UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Competition
Bureau of Economics

August 16, 2016

LaTonya Brown
Administrator of the Delaware Board of Dietetics/Nutrition
Delaware Board of Dietetics/Nutrition
Cannon Building
861 Silver Lake Blvd.
Dover, DE 19904

Dear Ms. Brown:

The staffs of the Federal Trade Commission's ("FTC") Office of Policy Planning, Bureau of Economics, and Bureau of Competition[1] (collectively, "FTC staff") appreciate the opportunity to respond to the Board of Dietetics/Nutrition's ("Board") notice requesting comments on its proposed telehealth regulation, 24 Del. Admin. Code § 3800-9.[2] The proposed regulation follows the Delaware legislature's amendment in 2015 to the state's Insurance and Professions and Occupations codes to encourage the use of telehealth and telemedicine, including for the provision of dietetic and nutrition services. The proposed Board regulation could promote the use of telehealth and potentially enhance competition and patient care by allowing licensed dietitians/nutritionists ("licensees") to determine whether telehealth is an appropriate level of care for a patient and to provide dietetics and nutrition services through telehealth. It could enhance consumer choice by providing an alternative to in-person care, potentially reducing travel costs and increasing access to care. The proposed regulation, however, would limit the flexibility of the revised Delaware code by requiring that "[a]ll initial evaluations shall be performed face to face and not through telehealth."[3] Delaware's 2015 telemedicine law for dietitians and nutritionists broadly defines the potential for telemedicine to include assessment and diagnosis, as well as subsequent phases of care.[4] The proposed regulation could unnecessarily discourage the use of telehealth for assessment and diagnosis and restrict consumer choice.

Regulators play an important role in determining the optimal balance of policy priorities when defining the appropriate scope of practice for health care professionals. Unnecessarily broad scope of practice restrictions, however, can impose significant competitive costs. Thus, we encourage regulators to avoid restrictions that do not address well-founded patient safety concerns, especially if they go beyond the scope of the enabling statute. As the Board conducts

its due diligence regarding the health and safety consequences of initial evaluations by telehealth, we encourage the Board to consider the implications for competition and consumer welfare if the use of telehealth is restricted for initial evaluations.

I. Interest and Experience of the Federal Trade Commission

The FTC is charged under the FTC Act with preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[5] Competition is at the core of America's economy,[6] and vigorous competition among sellers in an open marketplace gives consumers the benefits of lower prices, higher quality products and services, and increased innovation. Because of the importance of health care competition to the economy and consumer welfare, anticompetitive conduct in health care markets has long been a key focus of FTC law enforcement,[7] research,[8] and advocacy.[9] In particular, many of our recent state advocacy comments have addressed scope of practice and supervision provisions that unnecessarily limit the range of procedures or services a practitioner may provide, or unnecessarily restrict a particular type of practitioner from competing in the market.[10]

Telehealth is an area of particular interest to the FTC because of its potential to increase practitioner supply, encourage competition, and improve access to affordable, quality health care. In a 2004 report, the federal antitrust agencies considered the competitive effects of state restrictions on the interstate practice of telemedicine,[11] and the central finding of that analysis remains applicable today: "When used properly, telemedicine has considerable promise as a mechanism to broaden access, lower costs, and improve health care quality."[12] More recently, FTC staff submitted a comment to the Alaska legislature supporting proposed legislation that would allow Alaska-licensed physicians located out-of-state to provide telehealth services in the same manner as in-state physicians.[13] Staff also commented a few weeks ago on the Delaware Board of Occupational Therapy Practice's proposed Telehealth regulation.[14] The conclusions of the agencies' 2004 report and the prior FTC staff comments, which support reduction of barriers to telemedicine, underpin our comments in this letter.[15]

II. Delaware Law and the Proposed Telehealth Regulation for Dietitians/Nutritionists[16]

A. Delaware's Telehealth and Telemedicine Law for Dietitians/Nutritionists

In 2015, Delaware's legislature amended its Insurance and Professions and Occupations codes to enhance the use of telehealth and telemedicine services,[17] recognizing the potential patient benefits from the broader use of telemedicine and telehealth. The legislation added definitions of telehealth, telemedicine and related terms to the practice act for each health care occupation,[18] with the intent of providing greater access to health care by encouraging insurers and health care professionals to support and promote the use of telemedicine and telehealth.[19]

