The Massachusetts Medical Society is a statewide professional association of over 25,000 physicians, residents, and medical students across all clinical disciplines, organizations, and practice settings. The Medical Society advocates 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. Physicians in Massachusetts are among the most crucial providers working toward optimal health care for all patients in the Commonwealth. Physicians also play a central role in the state’s health care cost containment efforts and have demonstrated both commitment and ability to manage and contain total medical costs while continuing to provide the highest quality of care for their patients. The Medical Society stands in strong support of initiatives that seek to further those goals in the most efficient and effective manners. The Medical Society commends Governor Baker for filing Senate bill 2774, An Act investing in the future of our health, which offers solutions to many vital issues facing the patients and providers across the Commonwealth. Our positions and concerns relative to numerous key features of S.2774 are outlined below.

**Primary Care and Behavioral Health Investment**

The Medical Society strongly supports the intent behind Governor Baker’s proposal to invest in primary care and behavioral health as necessary and transformational; however, we remain concerned about the lack of guidance relative to most appropriately and equitably achieving such a significant increase in spending on these services over such a short period of time, especially in light of the incredible strain on the health care system at this time. Investments in primary care can promote higher quality and lower-cost care across the health care system. The role of the primary care provider in coordinating care is key, especially for increasingly aging population with high rates of chronic disease and for the pediatric population, where primary care providers can address adverse childhood experiences and promote optimal health and development at crucial points in a child’s life. Investing in a better integrated and more highly coordinated behavioral health system is also necessary to improve overall health and health outcomes.

While positive experiences in other states are instructive, many important details about this proposal remain unanswered. **How will ‘primary care’ be defined? Could the organization-specific provisions in this legislation unintentionally penalize current systems that have a much higher primary care spending baseline?** To help answer those questions, the Medical Society looks forward to engaging with the legislature to develop definitions and processes that will most appropriately and effectively advance the underlying goals of this bill.

The unknowns in this proposal are fundamental to understanding the impact that this policy will have on the health care delivery system in Massachusetts. Mandating a thirty-percent expenditure
increase while keeping total health care expenditure growth below the HPC’s cost growth benchmark creates a zero-sum game without additional, outside investment. As such, this policy initiative may harm medical practices that are struggling to remain afloat; dealing with significant backlogs in care caused by the necessary deferral of care during the early phases of the pandemic; encountering workforce challenges brought on by workforce shortages and historic increases in costs of labor; and facing overall expense growth resulting from extraordinary inflation and new demands on the pandemic-related practice of medicine. These challenges are underscored by CHIA’s recent Annual Report, which showed spending for physician services decreased by 12.0% in 2020. Further detail is needed regarding how money should be invested, and, perhaps most importantly, how the investments are to be evaluated. Any such proposal to increase spending in primary care and behavioral health must be accompanied by a plan for patient-centered evaluation that ensures patients will not bear any of the cost burden of this increased investment.

The Medical Society strongly supports the creation of the Primary Care and Behavioral Health Trust Fund, which would offer payments to qualifying to primary care and behavioral health providers with a high public payer mix located in underserved communities for the purpose of funding projects designed to advance health equity within local communities within the Commonwealth. This dedication to funding these providers is critical to promoting health equity in Massachusetts.

**Out-of-network Billing**

Right now in Massachusetts, patients are protected from surprise out-of-network (OON) medical bills by the federal No Surprises Act (NSA); and, as such, we oppose provisions in S.2774 that establish redundant OON rules that will only complicate and add cost to our health care system. The NSA protects patients by banning surprise out-of-network bills, and it also establishes a fair process for resolving billing disputes between insurers and physicians, which promotes sustainability and viability of the Commonwealth’s robust insurance market. An additional state law would unnecessarily create two very different systems for resolving payment disputes – one for ERISA-regulated plans and one for state-regulated plans – creating unnecessary confusion and administrative complexities.

We already see these challenges playing out as we work with the legislature to reconcile overlapping and competing notice and price transparency provisions contained in both the NSA and the Patient’s First Act (Ch. 260 of the Acts of 2020). The conflicting state requirements put physicians and providers in a difficult position as they attempt to navigate the complicated interplay between the state and federal requirements. The legislature has helpfully delayed implementation of the Chapter 260 state requirements and we greatly appreciate the commitment to finding a solution to better align our state requirements with the federal law so as to lessen the burden on providers and eliminate redundant and confusing information that is required to be given to patients. Amendments to the existing state notice requirements, as proposed in Section 36 of S.2774, will only further complicate the matter.

