September 29, 2020

The Honorable Ronald Mariano
Majority Leader
Massachusetts House of Representatives
State House, Room 343
Boston, MA 02133

The Honorable Cindy Friedman
Chair
Joint Committee on Health Care Financing
State House, Room 208
Boston, MA 02133

Dear Leader Mariano, Chair Friedman, and Honorable Committee Members:

On behalf of the more than 40 healthcare provider organizations, consumer advocates, technology organizations, and telecommunication associations who comprise *t*MED – the Massachusetts Telemedicine Coalition – we want to express our gratitude for the provisions included in both the House and Senate healthcare bills (HB4916 and SB2796, respectively) that seek to solidify the continued use of telehealth as a tool in the Massachusetts healthcare system. In particular, we appreciate that both bills seek to put in place a framework for telehealth that includes provisions requiring coverage and reimbursement parity across all payers, including the Group Insurance Commission (GIC) and MassHealth; proxy credentialing for healthcare providers; and comprehensive definitions of telehealth that include both synchronous and asynchronous technologies. These are the three legs of the policy framework for telehealth that we have been promoting for the past five years and are consistent with the current state executive orders in place during the pandemic.

The telehealth flexibilities and enhancements that the Baker Administration has introduced during the COVID-19 state of emergency have expanded access to synchronous forms of telehealth across Massachusetts. These policy changes have ensured that residents have had access to critical healthcare services while taking the necessary precautions to limit exposure to COVID-19. The flexibilities have also reduced the stress and burden of traveling to appointments (including the cost of public transportation, tolls and parking), reduced the use of MassHealth non-emergency medical transportation (PT-1 program), allowed continued social distancing, and preserved personal protective equipment for the healthcare workforce. Telehealth has now been proven as a powerful tool to maintain access to care for all residents of the commonwealth and to promote the principles of health equity and social justice.

As the commonwealth continues its phased reopening and encourages the use of telehealth to the maximum extent feasible, the *t*MED Coalition urges our state elected leaders to make the establishment of sustainable and equitable telehealth policies for both synchronous and asynchronous technologies a top priority. Telehealth now has been adopted by providers and

used by millions of patients across the state, in addition to addressing some gaps in coverage that had not been previously recognized. However, there remains significant anxiety among providers and patients alike that the policies that have been available during the state of emergency will be rescinded, creating barriers to access for patients, and clinical, operational, and financial challenges for providers. Preserving telehealth access will also allow healthcare providers to continue to limit exposure to COVID-19, promote continued social distancing, prepare for the upcoming flu season, and preserve personal protective equipment for the healthcare workforce.

The *t*MED Coalition would like to offer the following recommendations regarding telehealth to the members of the conference committee. We have also included detailed information regarding each recommendation following this list.

- **Coverage Parity for All Services That Can Be Provided Via Telehealth Wherever It Can Be Provided Safely & Effectively --** *Please adopt the coverage parity provisions included in the payer sections of SB2796.*

- **Definition of Telehealth –** *Please adopt the definition of telehealth included in the payer and proxy credentialing sections of SB2796 – with no limitations on prescribing via telehealth.*

- **Reimbursement Parity** – *Please adopt the reimbursement parity provisions included in sections 74 & 79 of SB2796.*

- **Health Policy Commission (HPC) Reporting Requirements** – *Please adopt section 72 of SB2796. However, the tMED Coalition would encourage you to amend the reporting timelines so that they line up with the expiration of reimbursement parity in order to offer time for consideration of insights from the HPC that could be included in additional legislative changes*.

- **Permanent Reimbursement Parity for In-Network Behavioral Health Services** – *Please adopt the permanent reimbursement parity provisions for in-network behavioral health services included in the payer sections of HB4916.*

- **Prior Authorization** – *Please adopt the prior authorization provisions that remain in effect during the state of emergency that mirror what is in-place for in-person services.*

- **Proxy Credentialing** – Please adopt subsection *(b) of Section 16 of HB4916 and section 68 of SB2796.*

- **Differential Reimbursement –** *Please oppose the provisions in HB4916 that permit differential reimbursement between interactive audio-visual services, audio-only*

telephonic services and other telehealth modalities, and instead direct the Health Policy Commission to review the evidence-base surrounding this issue.