The Dietitian/Nutritionist Licensure Act was among those amended by the legislation to address telehealth and telemedicine services.[20] The law's definition of "telemedicine" broadly sets the stage for licensees to deliver all phases of care remotely, including "assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's health care . . . ."[21] The law also calls for a licensee using telemedicine to practice

"within his or her scope of practice as would be practiced in-person with a patient and with other restrictions as defined in regulation."[22]

B. Delaware's Proposed Telehealth Regulation for Dietitians/Nutritionists

The proposed regulation would define telehealth as the use of electronic communications for a variety of health care and health promotion activities by dietitians/nutritionists, "including education, advice, reminders, interventions, and monitoring of interventions."[23] The proposed regulation would hold licensed dietitians/nutritionists using telehealth to deliver services to existing in-person standards of care.[24]

The proposed regulation would also generally rely on the judgment of licensees to determine whether to use telehealth by making them "responsible for determining and documenting that telehealth is an appropriate level of care for the patient."[25] However, the regulation departs from this paradigm by imposing a rigid requirement that "[a]ll initial evaluations shall be performed face to face and not through telehealth."[26] This prohibition on the use of telehealth for initial evaluations would limit the range of services that could potentially be available to consumers under the law's definition of telemedicine, which contemplates licensees' discretion to use electronic communication for assessment and diagnosis, as well as during subsequent treatment, education, and care management.[27]

III. Likely Competitive Impact of Delaware's Proposed Telehealth Regulation

A. Potential of Telehealth to Increase Competition and Access to Dietetics/Nutrition Services

Generally, competition in health care markets benefits consumers by containing health care prices, expanding access and choice, and promoting innovation. Telehealth can potentially increase the supply of practitioners and thereby enhance price and non-price competition, reduce transportation costs, and improve access to quality care.[28]

As a delivery model for dietetic and nutritional services, telehealth has the potential to enhance competition among providers and improve access to quality care.[29] The Delaware Division of Public Health has specifically recognized these potential benefits.[30] Similarly, many health care professionals and expert bodies support the use of telehealth to mitigate challenges in access to health care arising from an aging population, health care workforce shortages, and geographic and other maldistributions of providers that can lead to shortages in urban as well as rural areas. [31] Indeed, the Delaware *State Plan on Aging* acknowledges that the elderly and individuals with disabilities could greatly benefit from the use of telehealth.[32] The potential for better health outcomes and improved access to cost-effective medical care motivated the Delaware Medicaid Program's 2012 decision to reimburse services delivered by telemedicine, including medical nutrition therapy.[33] The use of telehealth to deliver dietetics/nutrition services and other health care services could also help reduce Medicaid's transportation expenditures as well as individuals' pecuniary and time costs.[34]

Dietitians and nutritionists can provide many preventive and therapeutic nutritional services, such as nutritional care for weight management, diabetes, and kidney disease,

remotely.[35] In 2000, the U.S. Congress recognized the value in providing medical nutrition therapy services for diabetes and renal disease management via telehealth, and added dietitians and nutritionists to the list of practitioners authorized to provide telehealth services to Medicare beneficiaries.[36] Subsequent regulatory changes expanded the list of covered telehealth services to include individual medical nutrition therapy and group nutrition services.[37] The U.S. Department of Veterans Affairs, the Indian Health Services, and Delaware's Medicaid program, among others, have recognized the benefits of tele-nutrition services, as have some private payers that cover telehealth nutrition services.[38]

B. The Proposed Prohibition on the Use of Telehealth for Initial Evaluations Could Unnecessarily Discourage the Use of Telehealth

The proposed regulation could foster the delivery of dietetics/nutrition services via telehealth, thereby increasing competition, consumer choice, and access to care. Proposed § 9.2.4.2 would hold licensees to existing in-person standards of care, and § 9.2.4.1 would entrust the decision whether to use telehealth to the practitioners best positioned to make that determination.[39] These aspects of the proposed rule provide flexibility that could encourage telehealth delivery of dietetics/nutrition services.

