



American Telemedicine Association

1100 Connecticut Avenue, NW, Suite 540, Washington, DC 20036-4146
202.223.3333 • Fax: 202.223.2787 • www.americantelemed.org

Examining Health Care Competition

**Comments by the American Telemedicine Association
for the Federal Trade Commission**

April 30, 2015

The American Telemedicine Association (ATA) is pleased to provide the Federal Trade Commission the following comments in response to your public workshop titled: “Examining Health Care Competition.” Our remarks focus on recent trends in telemedicine, including its impact on competition, advances in payment innovation, and barriers to its implementation.

Very similar to FTC objectives are the public policy objectives of ATA:

- Eliminate artificial government barriers to telehealth, such as geographic discrimination and restrictions on the use of telehealth in managed care;
- Prevent new barriers to telemedicine, such as practice rules that impose higher standards for telehealth services than in-person care;
- Encourage use of telehealth to reduce health delivery problems, such as provider shortages;
- Promote payment and service models to increase consumer and payer value using telemedicine: and
- Increase patient choice, outcomes, convenience, and satisfaction.

Parity

Payment and coverage for services delivered via telemedicine are one of the biggest challenges for telemedicine adoption. Patients and health-care providers alike may encounter a patchwork of arbitrary insurance requirements and disparate payment stream that do not allow them to fully take advantage of telemedicine. One of the biggest challenges facing telemedicine adoption is the lack of reimbursement parity for services provided via telehealth vs. traditional in-person services.

Telehealth-provided services should be covered to the same extent—and in a similar manner—as in-person services. Surprisingly, the most progress for parity is with private insurance. Notably 24 states and D.C. require such parity and many have more than 10 years successful experience with this requirement.

Most payers often impose a variety of restrictions on telehealth. Examples of such obstructive policies include: geography/distance limitations, requirements for an established patient-provider relationship or in-person exam, patient setting and provider-type restrictions, and limits on applicable technology. These restrictions are often arbitrary and provide no consideration for professional medical discretion, provider shortages or patient limitations. The primary goal of

any responsible health policy should be to eliminate these unreasonable, unnecessary restrictions on the practice of telemedicine.

A particular issue for the FTC is that, a covered service provided by telehealth should be reimbursable under the plain language of the explanation of benefits, in the absence or either a specific prohibition of telehealth or a specific restriction of coverage to in-person care. This would be “truth in advertising.” For example, since federal statute does not limit Medicaid, Federal Employees Health Benefits Program, and TRICARE coverage only to in-person services nor does it preclude telehealth, under the plain language these programs should be prohibited from denying any claim merely because a covered service was provided by telehealth. As long as the terms and conditions for telehealth service delivery are comparable to that of the in-person service, there is no basis to deny a telehealth claim.

Payment Innovation

Some of the biggest concerns about improving coverage of telemedicine are mostly related to the perverse financial incentives of the dominant fee-for-service reimbursement and a fear of adding to them.

As payment shifts to innovative, value-based payment methods, telehealth can and should be a new tool for providers to create value, especially when the providers are at greater financial risk. In addition, telehealth within payment innovations would allow patients to have more choices and to increase competition among providers on quality, price, accessibility, etc. Coverage for telehealth can also be a reward or competitive advantage for providers to take that difficulties and risks of payment innovation.

The most common form of value-based payment is managed care, such as the extensive range of Medicaid payment methods for managing care. Under a managed care plan, unless such coverage is already a part of the contract, each provider must negotiate their own terms for coverage and rate setting. While certain procedures and care are not applicable to delivery via telehealth, where services are contractually obligated and care can be provided via telehealth, reimbursement should be congruent with traditional in person care.

