MASSACHUSETTS MEDICAL SOCIETY
Every physician matters, each patient counts.

July 24, 2024

Representative John Lawn
Chair, Health Care Financing
State House, Room 236
Boston, MA 02133

Senator Cindy Friedman
Chair, Health Care Financing
State House, Room 313
Boston, MA 02133

Representative Frank Moran
Second Assistant Majority Leader
State House, Room 481
Boston, MA 02133

Senator John Cronin
Vice Chair, Health Care Financing
State House, Room 218
Boston, MA 02133

Representative Hannah Kane
Ranking Minority, Health Care Financing
State House, Room 167
Boston, MA 02133

Senator Bruce Tarr
Minority Leader 308
State House, Room 419
Boston, MA 02133

Dear Conferees:

On behalf of the over 24,000 physician, resident, and student members of the Massachusetts Medical Society (MMS), we wish to thank you for your efforts, as members of the conference committee, to produce a final health care package. The MMS is committed to working collaboratively with you all to craft policies that will increase appropriate transparency and oversight in the health care market, reign in cost growth, and improve affordability and equitable access to care for patients.

In a time of immense financial pressure and unprecedented workforce shortages, the current practice environment poses immense challenges, particularly for independent practitioners. We appreciate provisions in the bill aimed at alleviating undue administrative hassles, such as excessive quality measure reporting and prior authorization requirements. By the same token, we are wary of new rules and requirements that, despite being well-intentioned, may ultimately undermine the sustainability of independent practices and destabilize an already fragile practice landscape. To that end, we would like to offer the following comments for your consideration as you seek to reconcile S.2881 and H.4653.

Registration of Physician Practices (S.2881§100; H.4653 § 129)

With the goal of augmenting statewide health resources planning and given the current gaps in understanding of the physician practice landscape and associated patient access challenges, the Medical Society supports the concept of physician practices of a certain size registering with the Board of Registration in Medicine (BORIM). With this objective in mind, we make the following recommendations to establish a framework that facilitates achieving our shared policy goals while minimizing unnecessary burdens on the physician community.

- **Physician practices should be registered with BORIM, rather than DPH**. BORIM is the most appropriate entity to oversee a database of physician practices, with the ability to streamline a registration database and supplement

860 WINTER STREET
WALTHAM, MA 02451-1411
TEL (781) 893-4610
TOLL-FREE (800) 322-2303
FAX (781) 893-9136
WWW.MASSMED.ORG

additional physician information available to the Board obtained through the licensure process.

- **Registration should be limited to practices of 10 or more physicians.** Given the access issues resulting from the abrupt closure of Compass Medical, we appreciate the intention of enhanced oversight to ensure continuity of care for patients. However, from a public policy perspective, we must balance the burden of practice registration/oversight on solo practitioners and small practices, typically with very limited administrative supports, with the utility of increasing transparency efforts. Solo practitioners and practices with fewer than 10 physicians are less likely to have a substantial community impact – for perspective, Compass Medical employed approximately 80 physicians, caring for approximately 70k patients across 6 offices.
- **Registration should be primarily for the purposes of health resource planning** without imposing unnecessary regulatory burdens on physician practices, which are appropriately regulated under BORIM. Physicians are already subject to practice standards under the Board including existing Board regulations governing salient issues including handling of medical records, malpractice, business organization, and the practice of medicine. Additionally, in the wake of the closure of Compass Medical, BORIM has proposed draft guidance on the closure of a medical practice and associated issues, including notice for termination of a physician-patient relationship to prevent patient abandonment. The guidance outlines the common law duty to not abandon patients, as well as reiterating the legal obligation to maintain medical records. In addition to other recommendations to prevent patient abandonment, the guidance will recommend physicians notify patients of an impending retirement, transition, or closure date no later than 3 months (90 days) prior to the event, as well as providing specific referral for patients requiring continual follow-up care. The Medical Society and the Hospital Association have provided extensive input in this draft guidance, and this is the most appropriate mechanism for addressing these issues.
- **Provider Organizations registered with the Health Policy Commission (HPC) under the Registered Provider Organization (RPOs) should be exempt from registering with BORIM**. RPOs are already subject to broad financial and organizational disclosure requirements to the HPC, as well as subject to material change notification requirements. Registering with BORIM would be redundant. The Board should coordinate their practice registry efforts with the HPC to establish a comprehensive overview of the practice landscape.
- **Any fee associated with registering physician practices should be minimal** (e.g. $100) to cover the cost associated with maintaining a practice registration database, ensuring that independent practices are not unduly burdened financially.
- **We oppose proposals requiring practices to appoint a medical director.** This requirement does not augment any public policy purpose and only serves to further complicate the operation of physician practices, especially for solo practitioners and small practices. Liability should and will necessarily fall to the practice owners consistent with the corporate structure, and licensure implications are inappropriate. Implementing such a requirement would have a prohibitive practical impact, increasing the cost of care by adding management expenses without adding value or quality. The MMS also opposes a separate certification requirement outside of registering a practice.