However, because § 9.2.4.4 would require that all initial evaluations be performed in person, the proposed regulation may unnecessarily discourage the use of telehealth and limit its potential benefits.[40] Although we are unaware of published guidance or position statements by dietitian or nutritionist organizations regarding the use of telehealth for an initial evaluation, several physicians' organizations have recognized the need for flexibility with regard to the initial evaluation of a patient. These organizations have adopted telehealth policies permitting remote examination of a patient during an initial encounter, so long as a practitioner is held to an in-person standard of care.[41] By contrast, initial in-person examination or evaluation requirements in the health professions may restrict entry of qualified telehealth practitioners, potentially decreasing competition, innovation, and health care quality, while increasing price.[42] Thus, several state legislatures and health care regulatory boards, including Delaware's Board of Occupational Therapy Practice, have recently eliminated or declined to adopt provisions requiring an initial in-person evaluation.[43]

The rigid restriction in the Board's proposed regulation could be avoided by allowing a licensee to determine whether telehealth is appropriate for the initial evaluation as they are permitted to do for subsequent visits. Allowing the licensee to make the determination as to whether to use telehealth for the initial visit would be consistent with the discretion to use telemedicine for assessment and diagnosis, as set forth in Delaware law.[44] Moreover, doing so would allow the practitioner in the best position to weigh access, health, and safety considerations to decide whether to use telehealth. Under the Board's regulation, the standards of care for telehealth initial evaluations would be the same as for in-person initial evaluations.

In at least some situations, dietitians/nutritionists may have enough information about a patient to make an initial evaluation by telehealth. For example, licensees may receive a patient's diagnosis, lab data, and other relevant information from a referring physician. Such a referral is required for Medicare coverage of medical nutrition therapy services, whether provided in

person or by telehealth;[45] other programs or payors may also require a physician referral.[46] In addition, dietitians/nutritionists often conduct nutritional assessments of patients at nursing facilities, where nurses and other health professionals would be available to assist with a telehealth evaluation.[47] Finally, some sources support the use of self-reported anthropometric data for certain types of telehealth evaluations by dietitians and nutritionists.[48] In these situations and others, allowing a licensee to decide whether to use telehealth for the initial evaluation could encourage the use of telehealth and would be consistent with proposed § 9.2.4.1, which would make the licensee "responsible for determining and documenting that telehealth is an appropriate level of care."[49]

For these reasons, we encourage the Board to consider whether requiring licensed dietitians/nutritionists to conduct all initial evaluations in person is necessary for patient welfare. Well-intentioned laws and regulations may impose unnecessary, unintended, or overbroad restrictions on competition, thereby depriving health care consumers of the benefits of vigorous competition.[50] Thus, we suggest that regulators consider whether a restriction that could limit entry or access is narrowly tailored to the legitimate goals of the restriction, such as health and safety, and whether other provisions in the law or regulations already achieve, or could achieve, such goals through less competitively restrictive means.

Accordingly, FTC staff encourages the Board to consider whether the proposed regulation could be improved by eliminating the prohibition on the use of telehealth for initial evaluations and expressly stating that, consistent with Delaware law's definition of telemedicine, licensees have the option to use electronic communications for assessment and diagnosis. Health and safety standards would be maintained by relying on existing standards of care, just as is done with respect to in-person services. Such a clarification could enhance the availability of safe and appropriate telehealth-based dietetics/nutrition services, thus potentially increasing competition, reducing health care prices, and improving quality.

IV. Conclusion

The proposed regulation could promote the use of telehealth and enhance competition in the provision of nutrition services by allowing licensed dietitians/nutritionists to determine whether telehealth is an appropriate level of care and to provide dietetic and nutrition services through telehealth. It may, however, unnecessarily limit those benefits by requiring that all initial evaluations be carried out in person, rather than by telehealth. While supporting the proposed regulation's flexibility in generally allowing licensees to determine whether to use telehealth, we urge the Board to consider whether legitimate health and safety justifications support the restriction, or whether allowing licensees to decide whether to use telehealth during all phases of care would better promote competition and access to safe and affordable care.

We appreciate your consideration of FTC staff's views.

Respectfully submitted,

Tara Isa Koslov, Acting Director
Office of Policy Planning

Ginger Zhe Jin, Director
Bureau of Economics

Deborah Feinstein, Director
Bureau of Competition

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[1] This letter expresses the views of the Federal Trade Commission's Office of Policy Planning, Bureau of Economics, and Bureau of Competition. The letter does not necessarily represent the views of the Federal Trade Commission or of any individual Commissioner. The Commission, however, has voted to authorize staff to submit these comments.

[2] 3800 State Board of Dietetics/Nutrition, 19 Del. Reg. Regs. 1075 (proposed June 1, 2016) (Telehealth regulation to be codified at 24 DEL. ADMIN. CODE § 3800-9) [hereinafter Proposed Regulation].

[3] Proposed Regulation, *supra* note 2, § 3800-9.2.4.4.

