Jeremy D Sherer Associate
jsherer@health-law.com
Hooper, Lundy & Bookman, PC, Boston

Telemedicine in Massachusetts: an update

Here Jeremy D. Sherer, Associate at Hooper, Lundy & Bookman, summarises the state of affairs in Massachusetts regarding telemedicine, explaining the recent legislative history that has brought us to this point. Jeremy outlines the differences, involving telemedicine, between the healthcare bills that the Massachusetts House and Senate introduced in the 2017-18 legislative session, and some of the important issues on which the House and Senate appear to now be in agreement.

The Commonwealth of Massachusetts has long been considered a leader in progressive healthcare policy in the US. Indeed, Massachusetts' 2006 healthcare reform law, colloquially known as 'Romneycare' in reference to then-governor Mitt Romney, laid the foundation for the Patient Protection and Affordable Care Act 2010 ('ACA'). Massachusetts is also home to some of the finest healthcare institutions in the US, among them Massachusetts General Hospital, the Dana Farber Cancer Institute, Boston Children's Hospital, Brigham and Women's Hospital and Beth Israel Deaconness Medical Center, to name a few. The Commonwealth attracts top healthcare and life sciences innovators, but remains one of the few states across the US that lacks meaningful telemedicine regulations today.

Thanks to a murky regulatory landscape regarding coverage, reimbursement and scope of practice issues, many providers in Massachusetts are hesitant to provide services via telemedicine.

Recent legislative history

In July 2018, the Massachusetts legislature failed to agree on far-reaching healthcare financing legislation that would have impacted as many as 50 discrete areas of healthcare policy, one of which is telemedicine. There were a number of differences between the bills that the Senate and the House respectively introduced that ultimately prevented the chambers from reaching agreement. Most notably, problems relating to healthcare price variation in Massachusetts, where certain providers receive higher reimbursement for services than other providers, sank the legislation. On telemedicine, however, the differences were far less stark. Thus, it appears that the telemedicine provisions of the 2018 legislation failed not because of insurmountable differences between legislators in the Massachusetts House and Senate, but rather because of circumstances having nothing to do with the legislation's telemedicine provisions.

Where are the differences?

The two main differences between the telemedicine provisions introduced by the Massachusetts House ('House Bill') and those introduced by the Senate ('Senate Bill') in the 2017-18 legislative session related to coverage parity and proxy credentialling.

Broadly, coverage parity refers to the notion that an insurer must cover services provided via telemedicine if the same service would be covered when delivered in person. The Senate Bill provided that insurers 'shall not decline to provide coverage for healthcare services solely on the basis that those services were delivered through the use of telemedicine by a contracted healthcare provider. Healthcare services delivered by way of telemedicine shall be covered to the same extent as if they were provided by way of in-person consultation or in-person delivery.'

The House Bill, meanwhile, contained an additional qualifier, requiring insurers to cover services provided via telemedicine only if 'the healthcare services may be appropriately provided through the use of telemedicine.' The language included in the House Bill could have granted payers more leeway to decline coverage for services delivered via telemedicine, under the theory that it is not appropriate for such services to be provided by those means. It also appears that the language in the House Bill would have prohibited MassHealth and MassHealth managed care organisations ('MCOs') or primary clinician plans from covering services provided via telemedicine if they would not - or could not - cover the same service when delivered in-person.

Specifically, the House Bill stated that such entities can provide coverage for services provided via telemedicine if 'the healthcare services are covered by way of in-person consultation or delivery.' While most services provided via telemedicine can also be provided in person, such as physician services, some necessarily involve the use of communications technology, such as the 'virtual check-ins' that the Centers for Medicare & Medicaid Services ('the CMS') recently proposed to cover in the 2019 Physician Fee Schedule Proposed Rule. If the language in the House Bill were adopted, it appears that MassHealth, MassHealth MCOs and primary care clinician plans would be prohibited from covering such services. The second area in which the House

Bill and the Senate Bill differed is proxy credentialling. Generally, in order for a physician to provide services at a hospital, that physician needs to be a member of the hospital's medical staff. Credentialling individual physicians is a time-intensive process, so both the CMS and the Joint Commission have established processes whereby a hospital whose patient is obtaining treatment from a remote provider can rely upon the credentialling process of the hospital at which the clinician is physically located, instead of going through its full credentialling process independently. This process is known as 'proxy credentialling.' The House and Senate Bills both addressed this issue, but differed as to whether non-physician clinicians can utilise proxy credentialling. While the Senate Bill called for 'licensees' to be able to obtain proxy credentialling and privileging for telemedicine services in addition to physicians, the House Bill referenced only physicians. Therefore, it appears that the language in the House Bill would have prohibited non-physicians from utilising proxy credentialling to provide services via telemedicine in Massachusetts.