Not only is the OON proposal (Section 72) unnecessary but, as a policy solution, it is vastly inferior to the NSA, which establishes a thoughtful process for resolving payment of OON providers. First, it provides an initial qualifying payment and then, if that payment is not adequate or is denied, payment can be resolved through an independent dispute resolution (IDR) process. Instead of this balanced approach, S.2774 establishes a default payment rate of reimbursement for unforeseen
OON services, allowing insurers to reimburse certain OON services at carriers’ own median in-network rates, with no IDR process to settle reimbursement disagreements. Such a process treats health care services with a one-size-fits-all approach that does not appropriately consider important factors contributing to the valuation of care, including: the acuity of patients/complexity of cases; training, experience, quality, and outcome measurements; and market share of the parties. The default rate approach undoubtedly tips a delicate balance, giving insurers undue negotiation leverage, with little incentive to negotiate in good faith with physician practices. The lack of an IDR process leaves providers without recourse for pursuing exceptional cases requiring payment above the median in-network rate. Furthermore, setting this default rate at the carrier’s own median in-network rate gives complete control to insurers, as they will know that any resulting out-of-network billing dispute will be reimbursed at increasingly lower default OON rates. Provider-Carrier negotiations will quickly become a “take it or leave it” proposition, allowing insurers to lower their in-network rates each year and to pressure physicians to accept their proposed rates without any recourse for failure to contract. This proposal will lead to reduced rates for all care, which would significantly jeopardize the sustainability of many physician practices, leading to continued consolidation and threatening access to care for patients across the Commonwealth.

Instead, the Medical Society supports deference to the NSA to ease the burden of implementation and to make physician compliance less administratively burdensome, while providing a system of OON reimbursement that is more equitable and more sustainable than one that is based on an inappropriate default rate and which lacks IDR. The infrastructure for an OON billing solution is already in place, and the state would be wise to allow the NSA to govern this issue in Massachusetts.

**Administrative Simplification & Quality Measure Alignment**

*The Medical Society supports Governor Baker’s proposal to better align health care quality measures.* Section 1 establishes a task force to address quality measure alignment by creating a single set of core measures of health care provider quality and health system performance. Streamlining quality measures will reduce waste and administrative complexity, ultimately slowing cost growth. We are concerned, however, that Section 1 also allows for the creation of a “set of non-core measures” which can also be used in contracting. Alignment is only truly beneficial if it reduces both redundancy and the overall number of quality measures on which physicians are required to report. If the non-core set becomes a catch-all for all non-core measures that insurers still wish to utilize, then the Taskforce will not make a meaningful impact on the waste that is associated with the proliferation of quality measures.

*Additionally, the Medical Society supports the proposal to transition from the use of the paper-based Medical Order for Life-Sustaining Treatment (MOLST) system to the use of the electronic Portable Order for Life-Sustaining Treatment (ePOLST).* This transition will give health care providers better access to these important documents so that they can better understand their patients’ personal health care goals in a timely fashion.

*MMS opposes section 70,* which repeals an existing statute that prohibits carriers from requiring a provider to participate in a new select network or tiered network plan that the carrier introduces. In effect, this section would allow carriers to create a new network plan and contractually mandate providers to opt in.
**TELEMEDICINE & PHYSICIAN LICENSURE**

The Medical Society strongly supports section 37 of S.2774, which helpfully clarifies BORIM policy authorizing providers to render telehealth services without limitation to location or setting, so long as the provider is compliant with federal and state licensing requirements of the state in which the patient is physically located. This clarification will preclude undue restrictions placed by insurers on where providers can provide care to patients via telehealth. Of course, this bill also requires conformance with the standard of care that is applicable to the same services as if they were rendered in person, which is critical to ensure that patients continue to receive the highest quality of care. There is, however, more to be done to build 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. For example, S.2774 omits parity in reimbursement, which is critical to enabling physician practices to invest in telehealth technology, staffing, and other requirements to successfully maintain access to care through telehealth services. At its core, the use of telemedicine is about expanding access to care for patients; but, without parity in reimbursement, the expansion of telemedicine will remain unjustifiably limited.