[4] We refer to "telemedicine" or "telehealth" as those terms are used in Delaware law and in the proposed regulation that is the subject of this letter. *See infra* note 23. While both terms "describe the use of medical information exchanged from one site to another via electronic communications to improve the patient's health status," they are often interchanged. *See* INST. OF MED., NAT'L ACAD. OF SCIENCES, THE ROLE OF TELEHEALTH IN AN EVOLVING HEALTH CARE ENVIRONMENT: WORKSHOP SUMMARY 3 (2012). Accordingly, we follow the approach of the Institute of Medicine and do not attempt to regularize the usage of either term. *See id.*

[5] Federal Trade Commission Act, 15 U.S.C. § 45.

[6] Standard Oil Co. v. FTC, 340 U.S. 231, 248 (1951) ("The heart of our national economic policy long has been faith in the value of competition.").

[7] *See generally* FTC STAFF, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS (2016), https://www.ftc.gov/system/files/attachments/competition-policy-guidance/hcupdaterev.pdf.

[8] *See, e.g.*, FTC & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf.

[9] FTC and staff advocacy can include letters or comments addressing specific policy issues, Commission or staff testimony before legislative or regulatory bodies, amicus briefs, or reports. *See, e.g.*, Comment from FTC Staff to Valencia Seay, Senator, Ga. State Senate (Jan. 29, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-georgia-state-senator-valencia-seay-concerning-georgia-house-bill-684/160201gadentaladvocacy.pdf (regarding removal of direct supervision

requirements for dental hygienists); Brief of Amicus Curiae FTC in Support of No Party, In re Nexium (Esomeprazole) Antitrust Litig., No. 15-2005 (1st. Cir. Feb. 12, 2016), https://www.ftc.gov/system/files/documents/amicus_briefs/re-nexium-esomeprazole-antitrust-litigation/160212nexiumbrief.pdf; FTC STAFF, POLICY PERSPECTIVES: COMPETITION AND THE REGULATION OF ADVANCED PRACTICE NURSES (2014), https://www.ftc.gov/system/files/documents/advocacy_documents/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf.

[10] Many of these competition advocacy comments have focused on proposed state-level changes to statutes and rules governing the scope of practice and supervision of advanced practice registered nurses. The FTC staff report, *Policy Perspective: Competition and the Regulation of Advanced Practice Nurses*, presents an overview of these comments and an in depth analysis of the competitive effects of such statutes and rules. *See* FTC STAFF, POLICY PERSPECTIVES, *supra* note 9.

[11] *See* FTC & U.S. DEP'T OF JUSTICE, *supra* note 8, ch. 2, at 30 (section on "*State Restrictions on the Interstate Practice of Telemedicine")*. More recently, FTC staff held a workshop series, *Examining Health Care Competition*, where a panel on *Innovations in Health Care Delivery* explored competition issues related to telehealth. *See* Transcript of Examining Health Care Competition Workshop 67-122, Fed. Trade Comm'n (Mar. 20, 2014), https://www.ftc.gov/system/files/documents/public_events/200361/transcriptmar20.pdf.

[12] FTC & U.S. DEP'T OF JUSTICE, *supra* note 8, Executive Summary at 23.

[13] *See* Comment from FTC Staff to Steve Thompson, Representative, Alaska State Legislature (Mar. 25, 2016), https://www.ftc.gov/policy/policy-actions/advocacy-filings/2016/03/ftc-staff-comment-alaska-state-legislature-regarding (regarding telehealth provisions in Senate Bill 74, which would allow licensed Alaska physicians located out-of-state to provide telehealth services).

[14] *See* Comment from FTC Staff to the Delaware Board of Occupational Therapy Practice (Aug. 3, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-delaware-board-occupational-therapy-concerning-its-proposed-telehealth-regulation/v160014_delaware_ot_proposed_advocacy.pdf (regarding its proposed telehealth regulation).

[15] This advocacy also draws on knowledge acquired during the *Innovations in Health Care Delivery* panel of the 2014 FTC workshop, *Examining Health Care Competition*, *supra* note 11.

[16] Under Delaware law, the terms "dietitian" and "nutritionist" are used interchangeably, and the Board issues a single license, the L.D.N. (licensed dietitian/nutritionist), to such practitioners. *See* DEL. CODE ANN. tit. 24, § 3802 (4), (6).

[17] *See* 80 Del. Laws, c. 80 (2015-16) (Chapter 80, formerly H.B. 69, as amended by House Amendment No. 1, An Act to Amend Title 18 and 24 of the Delaware Code Relating to Telemedicine Services (July 7, 2015)), http://delcode.delaware.gov/sessionlaws/ga148/chp080.shtml#TopOfPage (Section 19 amended the Dietitian/Nutritionist Licensure Act, DEL. CODE ANN. tit. 24, § 3802).