What can we expect?

It appears that a consensus between the House and Senate has emerged on a number of important regulatory telemedicine issues, those discussed immediately above notwithstanding. Below is a list of issues on which the House and the Senate have introduced similar (or identical) language. While one can never be certain about the legislative process, it appears likely that these standards will be included when Massachusetts finally enacts telemedicine standards.

Defining telemedicine

Both Bills defined telemedicine as 'the use of interactive audio, video or other electronic media for diagnosis, consultation and treatment of a patient's physical, oral or mental health; provided however, that "telemedicine" shall not include audio-only telephone, facsimile machine, online questionnaires, texting or text-only e-mail.' This definition is more detailed than the pre-existing definition in the Board of Registration in Medicine's ('the Board') regulations, as it explicitly outlines the permitted - and prohibited - methods of communication that can be utilised to provide treatment via telemedicine. It also indicates that telemedicine can be utilised to treat physical, oral or mental health issues, indicating that behavioural health services are within the intended scope of this definition. The definition also explicitly excludes the use of online questionnaires from the definition of telemedicine, which is significant because an increasing number of start-up telemedicine providers have sought to provide services in this manner in recent years. If adopted, this language would prevent patients in Massachusetts from utilising such platforms. The Board's regulations, in comparison, define telemedicine as 'the provision of services to a patient by a physician from a distance by electronic communication in order to improve patient care, treatment or services.'

Coverage by private payers

Both Bills prohibited private payers from declining to cover healthcare services 'solely on the basis that those services were delivered through the use of telemedicine by a contracted provider' if such services are covered when delivered in person and it is clinically appropriate to provide them via telemedicine. On its face, this appears to mean that if a payer were to cover in-person psychiatric treatment, it would also need to cover those same psychiatric services when they are provided via telemedicine, so long as the treating provider (and, ultimately, the Board) believes that it is clinically appropriate to do so.

Coverage by MassHealth

The language in the bills would have permitted - but, notably, would not have required - Massachusetts Medicaid (MassHealth) and Medicaid MCOs to cover services provided via telemedicine. Particularly in light of the state's recent transition to increase the role of accountable care organisations (ACOs) in MassHealth, this will be an area for Massachusetts providers to follow.

Telemedicine practice standards

Neither bill addressed a number of the regulatory questions that will establish practice standards for practitioners treating patients via telemedicine in Massachusetts. Instead, deferring to the Board, the bills required the Board to 'promulgate regulations regarding the appropriate use of telemedicine to provide healthcare services.' Those regulations would cover important issues including prescribing medications, identifying services that cannot be appropriately provided via telemedicine, how a practitioner-patient relationship can be established via telemedicine, what consumer protection measures are needed, and how to ensure that telemedicine services are provided in accordance with the applicable standards of care, and as such leave quite a bit of discretion to the Board as to how expansive or limited the ability to offer telemedicine services would actually be in Massachusetts. Both Bills did state, however, that services provided via telemedicine will be subject to the same standard of care that applies when the services at issue are delivered in person.

Location requirements

Both Bills provide that a 'healthcare provider shall not be required to document a barrier to an in-person visit, nor shall the type of setting where telemedicine is provided be limited for healthcare services provided through telemedicine.' In essence, not requiring a provider to document a barrier to an in-person visit means that services can be sought via telemedicine because it is the patient's preference, not that there is necessarily some reason why the service cannot be provided in person. The omission of any location requirements means that patients would be eligible to receive telemedicine services from the home and other locations. This is particularly significant for patients with chronic conditions, limited mobility, or limited support systems, for whom traveling to obtain treatment is a challenge.

Conclusion

Despite its status as a leader in healthcare innovation in the US, Massachusetts remains one of the few states lacking meaningful telemedicine regulations as we enter the autumn of 2018. However, the Commonwealth does appear to be inching forward, and healthcare industry stakeholders should continue to monitor developments in the 2018-19 legislative session, when a telemedicine breakthrough could take place.