- **Global Reimbursement –** *Please adopt the provisions in the payer sections of HB4916 that account for telehealth when setting a global payment amount.*

- **Provider Regulations / Standards of Care / Consumer Protections –** *Please reject the provisions of subsection (c) in section 16 of HB4916 and Adopt House and Senate Consumer Protections.*

- **Repeal of Prior Insurer Telehealth law** – *Please adopt section 23 of HB4916 that would repeal the limited commercial coverage telehealth law that only allows for telehealth coverage through insurer approved telehealth networks.*

Coverage Parity for All Services That Can Be Provided Via Telehealth Wherever it Can Be Provided Safely & Effectively – *Please Adopt the following provisions in SB2796: subsection (b) of the new section 30 of Chapter 32A in section 3 of the bill; subsection (b) of the new section 79 of Chapter 118E in section 49 of the bill; subsection (b) of the new section 47CC of Chapter 175 in section 54 of the bill; subsection (b) of the new section 38 of Chapter 176A in section 55 of the bill; subsection (b) of the new section 25 of Chapter 176B in section 56 of the bill; subsection (b) of the new section 33 of Chapter 176G in section 57 of the bill; subsection (b) of the new section 13 of Chapter 176I in section 58 of the bill.*

All of these provisions ensure that contracted providers can offer both synchronous and asynchronous telehealth services, and patients will be covered under the GIC, MassHealth, and commercial insurers. In addition, healthcare services delivered via telehealth shall be covered to the same extent as if they were provided via in-person consultation or delivery. Combined, these provisions ensure that telehealth services provided to patients in Massachusetts are covered on-par with in-person visits – coverage parity for any services are to be determined by providers' professional judgment they are able to be provided via a telehealth modality. This language is also most closely aligned with the existing provisions that grant access to telehealth services during both the state of emergency and federal public health emergency, a critical consideration to ensure continuity of care for patients.

The *t*MED Coalition, however, has significant concerns with the provisions that were included in HB4916 since they unnecessarily limit the sites and types of care where telehealth can be used as a modality. These limits will curtail the services that commercial health insurers, MassHealth and the GIC will cover – services that are safely and effectively being provided to patients now.

First, the House bill puts a limitation on the originating site of care for patients – the location where patients may access behavioral health, primary care, and chronic disease management services -- to inside the patient's place of residence. While an improvement on prior language that made the originating site the patient's private residence, this language does not reflect the

complexity of locations where people may be accessing services. Today patients are accessing telehealth services in their workplace, in coffee shops, at their schools / colleges / universities, in their dormitories, homeless shelters, group homes, their own personal vehicles (due to the fact that they may not have access to privacy or broadband internet access in their place of residence), or in the homes of friends or relatives with which they are staying during the COVID-19 outbreak. Notably, many front-line medical providers are now accessing medical and behavioral health services for their own well-being in their clinic offices and hospitals as they do not have the luxury of accessing care while in their place of residence. From experience, the organizations and healthcare providers we represent know the unintended effects on productivity, time, and forgone care when putting artificial limitations on the locations where workers and patients can access treatment.

Second, the House bill severely limits coverage for telehealth services only to primary care, behavioral health, and Centers for Medicare and Medicaid (CMS)-defined chronic disease management services, in addition to: provider-to-provider consultation; services provided in licensed facilities or when patients are in the presence of a licensed healthcare professional; and any new services provided only in a patient's place of residence deemed appropriate by the HPC. It additionally applies a two-part test for telehealth coverage that will limit its use by requiring services to also be covered on an in-person basis and requiring that said services may be appropriately provided through the use of telehealth. This coverage definition will lead to confusion, bureaucracy, and lack of predictability both for patients and healthcare providers and undermine telehealth's use. CMS' defined list of chronic disease management services limits telehealth treatment only to certain diagnoses for certain diseases (and even limits treatment within those categories of diseases). Additionally, this definition is not representative of chronic conditions across a lifespan that affect the activities of daily living for patients. While well-intentioned, this definition of eligible services for telehealth does not represent all the clinically appropriate, effective care that has been provided to patients via telehealth for decades in other states and for the past six months in Massachusetts during the pandemic.

