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Every physician matters, each patient counts.

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

Dear Mr. Speaker:

The Massachusetts Medical Society wishes to record the following comments relative to S.2796, *An Act to promote resilience in our health care system*.

Telemedicine

The dramatic shift to telemedicine prompted by the COVID-19 pandemic has underscored how important telemedicine will be to ensuring Massachusetts remains a leader in health care, how critical it is to improving access to care for patients, and how beneficial the opportunities it provides will be toward reducing health disparities. **Telemedicine is the single most critical means to improve access to care for patients, both in the near term and the long term.** The need for physical distancing and enhanced protections for immunocompromised, high-risk patients will extend well beyond the duration of the State of Emergency. Accordingly, MMS supports continuity of current, across-the-board telemedicine coverage and reimbursement policies in the near term and codification of these policies by the legislature.

While the Medical Society commends the expansion in telemedicine coverage contained in S.2796, **we urge expansion beyond just primary care, behavioral health, and chronic disease management to ensure that patients with conditions not falling under a covered service are not left behind. This is especially important as we are likely to experience a future spike in COVID-19 cases that will similarly require comprehensive coverage of services to protect both patients and physicians.** Telemedicine that would not be covered by S.2796 could include:

- a telehealth visit with an infectious disease specialist for COVID-19 or the flu
- routine pregnancy care
- a post-surgical wound check for an elderly patient
- a patient who presented recently to a Massachusetts dermatologist for painful bumps on her toes who was ultimately diagnosed with COVID-19 (despite no other symptoms that would have prompted testing)

To keep patients safe, Massachusetts should adopt policy requiring comprehensive coverage, including synchronous and asynchronous technologies without limitation on origination site or distant site, **for all medically necessary care** that is a covered service and clinically appropriate to provide via telemedicine. Coverage for audio-only services is also very important and will go far in bridging the digital equity divide, especially in the context of behavioral health. Parity in reimbursement, on par with in-person services, is essential given the crucial role telemedicine is playing in keeping patients safe and maintaining access to care. Further, telemedicine policy should not be disrupted so that predictability for coverage and reimbursement can be provided for when the public health emergency ends and so continuity of care will be ensured.

Out-of-Network Billing

While the Medical Society continues to seek a comprehensive solution to ensure patients never receive surprise out-of-network bills, we have serious concerns about the policy approach taken in S.2796. If the legislature is looking to protect patients in the short term, the Medical Society recommends extending the Governor's strong out-of-network patient protections established for COVID-19 related care during the State of Emergency. Instead, by crafting a one-year, over simplified fix for all emergency care, S.2796 puts the state down a path towards setting rates for out-of-network care not based on average rates negotiated between insurers and physicians, but on the federal Medicare reimbursement fee schedule, which is an inappropriate benchmark for payment by commercial insurers. Out-of-network billing solutions based upon Medicare rates will cause long-term damage to the health care delivery system in Massachusetts by disincentivizing the longstanding tradition of fair negotiations between physicians and insurers. Medicare is not currently, and was never intended to be, a source for commercial physician payment, as Medicare rates have no relationship to fair market value or the cost of care and are based on federal budgetary considerations rather than on an appropriate valuation of the services provided. For these reasons, as Congress debates this same issue, all prevailing bipartisan out-of-network bill solutions incorporate "in-network" rates into a statutory reimbursement formula rather than solely resorting to Medicare rates.

The Medical Society was largely supportive of the reimbursement framework proposed in H.1046, which included references to "in-network rates", and which benefited from a public hearing and was subject to much thoughtful debate. Moreover, the lack of arbitration in this proposal is concerning – a fair system cannot be created, even on an interim basis, without the ability to resort to arbitration in exceptional instances where the primary statutory formula does not result in a reasonable reimbursement for the emergency medical care provided; however, we recognize the inherent challenges in establishing and implementing an arbitration system in a limited 1-year time frame.

At a moment of economic uncertainty, when physician practices are trying to withstand 60-70% reductions in patient volume over the past several months and acute care hospitals in Massachusetts will lose \$6 billion by Labor Day, this legislation sets a precedent that could lead to permanent policy that will disrupt the marketplace, further threatening physicians' ability to negotiate fair contracts with insurers and harming the health care system by leading to physician consolidation or practice closures, which will ultimately undermine patient access to care.

Scope of Practice

The Medical Society continues to believe that 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 critical patient protections and promoting access to high-quality care. The Medical Society supports practice autonomy for advanced practice registered nurses (APRNs) with legislative assurances that APRNs have a relationship with a physician for exceptional cases where consultation and collaboration are appropriate. In addition, we underscore that any expansion in practice authority for non-physician health care providers 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 due oversight appropriate for independent authorities. For the sake of patients, all providers responsible for treating patients independently must be held to the highest standards of accountability.

The Medical Society appreciates the opportunity to weigh in on these important issues. We look forward to continued discussion to achieve important improvements for patients across the Commonwealth.

Sincerely,

David A. Rosman, MD, MBA