

Ten Health Policy Changes That Should Outlive COVID-19

By Josh Archambault, Senior Fellow

Introduction

Governor Baker recently announced that on June 15, the public health emergency declaration for COVID-19 will end in Massachusetts.¹ With that declaration ending, some new flexibilities in the health care system will come to an end as well. The COVID-19 pandemic has highlighted many of the barriers in health care that make care less patient-centered, more expensive, and more difficult to access. Massachusetts policymakers should learn from this and remove these barriers permanently.

Governor Baker helped by temporarily suspending some of the barriers during the pandemic, but his executive orders often did not go far enough. Encouragingly, the General Court has shown some early willingness to codify some of these new flexibilities into law, but often they have chosen to grant long-sought changes that were the source of much debate and lobbying pre-pandemic.²

It is imperative that lawmakers step back and reevaluate how to make our health system more flexible so we are ready for the next pandemic. But making the right changes would also save significant money for patients and small businesses struggling to afford health coverage. It is not an understatement to say the health—both physical and economic—of the Commonwealth depends on taking meaningful action now.

Recommended Policy Actions:

Telehealth/Telemedicine

1. Continue to ensure that any provider is permitted to utilize telehealth/telemedicine, including teledentistry and any emerging category of practitioners to allow for more team-based care.
2. Avoid telehealth mandates that increase costs and may not result in better outcomes.
3. Facilitate across-state-line telehealth.
4. Allow patients to opt into the most accessible technology for telehealth to ensure lower-income and rural patients have access.

Provider Flexibility

5. Flexibility on staffing ratios.
6. Allow any providers in good standing to register to practice in Massachusetts and receive a full license.
7. Allow more flexibility regarding where providers may practice.
8. Allow more providers to practice at the top of their license (i.e., liberalize scope of practice).
9. Make it easier for well-trained international medical graduates to come to Massachusetts.

Health System Flexibility

10. Raise expenditure floors and suspend or repeal Determination of Need rules for a more flexible health infrastructure.



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Josh Archambault is a Senior Fellow at Pioneer Institute. Prior to joining Pioneer, Josh was selected as a Health Policy Fellow at the Heritage Foundation in Washington, D.C. In the past, Josh served as a Legislative Director in the Massachusetts State Senate and as Senior Legislative Aide in the Governor's Office of Legislative Affairs. His work has appeared or been cited in numerous news outlets. He is the editor and coauthor of *The Great Experiment: The States, The Feds, and Your Healthcare*. Josh holds a Master's in Public Policy from Harvard University's Kennedy School and a BA in Political Studies and Economics from Gordon College.

Intelligent Embrace of Telehealth

The pandemic has highlighted the many benefits of telehealth. Virtual visits with a medical provider can save patients time and help them avoid germier waiting rooms. Providers cut down on their risk of exposure and can see more patients from an office or home. Even Massachusetts seniors have embraced telehealth, as roughly half of Medicare fee-for-service visits since the start of the pandemic were electronic, one of the highest rates in the country.³

Back in March, in a series of executive orders and agency actions, Gov. Baker started the discussion by removing barriers and allowing more providers to utilize telehealth in the state, and even across state lines in some circumstances—which was then expanded in subsequent orders.⁴

The orders allowed all in-network providers to use telehealth in Massachusetts.⁵ This cleared up any question about who could use telehealth, which is important as many non-physician providers make up the backbone of our medical system—nurses, nurse practitioners (NP), or physician assistants (PA) all help to allow physicians to focus on the most complex or sickest patients.

Telehealth Mandates Hurt Vulnerable Patients and Small Business

Unfortunately, those orders also included mandates for telehealth that required the same reimbursement rate as for an in-office visit and mandated that most services be covered. The state must avoid coverage and payment mandates as these higher prices are especially harmful to people with disabilities, those with chronic conditions, seniors, and lower-middle-class patients. The artificially inflated cost of a telehealth visit can result in them not seeking needed care and pricing vulnerable patients out of accessing care from the start, as many are paying out-of-pocket until their insurance kicks in.

For these populations, transportation is often a barrier to accessing care, but telehealth can help overcome that barrier. Thankfully, the legislature did act to expand telehealth under the leadership of Ron Mariano, who has since become speaker of the House. They avoided permanent payment mandates for most telehealth services, but did leave them in place for 90 days after the end of the state of emergency (which would be September 13, 2021). However, in the new law, payment parity is permanent for behavioral health, and parity will remain in place for two years for primary care and chronic disease management.

Removing these mandates or letting them expire is important because telehealth has real potential to save money for patients and small companies. Since 2000, general price inflation has been 50 percent, yet Massachusetts employees are paying 276 percent more toward their health insurance premiums.⁶ For those at small companies that are struggling now, telehealth is one of only a few opportunities to lower health care spending. Future mandates could ruin this low-hanging-fruit savings opportunity, including coverage mandates.