For example, under this limited definition, oncology care or treatment for cancer in both children and adults would not be covered via telehealth. During the pandemic, oncology services have been successfully delivered via telehealth and have prevented this immunosuppressed population from taking the risk of attending appointments in person. In another example, in one major academic medical center, medical specialties were the second highest utilizers of telehealth care during the pandemic; primary care was the highest. Additionally, oral health and dental services, behavioral health, physical therapy, and many other services can be, and have been, provided via telehealth modalities both before and during the pandemic.

There should be no arbitrary distinction in law as to what services are eligible to be covered by telehealth since the medical service is not changing, only the modality used to deliver the service. As such, the *t*MED Coalition opposes language in HB4916 that limits coverage for services only to those that "may be appropriately provided through the use of telehealth" without further delineating that physicians and healthcare providers make the determination of

appropriateness. The language as written is vague and allows insurers to be the sole arbiter of whether a healthcare service can be appropriately provided via telemedicine. That determination is a clinical decision that should be made by clinicians and is inherently dictated by the clinician's required standard of care. Clinicians know what services can be provided safely and appropriately via telehealth. If specialty care services are not covered via telehealth, this limits timely access to care. This is particularly critical as healthcare providers move forward with reduced availability of in-person visits due to reconfigured spaces, staggered scheduling, social distancing, and increased demand for enhanced infection control protocols. In addition, many infectious disease experts have predicted a resurgence of COVID-19 this fall or winter; having specialty care services remain available via telehealth, without disruption, is critical to preparing for a possible second surge of COVID-19 during cold and flu season.

Definition of Telehealth / Limitations on Prescribing – *Please Adopt the following provisions in SB2796: subsection (a) of the new section 30 of Chapter 32A in section 3 of the bill; subsection (a) of the new section 79 of Chapter 118E in section 49 of the bill; subsection (a) of the new section 47CC of Chapter 175 in section 54 of the bill; subsection (a) of the new section 38 of Chapter 176A in section 55 of the bill; subsection (a) of the new section 25 of Chapter 176B in section 56 of the bill; subsection (a) of the new section 33 of Chapter 176G in section 57 of the bill; and subsection (a) of the new section 13 of Chapter 176I in section 58 of the bill; and section 68 of the bill.*

The *t*MED Coalition applauds both the House and Senate for including audio-only telephone in their definition of telehealth. This is essential from an equity perspective and has allowed many low-income and elderly patients, who do not have access to interactive audio/video, to access critical services during the pandemic. Both bills also have definitions that cover interactive technologies, including videoconferencing, in addition to asynchronous technologies, that comprise both store-and-forward technologies and, explicitly, remote patient monitoring. However, the *t*MED coalition supports the definition of telehealth that was included in the Senate bill that is flexible and broader by including text messaging and applications-based communications, and permits, but does not require, coverage for text-only email when it occurs for the purpose of patient management in the context of a pre-existing physician patient relationship. Text-messaging and applications-based telehealth services have been used during the pandemic and they reflect utilization by younger populations who rely upon and are more comfortable with these methods of communication with healthcare providers. As the *t*MED coalition has stated, coverage needs to be broad and flexible so that each time that a new technology is introduced it does not need to be added to the statute for telehealth coverage.