Protecting Clinical Autonomy & Regulation of Management Services Organizations (S.2881 § 100; H.4653 §§ 32, 129)

The Medical Society has concerns that the underlying commitment of private equity firms to return a profit to their investors, often within a set timeframe, has the potential to affect decisions ranging from staffing to reinvestments in equipment and facilities. These decisions ultimately can impact the availability and quality of care. We are particularly concerned that these profit motives can interfere with physician autonomy, potentially affecting clinical decision-making in ways that do not prioritize the best interest of patients and their families.

As such, the Medical Society is guided by our policies that seek to promote fairness, transparency, and accountability in private equity transactions to safeguard adequate access and quality of healthcare. We strongly support efforts to safeguard the clinical autonomy of physician practices and mitigate the potential for exploitation resulting from the corporatization of medicine.

Physician practices should and must maintain ultimate control of clinical decisions, as patient health outcomes and health care quality and safety should direct clinical decision making, not business decisions driven by the pursuit of profit and/or growth. However, we caution against an overly prescriptive approach to regulating management services organizations (MSOs) and other entities that may significantly impact practices that rely on contracting for a range of administrative services critical to their sustainability (e.g. staff benefits, accounting services, recruitment/human resource support). Opportunities for physician input and representation in decision-making processes related to private equity investments are crucial to ensuring that the needs of patients, communities, and healthcare providers are adequately considered.

Given the current levels and anticipated growth of private equity investment in health care in Massachusetts, we support efforts to craft sensible policies that will prioritize transparency and targeted oversight of corporate actors in the health care sector. This can be achieved through current proposals that expand reporting requirements for registered provider organizations and physician practices to include significant equity investors, health care real estate investment trusts, and management services organizations. We also support a legislative approach to affirmatively codify the concepts and decisions that are clinical in nature and should be within the ultimate control of the physician practice. Beyond that, we need more information about what's happening on the ground to better tailor policy solutions to address concerns about these entities and relationships. The current practice environment is already so administratively challenging for independent practices, we have real concerns that imposing additional regulation without more information could be destabilizing for independent practices and could result in more practice consolidation, or other unintended consequences. As such, we recommend a task force to dive deeper into the issues and make tailored policy recommendations.

Prior Authorization Reform (S.2881 §§ 113, 117, 119; H.4653 §§ 266A)

As the Medical Society noted, together with our colleagues from the Massachusetts Health & Hospital Association and Health Care for All, hospitals and physician practices across the Commonwealth are facing unprecedented capacity and workforce issues while patients continue to face barriers to care. We must address the underlying issues contributing to the challenges that affect the sustainability of medical practices and hospital systems. With the current crisis at Steward Health Care, these legislative proposals appropriately focus on addressing the ways in which private equity and the financialization of health care affects patients and our health care system. These trends, however, are a symptom of a destabilized system, not the cause.