A comprehensive research review by MedPAC in 2018 found that telehealth can be a game changer for post-stroke care, and for treatments for physically disabling and treatment-intensive conditions.⁷ Yet for other services, the evidence of better outcomes is far less certain. The research suggests that telehealth coverage mandates may turn out to be a poor decision. This is not to say that only services that have proven track records should be covered, but insurers, employers, and publicly funded programs should have a choice in what they cover. They should be allowed to try innovative models to learn what works best for less and not be mandated to cover all services, especially if some return no value, which just drives up wasteful spending and cements into policy inequitable reimbursement rates and inefficient models of care delivery.⁸

Open the Door to Across-State-Line Telehealth

For years special interest groups and state boards have erected barriers to prevent or slow care across state lines unless a provider obtains a full license in the state where the patient is, which in turn has led to higher-cost services and limited access to the best providers in the world.

Imagine that a family member gets sick and the nation's leading expert on treating coronavirus works at the Cleveland Clinic in Ohio. You could not see the specialist unless that provider went through the time and expense of obtaining a full medical license in Massachusetts. (They could

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technically jump through a myriad of hoops to obtain a temporary license, but are unlikely to do so for one Massachusetts patient.) If you are wealthy, you could travel there and pay cash, but lower- or middle-income residents have no such option. This is discrimination based on geography and economic status. It is time to remove that barrier and allow a simple registration system for providers to allow for across-state-line telehealth.

Many like to compare Massachusetts to Minnesota when it comes to health care, and the land of 10,000 lakes has been allowing across-state-line care since 2015.⁹ Minnesota has one of the better telemedicine laws in the country. It requires physicians to register with the board, provide some basic information about their license and alert the board of any restrictions or negative licensing actions at any time. Doctors must pay a \$75 annual fee, but otherwise they can focus on delivering care to patients. Massachusetts would be wise to follow a similar model and apply the same flexibility to all providers, not just doctors.

This flexibility is good for patients, small businesses, and for Massachusetts-based health care companies that want to work with experts around the country to help Massachusetts patients. It also helps to prepare us for a future pandemic as remote providers can't get sick from patient contact and can engage more quickly than if they had to relocate to the state. Diseases pay no mind to state borders, so our laws need to be modernized to allow providers in good standing to deliver care from their state of primary practice when medically necessary. The Department of Public Health (DPH) granted full across-state-line practice during the pandemic on March 29, 2020 and then updated those rules on April 3, but absent additional action by the legislature, that authority will run out this summer.¹⁰

In 2018, the Veterans Administration took an important step to allow veterans to access a provider from anywhere in the country through telehealth. As veterans in Massachusetts can see an expert living anywhere in America, it seems natural to allow other patients to do the same.

Telehealth does not replace in-person medical care, but it is proving to be an important tool in the toolbox. Massachusetts needs to ensure our laws reflect advances in technology and fully leverage what is possible today, instead of keeping in place protectionist policies that harm patient care in the long run.

Prevent Expensive Telehealth Technology as a Barrier

Without universal broadband, and with some telehealth systems being very expensive, state policy should be flexible enough to allow patients to utilize whatever technology is available to them. Eighty-five percent of American adults now own a smartphone, so they should be able to use it for telehealth visits.¹¹ This means that state laws need to explicitly permit patients and providers to utilize whatever technology is most easily available, as long as the patient grants consent to do so.

Additional Provider Flexibility

The Department of Public Health waived mandated staffing ratios at out-of-hospital dialysis units on April 28, 2020.¹² Massachusetts is an outlier as one of only a few states that mandate staffing ratios at these units. We have the lowest ratio, even though research has been inconclusive as to whether staffing ratios are helpful, so we are driving up the cost of care without evidence it improves quality.¹³

On March 24, 2020, the state suspended mandated nurse staffing ratios, granting hospitals more flexibility for how to staff units.¹⁴ The Board of Registration in Pharmacy also effectively suspended pharmacy technician supervision staffing ratios.¹⁵ Since 2016 nine states have relaxed the staffing ratio allowed, and four have removed it all together. Massachusetts should consider removing our staffing ratios and ensuring full scope of practice for pharmacists and pharmacy technicians.¹⁶

These flexibilities should be made permanent to ensure facilities don't have to wait on the government to give them this permission to respond to a pandemic.

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Reciprocal and Across-State-Line Providers

On March 11, 2020, the Board of Registration in Nursing adopted new policies to expedite the processing of reciprocal license applications for nurses who are licensed in another jurisdiction.¹⁷

Governor Baker built on this on March 17 by allowing any physician in good standing to practice in Massachusetts or across state lines during the pandemic, but under an emergency license.¹⁸ On March 29, and then updated on April 3, the Department of Health expanded patient access to any provider with a license in good standing from any state.¹⁹

While these both are directionally a good idea, more is needed. Massachusetts should allow any providers in good standing in their main state of practice to be able to register with the relevant board or commission that has oversight for them in the state, pay any licensing fees, and be granted a full license in the state to not only practice telehealth, but to see patients in the state if they move here, or even if they are here for a shorter time period to provide needed care.