The *t*MED Coalition additionally opposes the language that was included in the definition of telehealth throughout the coverage and proxy credentialing provisions in HB4916. This language would limit prescribing via telehealth to the treatment of a condition previously diagnosed during an in-person visit by the telehealth provider and permit the issuance of a one-time prescription to treat the sudden onset of an illness or injury or acute mental health or behavioral health episode, manifesting itself by acute symptoms and allowing as many refills of that prescription as a provider may issue, within their discretion. Prescribing and medication

management via telehealth is safe and effective – even for controlled substances and there are effective safeguards in place to guard against drug diversion that have been in place since the inception of the public health emergency. At a time when we are trying to promote social distancing, preserve personal protective equipment, and keep healthy patients away from healthcare facilities, it is unclear why a policy would be put into place that would potentially encourage unnecessary and inefficient overutilization of our healthcare system and compel already anxious patients to go to a healthcare facility in-person only to obtain a medication, thereby increasing their anxiety and stress when methods are in place to alleviate such concerns. This provision is effectively a ban on services that can be provided to consumers directly and will curtail access to safe, quality care for Massachusetts patients.

Reimbursement Parity – *Please Adopt the Reimbursement Parity Provisions included in the SB2796 in sections 74 & 79.*

The *t*MED coalition applauds both the House and Senate telehealth bills for including guaranteed reimbursement of telehealth services on par with in-person visits. However, the coalition supports the provisions included in SB2796 that would allow the provisions to remain in place until July 31, 2022. By providing equitable reimbursement on-par with in-person services during this timeframe, providers will have the predictability of reimbursement parity to allow them to make long-term investments to scale-up permanent telehealth practices. These investments include, but are not limited to, platforms, licenses, education and training, scheduling, coding and billing, and after-visit follow-up by office staff. The length of reimbursement parity in the Senate bill also adequately reflects the period of time within which it is anticipated that a vaccine will have been adopted and herd immunity can be achieved across the population – thereby allowing for an eventual reduction in the maximization of the use of telehealth. It would also provide Massachusetts healthcare consumers, especially those who are most vulnerable to the health and economic effects of COVID-19, including communities of color, with needed stability during these difficult times to know that they will have consistent, reliable access to care via telehealth. Finally, this longer time period will give state policymakers the opportunity to study the effects of telehealth coverage and access.

HPC Reporting Requirements – *Please support the provisions in Section 72 of SB2796; However, the tMED Coalition would encourage you to amend the reporting timelines so that they line up with the expiration of reimbursement parity in order to offer time for consideration of insights from the HPC reporting that could be included in additional legislative changes*.

The *t*MED Coalition appreciates that both the House and Senate bills are seeking to gather additional data regarding the impact of the coverage and reimbursement of telehealth on the healthcare system. The *t*MED Coalition recommends the extensive reporting under SB2796 as it seeks to understand the impacts on patients and their access to healthcare services. It additionally provides the detail to inform legislators about the value of telehealth and how to prioritize the valuation when considering the longer-term impact and support for telehealth beyond the COVID-19 pandemic. Additionally, the *t*MED Coalition suggests that should the Senate language be included in the conference committee report, the interim reporting of the

HPC should be moved up to July 30, 2021, and the final report of the HPC should be moved to six months before the expiration of the reimbursement parity provisions, which would be December 31, 2021. In this way, healthcare providers would have some predictability and a potential glide path of time to assist in a transition to further coverage and reimbursement changes for telehealth as recommended by the HPC. This sequence would also ensure that policymakers have the benefit of a full scope analysis relative to cost, access to care, and the equity implications of any reimbursement changes.

Permanent Reimbursement Parity for In-Network Behavioral Health Services – *Please Adopt the following provisions in HB4916: subsection (g) of the new section 30 of Chapter 32A in section 4 of the bill; subsection (g) of the new section 79 of Chapter 118E in section 22; subsection (g) of the new section 47MM of Chapter 175 in section 24; subsection (g) of the new section 38 of Chapter 176A in section 25; subsection (g) of the new section 25 of Chapter 176B in section 26; subsection (g) of the new section 33 of Chapter 176G in section 27; subsection (g) of the new section 13 of Chapter 176I in section 28.*