One pervasive issue plaguing our health care system that must be addressed is excessive prior authorization practices imposed by insurance carriers, which are harming patients, increasing practice costs, and driving burnout in the physician and provider communities. According to the HPC, they are a significant part of the "administrative and operational burdens on physician practices [that] often accelerate retirements, contribute to the sale of a practice, or make arrangements with management services organizations attractive."

The Medical Society appreciates inclusion of several policies aimed at addressing prior authorization and believes current proposals could be strengthened for the benefit of patients, physicians and providers, and hospital systems. We support a framework for prior authorization reform that will:

- Improve timely access to care by establishing a 24-hour response time to authorize "urgent care".
- Promote and improve patient continuity of care by ensuring that patients who are stable on medications or a course of treatment are allowed to maintain uninterrupted access to that care for 90 days during the transition to a new health plan and requiring approvals to last for the duration of prescribed treatment or at least one year;
- Improve transparency by requiring plans to disclose the treatments, services, and medications subject to prior authorization and to submit to the Division of Insurance on an annual basis data relating to approvals, denials, appeals, wait times, and more consistent with federal requirements established by CMS that will go into effect in 2026;
- Alleviate administrative burden on practices and patient care delays by prohibiting retrospective denials and requiring that if insurance carriers do not respond to prior authorization requests in the statutorily prescribed timeframes, those requests are deemed approved; and
- Promote further objective, data-informed policy reforms through a government agency led task force to make targeted policy recommendations to improve timely access to care and reduce administrative burden. Respectfully, the Mass Collaborative has been working on updating PA forms and exploring simplification processes for over a decade, but has not yet solved for this problematic issue. We believe the HPC, in collaboration with CHIA and informed by data from the DOI, is best suited to make objective recommendations consulting with members of the Massachusetts Collaborative, the executive office of health and human services, health care providers and payers, and other health care experts as appropriate.

Primary Care Task Force (S.2881 § 116)

We have a primary care crisis in the Commonwealth. We support establishing a task force to study primary care access and delivery and make recommendations to improve equitable access and affordability of primary care services. This effort is sorely needed, as a high-functioning primary care system is critical to the overall health care system and is key to improving health outcomes, lowering costs, and ensuring equitable access to care.

Licensure of Office-Based Surgery Centers (S.2881§ 94; H.4653 § 121)

There is not a strong public policy purpose for licensing office-based surgery centers (OBSCs). The quality of care and patient outcomes from OBSCs are commensurate to those with ASCs/hospitals. Moreover, BORIM already regulates OBSCs with stringent

guidelines and physicians are subject to oversight and discipline pursuant to these guidelines. Currently, office-based surgery centers represent a cost-effective alternative to hospital-based surgery. Imposing additional licensure, fees, and regulatory requirements will increase associated operational costs for OBSCs, thereby undermining their roles as a lower-cost alternative to hospital-based surgery.

Recognizing that OBSC practices have special considerations, such as size, staffing, and areas of specialty, the Joint Commission and the Accreditation Association for Ambulatory Health Care, among others, maintain reputable accreditation programs that provide standards for patient care, ongoing education, and resources. Should the legislature move forward with licensure for OBCSs, we recommend the licensure period be changed from 2 years to 3 years to align with the national accreditation cycle and to reduce administrative burden.

Placing BORIM Under DPH (S.2881 §§ 79, 80; H.4653 §§ 78, 79)

BORIM should remain independent. The Board has successfully operated independently, regulating the practice of medicine and promoting patient safety above all. BORIM already maintains a close working relationship with the Department of Public Health, which in practice reviews all proposed BORIM rules and regulations.

Thank you for your consideration of this important initiative. Please do not hesitate to reach out with any questions or if we can be of further assistance.

Sincerely,

Hugh M. Taylor, MD President	Barbara S. Spivak, MD Immediate Past President	Olivia C. Liao, MD President-Elect