ataACTION
Telehealth Policy to Transform Healthcare

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State Representative John Lawn
House Chair, Joint Committee on Health Care Financing
24 Beacon St.
State House, Room 236
Boston, MA, 02133
john.lawn@mahouse.gov

State Senator Cindy F. Friedman
Senate Chair, Joint Committee on Health Care Financing
24 Beacon St.
State House, Room 313
Boston, MA, 02133
cindy.friedman@masenate.gov

RE: ATA ACTION CONCERNS WITH SENATE BILL 2881 SECTION 100, PROPOSING NEW SECTION 4B WITHIN CHAPTER 112

Dear Members of the Conference Committee on S2881 & H4643,

ATA Action believes in improving the access and quality of care for patients in Massachusetts and supports broader intent and many of the proposed safeguards in both House bill 4653 and Senate Bill S2881 before the Conference Committee. However, ATA Action and the over 400 organizations we represent have serious concerns about Section 100 of Senate Bill 2881 (adding a new section to Chapter 112, "Section 4B"). We believe the blanket prohibitions in the proposed Section 4B on how management service organizations and provider groups interact may have severe unintended consequences for a subset of the healthcare industry that may not have been considered by the drafters of this section. We request this Committee to not include Section 4B created by Section 100 in the final Conference Committee report and bill without additional stakeholder input on these mandates and the necessary refinement that this language warrants.

ATA Action, the American Telemedicine Association's affiliated trade association focused on advocacy, advances policy to ensure all individuals have permanent access to telehealth services across the care continuum. ATA Action supports the enactment of state and federal telehealth policies to secure telehealth access for all Americans, including those in rural and underserved communities. ATA Action recognizes that telehealth and virtual care have the potential to truly transform the health care delivery system—by improving patient outcomes, enhancing safety and effectiveness of care, addressing health disparities, and reducing costs—if only allowed to flourish.

Many telehealth medical practices serving Massachusetts patients – similar to those that deliver care in-person – operate using a model where non-physicians (or "lay entities") provide administrative support to a provider or group practice, while the provider controls all clinical decisions, protocols, and patient care. This "PC-MSO model" allows telehealth providers to focus their time and expertise on patients and contract out to other personnel nonmedical duties, including billing, credentialing, and contracting, to other personnel.

The MSO and PC Model's division of responsibility between medical and administrative tasks ensures that providers have support navigating the complex legal and regulatory requirements involved in telehealth, helps physicians reach more patients by assisting in scaling their practice, and maintains quality assurance of the technology involved in the telehealth service. Ultimately, these advantages result in decreased health care costs, legally compliant healthcare, increased access to safe healthcare, and higher quality of care. Importantly, this structure has also provided a way for innovative technologies and medical providers in Massachusetts to develop new care delivery models, including emerging telehealth companies capable of reaching stigmatized communities and individuals in Massachusetts.

ATA Action has significant concern that Section 100 of the bill, which creates new Section 4B within chapter 112 of the Massachusetts Code, would unnecessarily jeopardize this long-established PC-MSO model and disrupt access to care for thousands of Bay Staters currently being served by telehealth entities. Section 4B proposes several sweeping mandates that would upend and prohibit how currently compliant telehealth provider entities contract with lay entities for business operations, non-physician expertise, and investment.

Specifically, Section 4B would (1) prohibit non-physicians from any input or contractual safeguards in the leadership of the medical practice they invest in and support; (2) prohibit health care practices from holding any ownership interest, or direct and indirect control over an affiliated MSO; (3) ban physicians from serving as clinical directors at an MSO for which the MSO provides services to the same clinical practice; and (4) confer broad authority to the Department of Public Health and the Health Policy Commission to create a wide range of new, consequential regulations which may not even be contemplated within this legislation. We believe these provisions will have the unintended consequence of stifling investment in the advancement of telehealth, which will undoubtedly slow or prevent telehealth from positively impacting patient outcomes, safety and effectiveness of care, health disparities, and costs.

Proposed Section 4B's Broad Language Will Constrain Innovative Care Delivery Models

Turning to the specific concerns with proposed newly created Section 4B from Section 100 of S2881. First, ATA Action believes the prohibition (Section 4B(c), lines 2171-74) on medical corporations from entering into any contracts which include succession agreements will significantly chill meaningful and well-intentioned investment into the healthcare innovation sector and in physician practices that are facing increasing cost pressures and an increasingly

complicated administrative environment. As legal commentators have highlighted,[1] physician practices seeking to attract investment will find doing so challenging if non-physician investors have no safeguards to limit financial risk. The ability for non-physician lay-entities to invest and partner with physicians in new healthcare ventures—while at the same time ensuring physicians have control over treatment and patient care decisions—need not be mutually exclusive endeavors. ATA Action recommends taking an approach focused on empowering physician control over actual treatment decisions and care, rather than an approach that restricts their ability to attract and partner with growth investors.

Indeed, ATA and ATA Action's membership includes physician groups, technology companies, and investors who have partnered to innovate, build, and deploy new and affordable models of care delivery that are currently serving Massachusetts patients and addressing workforce shortages. The potential negative impacts of this legislation cannot be understated, particularly for burgeoning telehealth companies that are treating patients in fields where innovation is desperately needed, like behavioral health reproductive health, substance use disorder treatment, gender-affirming care, and chronic condition management. Scaling down investment in these delivery models – and demanding resource intensive changes that will be unique to this state– will reduce Massachusetts patients' easy and efficient access to the quality health care services they deserve at a time when it is needed most.