For Medicare payment innovation, Congress recently enacted a provision so that the Medicare restrictions on telehealth will not apply to the “alternative payment methods” program to be started in October 2016. CMS recently announced a new model for accountable care organizations, Next Generation ACOs, which would allow telehealth coverage from any patient location. This flexibility ought to be applied more broadly now to all Medicare for all ACOs and other payment programs undertaken by the Center for Medicare and Medicaid Innovation, notably bundled payments for acute episodes and medical homes.

Medicare Coverage for Telehealth

Allow telehealth in payment and service innovations: ATA believes providers in value-based payment innovations, such as accountable care organizations, bundled payments for acute care episodes, and medical homes, should have the flexibility to fully use telehealth.

Encourage chronic care management: Medicare relies on an outmoded approach to manage the needs and costs for the growing number of beneficiaries with multiple chronic conditions, who are homebound, or at-risk for inpatient stays. The current system wastes billions of dollars and costs lives. To improve care for beneficiaries and reduce costs to the system:

- Authorize a state’s Medicaid “health home” plan for chronic care to cover the state’s Medicare beneficiaries;
- Reward hospitals for extra reductions in readmissions by sharing the extra savings and, thus, compensate a hospital for costs related to patient monitoring, home video, etc.;
- Allow the use of home telehealth as a recognized and reimbursable component under the home health care and hospice benefits;
- Adjust Medicare payment methods for federally-qualified health centers to facilitate the provision of chronic care coordination and remote monitoring; and
- Cover innovative services for on-line internet assessments, critical care, computerized clinical data analysis, and the collection and interpretation of physiological data.

State Policy Trends in Medicaid Managed Care and Telehealth

Telehealth and alternative payment plans will be important items for states to consider as they implement these new options and look for innovative models to combat the growing cost of healthcare. In particular, fully enabling and appropriately reimbursing Medicaid managed care organizations (MCOs) to use telehealth for improving care, access, cost and quality can provide immediate benefits. The use of telehealth for early diagnosis and treatment, care coordination, and prevention has proven to be a cost-effective delivery method that supports innovation, rather than being a driver of costs.

MCOs experimenting with innovative delivery models including medical homes and dual-eligible coordination have incorporated telehealth as a feature of these models especially because it helps to reduce costs related to emergency room use and hospital admissions. It also improves timely access and care coordination. Given the fact that MCOs already have established provider networks, incorporating telehealth into these models is often a less disruptive option.

Some states have also incorporated telehealth as integral parts of their innovative service delivery models. For example, Illinois has included the coverage of telemonitoring as a value added service supporting its primary care-behavioral health integrated model for older adults and adults with disabilities that have ongoing health conditions.

In some more progressive Medicaid managed care markets, such as Georgia, the use of telehealth by MCOs has been used to further collaborate and integrate behavioral health care within the patient centered medical home (PCMH). Increasing access to behavioral health services for the Medicaid population is a critical need and can be integrated within the PCMH more effectively via the application of telehealth.

Barriers

The use of telemedicine offers many opportunities to improve the delivery of health care; however, the growth of telemedicine faces artificial barriers to competition. Just as innovation

is blossoming in the way we delivery healthcare, so too must innovation occur in the way we regulate healthcare. Reducing barriers to access and implementation to telehealth leads to increased economic protection.

Consumer Empowerment and Competition

The greatest impact of telemedicine is on the patient, their family and their community. Using telemedicine technologies reduces travel time and related stresses for the patient. Over the past 15 years study after study has documented patient satisfaction and support for telemedical services. Such services offer patients the access to providers that might not be available otherwise, as well as medical services without the need to travel long distances.

Today, telemedicine takes many forms. Patients suffering a stroke can be seen and treated by a neurologist as soon as they arrive in an emergency room thanks to telestroke networks. Consumers can download a growing variety of applications to their wireless digital devices to monitor vital signs and remind them to take medications. Specialists can use telemedicine to monitor Intensive Care Units, follow-up with discharged patients or provide a simple diagnosis to someone in a rural area. Travelers can check back with their primary care doctor while on the road.