The legislature should just codify a slightly adapted version of the language used in the DPH guidance for across-state-line care and telemedicine/telehealth.²⁰

Flexibility of location for practice

Also on March 17, the DPH issued rules that allowed all staff at hospitals and facilities licensed or operated by DPH to be authorized to work at any other facility.²¹ This commonsense flexibility should remain in place permanently to ensure better patient access, and also to make sure we are ready for the next pandemic, when rotating staff may be necessary.

Scope of Practice

On March 18, 2020 the commissioner of public health issued rules granting some flexibility for reassignment of supervision of physician assistants to a different physician.²² But in that order, the state still left the decision to reassign the PA up to the supervising physician. Going forward the state should allow physician assistants to have more control of their career and not be 100 percent dependent on one supervising physician.

On March 24, the DPH issued emergency rules that allow more flexibility for pharmacists.²³ It permitted remote processing of prescriptions by pharmacy technicians and authorized pharmacists with out-of-state licenses to practice in a Massachusetts licensed pharmacy or health care facility upon written approval, among other changes. These changes are positive and should be codified going forward along with the additional ability for pharmacists to extend our health care system by allowing them to administer all vaccines outside of a public health emergency, adapt prescriptions, and prescribe tobacco cessation aids, as just a few examples.

The state should also finally create a dental therapist registration without extra rules and regulations that limit their practice in the state.

Finally, on March 26, and then updated on April 3, the DPH allowed certain advanced practice nurses to have more independence in practice.²⁴

In a welcome resolution to a long-fought legislative battle, the General Court codified this flexibility for advanced practice nurses in a bill Governor Baker signed on January 1, 2021.²⁵ Massachusetts was the 23rd state to do so. The new law also granted additional flexibility for optometrists. The benefits for patients and small employers will be better access to care and potentially some cost savings. The General Court should ensure that all providers are able to practice at the top of their license.

Internationally Trained Medical Professionals

On April 9, 2020, Governor Baker signed COVID-19 Order No. 23 which permitted expedited licensure of physicians who are graduates from an international medical school and have completed at least two years of postgraduate medical training.²⁶ This was a good first step, but was mainly focused on increasing the providers available to practice in the state by switching those already practicing under a limited license to something that looked like a full license. Looking forward, the executive order still leaves barriers in place for those wanting to come to Massachusetts to practice, but who are practicing abroad now, a much bigger pool of high-quality providers than those with a limited license who are already here.

On March 29, and then updated on April 3, the Department of Health expanded patient access to any provider with a license in good standing from any state.

The state should also finally create a dental therapist registration without extra rules and regulations that limit their practice in the state.

Currently, international medical graduates (IMGs) have to repeat their residency when they come to the United States. The state should instead create a streamlined licensing pathway under which a provider group or hospital can vet the credentials of IMGs, and once they have passed any required state exams and paid a fee, they are granted a full license in the state. There should also be a pathway for an individual to come practice independently as well.

Health System Flexibility

Determination of Need (DON)

On March 24, the Department of Public Health suspended the government permission slip for some capital expenditures, some changes in service, or a transfer of site of care if it was deemed necessary to address COVID-19.²⁷ In many cases, this meant an application would get an expedited review. It was a good first step, but much more is needed.

DON statutes and regulations artificially restrict the variety and number of care settings and equipment that can be utilized to treat patients. As the Federal Trade Commission (FTC) has noted, such laws and regulations create barriers to new health care competitors entering the market.²⁸ DON appears to be a shortsighted approach that has been demonstrated to raise prices and diminish patient health.²⁹

Massachusetts has twenty-two separate DON processes that cover hospital beds, beds outside hospitals, equipment, facilities, services, and emergency medical transport. Outside of a public health emergency, Massachusetts requires a DON for changes of any dollar amount, with a few exceptions in the law.³⁰

Policymakers should consider phasing out or raising the expenditure floor that requires a DON, as this would increase access to care for patients, increase competition, lower prices, and improve the quality of care provided. The federal government repealed its certificate of need (CON) requirement in the 1970s, and twelve states have no CON processes. Both the FTC and Department of Justice, under both Democratic and Republican leadership, have encouraged states to repeal or reduce their CON processes.

Conclusion

Massachusetts has spent more than twenty years talking about how to lower health care costs as the state has expanded health care access. It would be counterproductive to pass up this moment to not codify the flexibilities that result in more patient-centered care and can lower costs.

The codification of more independent practice for advanced practice nurses should serve as a model for the rest of the new flexibilities mentioned above: more flexibility for telehealth services, how providers can practice, and flexibility for how the health system operates. In some instances, a few tweaks may be needed to some of the reforms to ensure that it is the most patient-centered and cost-effective manner to reform the health system, but not doing so will harm access to care, and return the Commonwealth to many pre-pandemic practices that drive up costs and lower the quality of care delivered.

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Endnotes

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📍 185 Devonshire Street, Suite 1101 Boston MA 02110 📞 617.723.2277 📠 617.723.1880
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