



# MASSACHUSETTS MEDICAL SOCIETY

*Every physician matters, each patient counts.*

**TESTIMONY IN SUPPORT OF H.1101/S.678,  
AN ACT RELATIVE TO TELEHEALTH AND DIGITAL EQUITY FOR PATIENTS  
BEFORE THE JOINT COMMITTEE ON FINANCIAL SERVICES  
JULY 1, 2021**

The Massachusetts Medical Society (MMS) is a professional association of over 25,000 physicians, residents, and medical students across all clinical disciplines, organizations, and practice settings. The Medical Society is committed to advocating on behalf of patients, to give them a better health care system, and on behalf of physicians, to help them provide the best care possible. **We write in support of H.1101/S.678, An Act Relative to Telehealth and Digital Equity for Patients.**

The dramatic increase in telemedicine utilization prompted by the COVID-19 pandemic has underscored the vital role telemedicine plays in providing continuity of and improved access to care. Telemedicine has quickly become an essential part of the core health care infrastructure in the Commonwealth. This telemedicine legislation is an important next step, building upon the comprehensive framework laid out in chapter 260 of the acts of 2020 to promote equitable access to care through telehealth for all patients.

The overarching theme of this bill is focused on addressing issues of equity and access, which are well-aligned with the Medical Society's goals to advance patient health and well-being, prioritizing the most critical individual and public health areas, as well as to increase patient access to appropriate care, also with prioritized focus on vulnerable populations. The centerpiece of this legislation directs the Health Policy Commission (HPC) to establish two pilot programs – a Digital Bridge Pilot Program and a Digital Health Navigator Tech Literacy Pilot Program—to support expanded access to telehealth technologies and technological literacy for patients. The Digital Bridge program aims to increase access to telehealth services through investments in telecommunications services, broadband and internet connectivity services, and digital technology. The Tech Literacy program directs HPC to engage with community health workers and other professionals who can act as telehealth navigators for underserved and elderly populations who may need greater assistance in accessing telehealth services. Another important equitable measure contained in this legislation requires insurers to cover interpreter services for patients with limited English proficiency and for those who are deaf or hard of hearing. With increased utilization of telehealth comes the opportunity to reduce racial, socio-economic, and other inequities in access to care and health outcomes, but only if we are intentional about building policies that identify and address barriers to accessing care via telehealth for communities that have historically faced traditional barriers to in-person care. These pilot programs support investment in equity that can be built upon in the future and help ensure that our telemedicine policies support access to care for all.

Importantly, this legislation also creates a task force to study the interstate medical licensure compact (IMLC) and licensure reciprocity. Whether physicians can continue to see their patients via telehealth across state lines is one of the top concerns of MMS members. The IMLC can be a useful mechanism to streamline multi-state licensure for some physicians; for example, the IMLC may benefit physicians who live near a neighboring state and see patients across state lines, or the specialist who contracts with an out-of-state hospital to provide specialty care via telemedicine. However, the IMLC was created in 2014, long before telemedicine became widely adopted as a mainstream delivery modality because of the COVID-19 pandemic. While it may benefit physicians and patients in some

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circumstances, the IMLC may not address the licensure challenges the majority of physicians face today in seeking to provide continuous care via telemedicine to their patients, wherever they may be located. The IMLC does not necessarily provide a viable solution to the physician whose patients increasingly live, work, and travel in different states, but who seek to maintain a relationship with their trusted physician in Massachusetts. Given the widespread adoption of telemedicine and high levels of patient satisfaction in accessing care virtually, MMS seeks further exploration into alternative licensure-reciprocity models that better suit the needs of physicians and patients today. Specifically, the Medical Society supports exploration of an initial regional approach to licensure reciprocity that would allow MA-licensed physicians to provide care via telemedicine across state lines to their patients with whom they have an established clinical relationship.

Another important provision in this legislation prohibits insurers from imposing prior authorization requirements on medically necessary telehealth visits that would not apply to in-person visits. The Medical Society strongly believes that at its core, 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 requisite standard of care. Telemedicine has the power to improve access to health care by removing physical and logistical barriers for patients. We strongly encourage the state to explore and implement critical safeguards to ensure that we do not create new barriers to accessing care through telemedicine by allowing unfettered, unnecessary, or burdensome utilization review and prior authorization requirements. Prohibiting the use of prior authorization for services delivered via telehealth only to where it is required for that same service delivered in-person is a sensible limitation. Appropriate limitations on the utilization management protocols is not only critical in telehealth, but relates to broader policy concerns relative to the use of prior authorization and other utilization management techniques. The Health Policy Commission has consistently highlighted concerns associated with prior authorizations, including barriers to care and unnecessary administrative burden, and targeted this area for reform. A recent AMA study noted that “medical practices complete an average of 40 prior authorizations per physician, per week, which consume the equivalent of two business days (16 hours) of physician and staff time. To keep up with the administrative burden, two out of five physicians employ staff members who work exclusively on tasks associated with prior authorization.” It is imperative that we do not allow overuse of prior authorization to create barriers to accessing care via telehealth.

Lastly, this legislation removes the sunset dates for reimbursement parity for telehealth services contained in c. 260, putting all other services on par with behavioral health services. Telehealth utilization surged during the COVID-19 pandemic; current utilization rates, alongside high rates of physician and patient satisfaction, indicate that telehealth has become a permanent modality for health care delivery in the Commonwealth. The legislature recognized the importance of promoting access to behavioral health services via telehealth by requiring parity in reimbursement for said services. We would contend this should extend to all services that can appropriately be delivered via telehealth, especially services delivered through synchronous technologies, whether they be interactive audio/visual or audio-only technologies.

In fact, the Medical Society strongly urges against differentiating between interactive audio-visual technology and audio-only technologies and would instead recommend approaching differential reimbursement as it applies to synchronous v. asynchronous technologies. In terms of these synchronous technologies, MMS would encourage the legislature not to consider not the specific technology, but rather on more salient considerations, including the medical complexity and medical judgment involved, the overall time spent on the patient encounter, and the services provided. Telehealth visits that are audio-only v. audio-visual may still require the same expertise, the same follow up, order entries, etc. that an in-person visit requires and should be compensated similarly. Moreover, in crafting reimbursement models, we must be careful not to create bright-line distinctions that may codify policies that perpetuate racial disparities and other forms of discrimination into our payment system, further exacerbating inequities in access to care for patients. Distinguishing real-time audio-only would increase disparities in care and be discriminatory in the case of patients – particularly elderly, differently-abled, and patients of color or those with low-incomes – who only have telephone access or are not able to use more advanced

communications devices including smartphones, tablets, laptops, etc. or who do not have broadband access.

As such, the Medical Society would urge a favorable report of H.1101/S.678. Thank you very much for your consideration of these important issues. We appreciate the opportunity to offer these comments.