



MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

**TESTIMONY IN SUPPORT OF H.986/S.655,
AN ACT RELATIVE TO TELEHEALTH AND DIGITAL EQUITY FOR PATIENTS
BEFORE THE JOINT COMMITTEE ON FINANCIAL SERVICES
MAY 2, 2023**

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.986/S.655, An Act Relative to Telehealth and Digital Equity for Patients.

The dramatic increase in telehealth utilization prompted by the COVID-19 pandemic underscored the vital role telehealth plays in providing continuity of care and improving equitable access to health care by helping patients overcome traditional barriers to in-person care. This is strongly supported by data released by the Health Policy Commission (HPC) showing how critical telehealth has been to maintaining and improving access to care for patients while not increasing cost in the system overall.¹ The HPC report on telehealth utilization also contains numerous policy recommendations, which align with many of the provisions of this legislation, which we believe is a critical 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.

To promote the sustainability of telehealth as a key care delivery modality, 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. We believe this is essential to supporting physicians' ability to continue offering care via telehealth. The requirement for payment parity for primary care and chronic disease management services delivered via telehealth expired at the end of 2022. For now, Blue Cross Blue Shield of Massachusetts will continue to pay at parity for these services, regardless of a statutory mandate. MMS applauds such policies, as we believe they recognize the importance of equitable reimbursement as foundational to the sustainability of providers' ability to offer care via telehealth and to continue to invest in technology and innovate in the digital health space. However, other major commercial insurers have slashed reimbursement across the board. This variation in payment for commercial plans, with some continuing to pay at parity and others regressing to pre-pandemic payment policies for telehealth, which leads to confusion and instability for providers and ultimately decreased access to care for

¹Health Policy Commission, TELEHEALTH USE IN THE COMMONWEALTH AND POLICY RECOMMENDATIONS, Report to the Massachusetts Legislature, JANUARY 2023, *available here* <https://www.mass.gov/doc/telehealth-use-in-the-commonwealth-and-policy-recommendations/download>.



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patients. Long-term, stable reimbursement policies across payors and predictability for providers and patients is essential, as a patchwork of varying payment policies across carriers leads to confusion and instability for providers and decreased access to care for patients.

MassHealth continues to be a leader in telehealth, setting a standard of broad coverage and payment parity across the board — policies that have enabled providers to invest in telehealth and virtual care. This policy reflects the clinician experience of telehealth utilization and the impact on patient access to care. This legislation would make that policy permanent. We believe this is fair and appropriate, as patients are receiving the same high-quality care regardless of the modality and physician practices, the majority of which are hybrid, continue to carry the same practice costs, which are incredibly challenging at the moment, including increased labor costs and other fixed costs such as rent and equipment. 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. For example, telehealth has been critical to improving access to specialty services in regions like the Cape, where access to specialty care is severely limited. Reduced reimbursement for specialty services may limit access to those services in geographically underserved regions. Notably, the HPC recommendation differs slightly here, calling not for permanent codification of payment parity, but instead for extending payment parity for primary care and chronic disease management services (which expired at the end of last year) for at least 2 more years, consistent with Medicare. We also support the HPC's recommendation as an intermediary step to allow for more data collection to inform and develop more permanent payment policies.

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 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.



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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 and the HPC's policy recommendations 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. Importantly, 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 circumstances, the IMLC may not address the licensure challenges most 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.



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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.

For these reasons, the Medical Society strongly urges a favorable report of H.986/S.655. Thank you very much for your consideration of these important issues. We appreciate the opportunity to offer these comments.