All of these sections permanently delineate that rates of payment for in-network providers of behavioral health services delivered via interactive audio-video technology, and mandate that audio-only telephone reimbursement shall be no less than the rate of payment for the same behavioral health services delivered via in-person methods. More than 50% of all visits that have taken place during the pandemic have been behavioral health visits. According to a CDC survey conducted between June 24-30, U.S. adults are reporting considerably elevated adverse mental health conditions associated with COVID-19. Younger adults, racial/ethnic minorities, essential workers, and unpaid adult family caregivers have reported disproportionately worse mental health outcomes, including increased substance use and elevated suicidal ideation. The use of telehealth has added capacity to the healthcare system and compelled insurers to increase their capabilities to add more providers to their networks. The reimbursement parity for these services will ensure that providers continue to join these networks, thereby ensuring access for patients.

Prior Authorization – *Please Adopt the prior authorization provisions currently in use during the state of emergency.*

The *t*MED Coalition recommends that any conference committee report include the telehealth language put forward by the Division of Insurance Bulletin 2020-04, which is the policy in place during the state of emergency. It states that "Carriers are directed not to impose any prior authorization barriers to obtain medically necessary health services via telehealth that would not apply to receipt of those same services on an in-person basis." The coalition believes that this policy ensures that there are not undue barriers placed on telehealth services solely because the service is being provided via telehealth. Prior authorization should not be used by insurance carriers and government programs to determine whether a service is suitable to be performed via telehealth – as is included under both the House and Senate bills. Clinicians know which services can be conducted via telehealth and which cannot. Prior authorization should be used to determine whether a healthcare service is medically necessary. A 2019 study

by the American Medical Association found that more than 90% of physicians reported that prior authorization requirements caused delays in accessing necessary care for patients and 74% reported that issues related to the prior authorization process led to patients abandoning their recommended course of treatment.

Proxy Credentialing – *Please Adopt Proxy Credentialing Provisions in subsection (b) of Section 16 of HB4916 and Section 68 of SB2796.*

We strongly recommend the adoption of the language in subsections (a) and (b) of Section 16 of HB4916 and Section 68 of SB2796 that will align Massachusetts rules with federal standards allowing for a streamlined, less-duplicative process for all providers to be credentialed to deliver telehealth services. Currently, Massachusetts requires a provider to go through an extensive credentialing and privileging process at each proposed site of care, which requires detailed documentation of Primary Source Verification of each clinician's education, skills, training, and more. These procedures add to the overall cost and internal resources for each facility where a provider is seeking to offer remote telehealth services. By adopting the provisions outlined above, Massachusetts can ensure that all healthcare providers, whether licensed through the Board of Registration in Medicine, Department of Public Health, or Office of Consumer Affairs & Business Regulation, can access proxy credentialing.

Differential Reimbursement – *Please oppose the provisions in HB4916 that permit differential reimbursement between interactive audio-visual services, audio-only telephonic services and other telehealth modalities and instead direct the Health Policy Commission to study this issue. However, if these provisions are to be included please consider not allowing for differential rates of reimbursement relative to audio-only telephonic services in the commercial payer and GIC sections of the legislation*

Under the coverage and payer provisions of HB4916, the rate of payment for telehealth services provided via interactive audio-video technology (and audio-only telephone under MassHealth) may be greater than the rate of payment for the same service delivered by other telehealth modalities. The *t*MED Coalition believes that rates of reimbursement should be on-par with in-person visits regardless of the telehealth modality that is used and that the HPC should undertake further study on differential rates of reimbursement to determine if differentiation is appropriate. The *t*MED Coalition acknowledges that some differentiation may be appropriate in certain cases but should be based upon evidence collected and analyzed by the HPC and not be left solely in the discretion of the insurers. The coalition would be pleased to work with the legislature to review evidence-based nuances relative to differential reimbursement in the future.

