the ability for providers and insurers to arbitrate disputes in instances where the statutory formula does not result in a reasonable reimbursement.

Additionally, the Medical Society supports the intent of thoughtful carrier and clinician disclosure requirements to provide notice of non-emergent out-of-network care and important consumer protection information as contained in sections 28 and 62-64 of S.2796. MMS believes that notice requirements can provide meaningful safeguards for patients, ensure transparency, and protect against potential surprise billing situations. While considerable progress has been made toward ensuring that these

requirements can be reasonably implemented in practice, we continue to oppose mandatory fines for accidental non-compliance and look forward to working with the conference committee to further refine the notice provisions to ensure an appropriate balance in the disclosures such that they provide meaningful notice to patients while not unduly burdening physicians.

Scope of Practice

The Medical Society continues to believe in a physician-led, team-based model of care and therefore opposes the expansions of scope of practice authority for practitioners contained in these bills. A physician-led, team-based model of care best promotes coordinated, patient-centered care by maximally utilizing all health care professionals in their most appropriate capacities while maintaining important patient protections and promoting access to high-quality care. Expanding independent practice encourages the siloing and separation of healthcare practice and is antithetical to general movement away from fee-for-service models and toward more integrated, value-based accountable care models. Any effort to modify our current laws should carefully consider the benefits and patient safety protections that are afforded by a team-based model.

In the case that one expansion of scope approach prevails, however, the Medical Society recommends the limited scope authorization for nurse practitioners and psychiatric nurse mental health clinical specialists as contained in H.4916 and further advises additional measures be included to promote patient safety. In particular, the Medical Society supports the continued requirement that advanced practice registered nurses (APRNs) have clinical relationships with a physician, especially as it relates to prescriptive practice. Such relationships provide opportunity for timely physician oversight and consultation that would otherwise be absent in cases where collaboration with a physician is essential to positive patient outcomes. Importantly, we underscore that any expansion in practice authority for non-physician health care clinicians should be accompanied by commensurate administrative oversight and licensing requirements, such as online provider profiles with malpractice information and a robust licensing board with the resources to provide appropriate oversight. For the sake of patients, all providers responsible for treating patients independently must be held to the highest standards of accountability, as physicians are by the Board of Registration in Medicine.

COVID-19 Provisions

Testing

The Medical Society believes that low-barrier testing is a key component to effectively combatting the COVID-19 pandemic in Massachusetts. As testing capacity increases and as we continue to learn about the transmissibility of asymptomatic persons, expanding access to appropriate testing of asymptomatic persons is critical. Assuring no-cost testing—especially for front-line health care workers and persons who work in the restaurant, retail, and hospitality industries—will be essential to mitigating any future outbreaks in the Commonwealth. MMS thus supports provisions in Section 34(b) to remove cost barriers to this critical public health tool.

Personal Protective Equipment

The Medical Society strongly encourages the inclusion of several provisions included in H.4916 relative to personal protective equipment (PPE). Procuring and maintaining sufficient supplies of PPE has been and continues to be a central challenge for physicians, hospital systems, and the health care system at large throughout the COVID-19 pandemic. With rising rates of infection and potential for a future surge, we cannot be complacent – we must act now to ensure that we are prepared to scale up the acquisition of PPE in the event of sudden increases in demand. MMS supports inclusion of Section 45 of H.4916, which directs the Executive Office of Health and Human Services to organize and establish an online Personal Protective Equipment Exchange for the purpose of identifying, aggregating and making available for purchase and procurement necessary personal protective equipment to be utilized by health care and elder care providers. We further support Section 33C of H.4916, which directs the House Special Committee on Resilience and Recovery to hold a hearing evaluating the supplies of personal protective equipment that are available to hospitals and other entities identified by the Committee.

In conclusion, the MMS again thanks you for your service as a member of conference committee and for your consideration of these comments. We look forward to working with the conference committee and staff to protect and improve access to care for patients and to promote the best possible public health response to the COVID-19 crisis.

Sincerely,

David A. Rosman, MD, MBA