Second, ATA Action has concerns for how the Act bans any shareholder or director of the medical corporation from also being employed by or holding any shares in the contracted MSO (Section 4B(d) and (e), lines 2203-06, 2192-94; except in limited circumstances). Many ATA and ATA Action member entities currently have a physician who is a director or shareholder in a professional medical corporation who also serves as a clinical director or holds a management role in an MSO (the MSO in turn manages the administrative functions and owns the technology powering the telehealth visit). These clinical directors, who bring a wealth of practice experience and a day-to-day perspective of the professional medical corporation, are crucial for ensuring that MSOs understand the effects their business decisions can have on the patients who seek care through their platforms as well as the needs of providers who use the platform to deliver high quality services. Rather than physicians being totally detached and isolated from the MSO infrastructure supporting and helping to grow the medical practice, many telehealth entities have found that having a physician affiliated with both the medical corporation and the MSO improves decision making, provides direct and open lines of communication, and leads to heightened patient and provider satisfaction.

Unfortunately, by eliminating the ability for Massachusetts licensed practitioners to continue as both practitioners and as in-house advisors to their contracted MSOs or telehealth platforms, Section 4B would prohibit, or at best significantly frustrate, the ability for these MSOs to include this extensive practical knowledge base at the boardroom table. ATA Action acknowledges that

[1] Pending Oregon Law Undermines Traditional Physician Practice Structure, Feb 16, 2024, (here).

under certain circumstances these dual roles can and have posed conflicting ethical duties for physicians. Rather than broadly prohibiting physicians from entering contracts they deem appropriate; ATA Action encourages legislators to mitigate these concerns through enforcing existing ethical guardrails and/or requiring the parties clearly delineate and agree to the separate responsibilities.

Third, ATA Action is concerned with the broad authority granted to the Department of Public Health and the Health Policy Commission to construct any additional rules and prohibitions they deem appropriate in addition to those proposed by the legislature, which could be equally as problematic as those discussed above. (See lines 2153-2156, 2163-2166, and 2186-2189) In order for Massachusetts physicians to attract investment in their clinics there needs to be a sense of regulatory consistency over the long-term future, particularly when such new regulations directly relate to the economics of that investment. Allowing a regulatory agency sweeping power to affect those investments—and adopt rules legislators themselves may forgo in this bill out of caution—will add to the chilling effect of Section 4B on investment in the Commonwealth.

Recent Efforts in Oregon Showcase Need for Further Stakeholder Input

ATA Action is not aware of any state with a framework—including "strict" corporate practice states like New York, California, or Texas—that include the sorts of sweeping mandates proposed in Section 4B. There is a good reason for this: the language and untested concepts proposed here would in practice seem to prohibit or severely limit the ability for medical practices to contract with management and administrative service providers or attract investment, despite some proponents' claims to the contrary.

Recent legislation in Oregon, House Bill 4130, is a testament to the complexity of these proposals and potential for unintended consequences, particularly for emerging healthcare entities. During Oregon's 2024 legislative session, the initial draft of HB 4130 contained nearly identical proposals to those in Section 4B to regulate PC-MSO relationships.[2] HB 4130 was met with sweeping criticism across the healthcare industry, from Oregon hospitals, local clinicians, and telehealth providers, as well as investors with decades of experience successfully partnering with Oregon clinician practices to expand access to care in the state.

After months of discussions between stakeholders and the sponsor—as well as 11 separate substitute amendments offered by the sponsor to correct issues with the bill—HB 4130 still failed to pass out of the legislature. Subsequently, the sponsor has held five summer stakeholder meetings focused on redrafting the bill, with dozens of interested groups participating and listening in on the discussions.

[2] Oregon House Bill 4130, 2024 Regular Session, (here).

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The experience in Oregon instructs that these complicated proposals with possible wide-ranging and unintended consequences deserve broad public comment and time for review, rather than a rushed process. ATA Action therefore encourages Massachusetts legislators to first hold a meaningful process for seeking out stakeholder input on Section 4B's proposed restrictions and mandates before adopting them this session.

Conference Committee Should Focus on Targeted Reforms

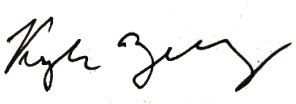
Finally, ATA Action supported Senator John Cronin's proposed amendment 142 to exempt telehealth entities from the problematic aspects of the legislation discussed above, which will be a positive development for some of our membership. However, this proposed amendment will not apply to our members who maintain brick-mortar locations so that they can provide a holistic range of services outside of telemedicine. This amendment would make it impractical for these telehealth providers to expand their offerings to in-person care services where clinically appropriate. ATA Action believes that state health policy must be technology, modality, and site-neutral and requests that any amendment to exempt telehealth entities include those with a physical presence in the state.

ATA Action understands legislators wish to introduce new oversight and address recent disruptions in access to healthcare due to the collapse of one of the commonwealth's largest institutional providers. To that end, ATA Action largely agrees there are some instances when non-physician entities and investors have plausibly failed to put the interests of clinicians and patients first.

However, the solution to these well-meaning goals is not to hastily implement these onerous, untested concepts in proposed Section 4B of Section 100 that will—whether intended or not—restrict the growth and development of innovative care models to Massachusetts patients. Now is not the time to enact barriers to care. Rather, we encourage the Conference Committee to focus on transparency, such as those proposals included in the House and Senate versions of this legislation and possibly new guardrails to ensure clinicians have ultimate decision-making authority over patient care decisions.

ATA Action thanks you for your time and interest in telehealth. If you have any questions or would like to discuss further the telehealth industry's perspective, please contact me at kzebley@ataaction.org.

Kind regards,



Kyle Zebley
Executive Director
ATA Action

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cc:
Assistant Majority Leader Frank Moran - frank.moran@mahouse.gov
State Representative Hannah Kane - hannah.kane@mahouse.gov