The *t*MED coalition appreciates the recognition that many MassHealth patients may not have access to audio-video technology. The digital divide is not solely a function of insurance status, however. Many other patients also lack this access because they may not own the necessary hardware, may not have the required internet access, or may not be able to use the applicable software or application. The *t*MED Coalition recommends that if the House language were to be

included in any final legislation, "audio-only telephone" in addition to "interactive audio-visual technology" be treated with the same reimbursement and not be subject to the differential rate provisions. Accordingly, we recommend that for all payers, conferees insert the words "and audio-only telephone" after the words "via interactive audio-visual technology" in each of the following sections of HB4916: subsection (e) of the new section 30 of Chapter 32A in section 4 of the bill; subsection (e) of the new section 47MM of Chapter 175 in section 24; subsection (e) of the new section 38 of Chapter 176A in section 25; subsection (e) of the new section 25 of Chapter 176B in section 26; subsection (e) of the new section 33 of Chapter 176G in section 27; subsection (e) of the new section 13 of Chapter 176I in section 28.

Global Reimbursement Provisions --- *Please Adopt the following provisions in HB4916: subsection (f) of the new section 30 of Chapter 32A in section 4 of the bill; subsection (f) of the new section 79 of Chapter 118E in section 22; subsection (f) of the new section 47MM of Chapter 175 in section 24; subsection (f) of the new section 38 of Chapter 176A in section 25; subsection (f) of the new section 25 of Chapter 176B in section 26; subsection (f) of the new section 33 of Chapter 176G in section 27; subsection (f) of the new section 13 of Chapter 176I in section 28.*

HB4916 directs that any payer coverage for telehealth services that reimburses a provider with a global payment must account for the provision of telehealth services in setting the global payment amount. This provision is intended to ensure that healthcare providers who are transitioning away from a fee-for-service model and are entering into global payment arrangements will be reimbursed for the services that they are providing via telehealth and that the methodologies used must take into consideration the use of telehealth.

Provider Regulations / Standards of Care / Consumer Protections – *Please Reject the provisions of subsection (c) in section 16 of HB4916 and Adopt House and Senate Consumer Protections.*

HB4916 directs the state's Board of Registration in Medicine (BORIM) to promulgate regulations on the appropriate use of telehealth services including: services that are not appropriate to provide through telehealth; the establishment of a provider-patient relationship; consumer protections; and ensuring that services comply with appropriate standards of care. The adoption of these provisions is unnecessary for this legislation – particularly since BORIM has addressed some of them already or they are included in this legislation. On June 25, 2020, BORIM adopted a permanent policy that was in place on an interim basis during the pandemic to not require a face-to-face encounter between a physician and a patient prior to healthcare delivery via telehealth. The practical effect of this policy is to permit the establishment of a provider-patient relationship via telehealth. Second, BORIM's policy is very clear with regards to the standard of care for telehealth. It states that "[t]he standard of care applicable to the physician is the same whether the patient is seen in-person or through telemedicine." This makes clear that there is no difference in the standard of care for telehealth. Third, BORIM does not have the authority to define the standards of care for telehealth services delivered by non-medical professions, such as dental providers and others. Such standards and provider

regulations should be defined by BORIM or the authority governing their given profession or specialty. Finally, it is unnecessary for BORIM to undertake a regulatory process to determine which services are not appropriate to provide via telehealth. Clinicians know which services can and cannot be provided via telehealth.

The *t*MED Coalition would like to express our gratitude to both the House and Senate for adopting several consumer protections in both of their bills and would urge their inclusion in any conference committee report. Those protections include:

- Carriers are not permitted to meet network adequacy through significant reliance on telehealth providers and shall not be considered to have an adequate network if patients are not able to access appropriate in-person services in a timely manner upon request.
- Providers are not required to document barriers to in-person visits, nor shall the type of setting where telehealth services are provided be limited for healthcare services delivered via telehealth.
- Patients may decline receiving services via telehealth in order to receive in-person services.
- Coverage for telehealth services may include a deductible, co-payment, or co-insurance requirement if the deductible, co-payment or co-insurance does not exceed the same out-of-pocket costs for the applicable in-person consultation or in-person delivery of services.