The MMS offers nuanced support for Section 53, which contains enabling language for Massachusetts to join the Interstate Medical Licensure Compact (IMLC) but cautions that the IMLC is not the optimal solution to today’s licensure challenges. Physicians’ ability to continue seeing their patients via telehealth across states lines is a top priority 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 the state line and regularly see patients in a different state 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 the COVID-19 pandemic changed the health care delivery environment and made telemedicine a mainstream delivery modality. While the IMLC may benefit physicians and patients in certain circumstances, it does not address the licensure challenges that many physicians currently face when seeking to provide continuous care to their patients via telemedicine, wherever they may be located.

In particular, the IMLC does not necessarily provide a viable solution to the physician whose patients increasingly live, work, and travel in multiple states but who seeks to maintain a relationship with their trusted physician in Massachusetts. While the IMLC streamlines the licensing process, it does not eliminate the administrative burden of obtaining and paying full-licensure fees in multiple states. Given the widespread adoption of telemedicine and high levels of patient satisfaction in accessing care virtually, MMS strongly urges the legislature to set up a task force to explore alternative licensure-reciprocity models that better suit the needs of patients and physicians in today’s digital nomad environment. Specifically, the Medical Society supports exploration of a regional approach to licensure reciprocity that would allow Massachusetts-licensed physicians to provide care via telemedicine across state lines to the patients with whom they have an established clinical relationship.

**PRESCRIPTION DRUGS**

The Medical Society supports the numerous provisions in S.2774 that shed light on the opaque pharmaceutical pricing process, subject pharmaceutical manufacturers and PBMs to the Health Policy Commission’s cost trends oversight, and impose strong penalties for excessive drug price increases. High prescription drug costs are a major impediment to patients’ access to medically indicated care and a major priority
for the Medical Society. CHIA’s latest Annual Report shows, yet again, that prescription drug spending continues to be a major driver of cost growth; from 2019-2020, among the four largest service categories, prescription drug spending was the only one to experience cost growth, with gross pharmacy spending increasing by 8.2% in 2020, a 7.7% increase net of rebates. For the physician community, the high costs of prescription drugs do not just strain global budgets or health care systems, they also impact patients directly and prevent patients from achieving the highest attainable standard of health and quality of life. Senate bill 2744 takes strong steps toward addressing the soaring prescription drug costs in the private market by imposing transparency and accountability in the pharmaceutical industry, specifically for manufacturers, pharmacy benefit managers (PBMs), and pharmacists.

Physicians are keenly aware of the value of prescription drugs and their development – innovation in pharmaceutical medicine helps physicians improve patient outcomes and quality of life – but when those gains are threatened because the cost of medicine becomes a substantial barrier, we know the system is flawed and in need of reform. Overall, these provisions in S.2774 strike an appropriate balance that will maintain continued support for innovation while ensuring affordability for patients in our Commonwealth.

**Scope of Practice**

*The Medical Society opposes expanding scope of practice authority for physician assistants and podiatrists.* Our current laws and regulations maintain an important balance between ensuring access to high quality care and allowing independence and flexibility for physician assistants to care for patients. Physicians deeply value the important care that all members of the health care team provide to patients and therefore support team-based care that already sees physician assistants provide clinical care at the top of their license with physician guidance available as needed. Current requirements for supervisory relationships work well within physician-led teams structured to deliver the highest quality patient care. Patients should continue to the benefit from our law’s longstanding patient protections that safeguard the highest quality of health care. Our current laws do just that by ensuring physician assistants are appropriately supervised by physicians. S.2774 establishes a vague concept of working "in collaboration" with a registered physician as an alternative to a supervisory relationship, while still maintaining legal responsibility on the employing physician or facility – a proposal rejected by the Massachusetts Association of Physician Assistants. Accordingly, we oppose the proposed expansion of scope of practice for physician assistants.

The Medical Society also opposes S.2774’s expanded scope of practice for podiatrists, whose specialized education and experience situate them particularly well to care for a specific area of patients’ bodies. To expand their care beyond that for which they have adequate training and education would be an overreach that unnecessarily puts patient wellbeing at risk. For that reason, MMS opposes the expanded scope of practice provisions for podiatrists in S.2774.

**Conclusion**

The Medical Society commends the Governor on his steadfast dedication to health care cost containment and greatly appreciates the opportunity to provide comment on this thoughtful, comprehensive legislation. We look forward to continuing to engage with the Health Care Financing committee, as well as other key stakeholders and the legislature at large, to find the best path forward to contain health care costs and promote a system that continues to provide high-quality care for the patients of the Commonwealth.