As with every disruptive innovation, such improved choices and new competition brings with it the real possibility of higher quality and lowered costs. Of course, it also brings challenges to prevent possible fraud and abuse.

But this increased competition also presents a challenge to providers, health systems and regulators used to old, traditional delivery systems. Many feel threatened by the fact that their patients may be able to seek health care from a provider located somewhere else. Thus, it is not surprising that resistance to the growth of telemedicine can be attributed, in part, to the fear of competition from individual providers as well as local health systems. Nevertheless, consumer choice and competition flourish when barriers to access and innovation are removed.

Artificial Coverage Barriers in Fee-For-Service Medicare

Congress should remove statutory barriers in Social Security Act 1834(m) and allow Medicare telehealth services for:

- The almost 80% of Medicare beneficiaries not covered because they live in a “metropolitan area”;
- “Store-and-forward” services, such as for wound management and diabetic retinopathy;
- Provider services otherwise covered by Medicare, such as physical therapy, occupational therapy and speech-language-hearing services;
- Services delivered wherever the beneficiary is, including home or mobile; and
- Any already-covered health procedure code possible by a telehealth method.

Licensure

Given the challenges of modern day care delivery with often limited access, and the proliferation of new tools, licensing boards owe it to their citizens to facilitate the integration of new solutions into existing care paradigms.

An increasing problem for telemedicine is state authorities imposing practice rules with higher specifications for telemedicine than in-person care. For example, some boards have proposed requirements—only for telemedicine—that a patient must be an established patient of the professional or have had an in-person physical examination from that provider. Moreover, one-size-fits-all requirements are clinically unnecessary and add to costs in many situations. Unfortunately, some states have taken action to prohibit the use of telemedicine by providers located out of state. Others have enacted separate licensing for remote providers.

ATA has held that the use of telemedicine, like the use of other technologies in health care such as a stethoscope, does not require a unique telemedicine license. In addition, ATA has held that any reform in the state licensing system should eliminate existing barriers to peer-to-peer consultation and coordination. Furthermore, ATA has stated that duplicative and conflicting licensing and regulatory requirements for healthcare professionals in every state where they serve a patient has become a significant barrier to both patients and professionals increasing costs, reducing choice and impeding economic trade. State-based licensure and practice regulations limit a patient's access to the best possible health care.

ATA opposes artificially higher standards for telemedicine services. In particular, there should be comparable requirements for non-clinical items, such as notices to patients, informed consent from patients and use of electronic health records. In addition, there should be comparable standards for a patient's ability to receive non-controlled prescriptions from a qualified telemedicine professional.

Licensure Innovation

A range of options have been proposed for licensure reform including interstate compacts based on mutual state recognition or not and even national licensure. Regardless of the approach used, ATA encourages policy makers to promote such change nationwide. Prolonged delay only will exacerbate the problem.

Congress, with strong bipartisan support, expanded the exemption from multiple state licenses for the Department of Defense health care – one state license is now sufficient throughout the country. The “one state license” rule should be applied to all federal health care (covering all agencies, health programs, and federally-funded health sites). The U.S. Constitution grants authority to regulate interstate commerce to Congress and for intrastate commerce to the states.

An increasing problem for telehealth is state medical boards adopting practice rules with higher specifications for telehealth than in-person care, such as requirements *only* for telehealth that a patient must be an established patient of the physician or has had an in-person physical exam from that provider. ATA opposes higher standards for telehealth than in-person services.

Concluding Observation

The Commission could make a valuable contribution to the public debate by issuing a clear statement about how the FTC views the applicability of the Constitutional authority of Congress to regulate interstate commerce. For example, if interstate reciprocity is considered, such an approach must include allowing a state licensing board to share information about professional disciplinary actions with other states. Barriers to access and others that inhibit payment innovation, along with outdated licensure rules for health professionals, are germane issues that will limit the successful diffusion of telemedicine throughout the United States and limit the often critical services patients need.