Repeal of Prior Insurer Telehealth Law – *Please Adopt Section 23 of HB4916*

Chapter 224 of the Acts of 2012 added language to Massachusetts General Laws to give commercial insurers the authority to allow telehealth care to only be conducted through insurer-approved telemedicine networks. Section 23 of HB4916 removes these provisions, as was also proposed in Governor Baker's omnibus healthcare reform bill. This change will prevent confusion and provide predictability for healthcare providers who would otherwise need to interpret the inter-play of two conflicting telehealth laws pertaining to commercial insurers.

Thank you for your time and consideration of these important matters. Should you have any questions or concerns, please contact Adam Delmolino, Director of Virtual Care and Clinical Affairs at the Massachusetts Health & Hospital Association, at (617) 642-4968 or adelmolino@mhalink.org.

Sincerely,

*t*MED - The Massachusetts Telemedicine Coalition

Massachusetts Health & Hospital Association
Massachusetts Medical Society
Massachusetts League of Community Health Centers
Conference of Boston Teaching Hospitals

Massachusetts Council of Community Hospitals
Hospice & Palliative Care Federation of Massachusetts
American College of Physicians – Massachusetts Chapter
Highland Healthcare Associates IPA
Health Care for All
Organization of Nurse Leaders
HealthPoint Plus Foundation
Massachusetts Association of Behavioral Health Systems
Massachusetts Academy of Family Physicians
Seven Hills Foundation & Affiliates
Case Management Society of New England
Massachusetts Occupational Therapy Association
Atrius Health
New England Cable & Telecommunications Association
Association for Behavioral Healthcare
National Association of Social Workers – Massachusetts Chapter
Massachusetts Psychiatric Society
Digital Diagnostics
Zipnosis
Perspectives Health Services
Bayada Pediatrics
American Heart Association / American Stroke Association
Planned Parenthood Advocacy Fund of Massachusetts
Mass. Family Planning Association
BL Healthcare
Phillips
Maven Project
Upstream USA
Cambridge Health Alliance
Heywood Healthcare
Franciscan Children's Hospital
American Physical Therapy Association – Massachusetts
Community Care Cooperative
Fertility Within Reach
Virtudent
Resolve New England
Massachusetts Association of Mental Health
AMD Global Telemedicine
hims | hers

cc: Honorable Members of the Conference Committee
House Speaker Robert DeLeo
Senate President Karen Spilka
Governor Charlie Baker
Secretary Marylou Sudders


Massachusetts Medical Society
Every physician matters, each patient counts.
COBTH
MHA
Massachusetts Health & Hospital Association
Massachusetts Council of Community Hospitals
MCH
Hospice & Palliative Care Federation of Massachusetts
Health Care For All
AMD Global Telemedicine
ACP American College of Physicians
Massachusetts Chapter
ONL Organization of Nurse Leaders
HealthPoint Plus Foundation
Massachusetts Association of Behavioral Health Systems
Massachusetts Academy of Family Physicians
Strong Medicine for Massachusetts
CMSNE
MAOT, Inc.
NECIA
ABH
NASW National Association of Social Workers Massachusetts Chapter
Atrius Health
Massachusetts Psychiatric Society
zipnosis
Perspectives
BAYADA Pediatrics
Massachusetts League of Community Health Centers
American Heart Association
American Stroke Association
life is why
Planned Parenthood
BL Healthcare
Mass. Family Planning Association
PHILIPS
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Franciscan Children's
So every kid can.
APTA Massachusetts
COMMUNITY CARE COOPERATIVE
Fertility Within Reach
Advocating for Fertility Health Benefits
Seven Hills Foundation & Affiliates
MAVEN PROJECT
Medical Alumni Volunteer Expert Network
Heywood Healthcare
Athol Hospital | Heywood Hospital | Heywood Medical Group | Quabbin Retreat
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MAMH Massachusetts Association for Mental Health
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