[18] The 2015 law added telehealth and telemedicine provisions to the practice acts of at least 19 types of health professionals. *See* 80 Del. Laws, c. 80 (2015-16).

[19] *See Committee Report: H.B. 69*, DEL. STATE LEGISLATURE, COMM. ON ECONOMIC DEVELOPMENT/BANKING/INSURANCE/COMMERCE (April 1, 2015), http://legis.delaware.gov/LIS/lis148.nsf/d81ce478bd9ae572852568730079e2fe/df26340ba3dd31eb85257e1a0074c475?OpenDocument.

[20] *See* DEL. CODE ANN. tit. 24, § 3802 (2), (5), (9), (10), (12), (13). The law's definition of telehealth provides for the use of electronic communications to "support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services as described in regulation." *Id.* § 3802 (12). It defines telemedicine as a "form of telehealth" in which licensees use electronic communications to provide or support clinical care. *See id.* § 3802 (13).

[21] *See id.* § 3802 (13) ("'Telemedicine' means a form of telehealth which is the delivery of clinical health-care services by means of real time 2-way audio, visual, or other telecommunications or electronic communications,

including the application of secure video conferencing or store and forward transfer technology to provide or support health-care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's health care by a licensee practicing within his or her scope of practice as would be practiced in-person with a patient and with other restrictions as defined in regulation.").

[22] *Id.*

[23] Proposed Regulation, *supra* note 2, § 3800-9.1 ("Telehealth is the use of electronic communications to provide and deliver a host of health-related information and health-care services, including dietetics and nutrition-related information and services, over large and small distances. Telehealth encompasses a variety of health care and health promotion activities by, including education, advice, reminders, interventions, and monitoring of interventions."). Unlike Delaware law, the proposed telehealth regulation does not refer to clinical care or telemedicine (which Delaware law defines as a form of telehealth). *See* DEL. CODE ANN. tit. 24, § 3802 (13) However, the regulation's references to health-care services, interventions, and evaluations indicate that it covers the delivery of clinical services generally characterized as telemedicine. *See* Proposed Regulation, *supra* note 2, §§ 3800-9.1, 9.2.4.4. To make it clear that the regulation covers such services, we suggest that the Board consider revising the proposed regulation to expressly cover clinical care and telemedicine in a manner consistent with the provisions in Delaware statutory law.

[24] *See* Proposed Regulation, *supra* note 2, § 3800-9.2.4.2 ("The licensee shall comply with the Board's law and rules and regulations and all current standards of care requirements applicable to onsite care.").

[25] *Id.* § 9.2.4.1.

[26] *Id.* § 9.2.4.4.

[27] *See supra* note 21 and accompanying text.

[28] *See, e.g.*, Comment from FTC Staff to Steve Thompson, *supra* note 13.

[29] *See, e.g.*, Megan E. Rolio et al., *Video Consultations and Virtual Nutrition Care for Weight Management,* 115 J. ACAD. NUTR. & DIETETICS 1213 (2015) (virtual nutrition services "have the potential to extend the reach of dietetics-related services" and overcome barriers arising from cost restrictions and logistical constraints).

[30] *See, e.g.*, Delaware Division of Public Health, State Office of Primary Care, Delaware Primary Care Health Needs Assessment 2015 (Feb. 2016), at 60, www.dhss.delaware.gov/dph/hsm/files/depchealthneedsassessment2015.pdf ("The use of telehealth in Delaware is supported by state government as an important cost-effective, access improvement tool.").

[31] *See generally* Rashid L. Bashshur et al., *The Empirical Foundations of Telemedicine Interventions for Chronic Disease Management,* 20 TELEMED. & E-HEALTH 769, 770 (2014) ("Differences in *access* to care reflect economic, geographic, and functional as well as social, cultural, and psychological factors . . . . many residents of the inner city have limited access to medical resources for economic reasons."); Am. Acad. of Pediatrics, *Policy Statement: The Use of Telemedicine to Address Access and Physician Workforce Shortages,* 136 PEDIATRICS 202, 203 (2015) (urban as well as rural children "face significant disparities in access and time-distance barriers, which could be partly alleviated by the use of telehealth"); Hilary Daniel & Lois Snyder Sulmasy, *Policy Recommendations to Guide the Use of Telemedicine in Primary Care Settings: An American College of Physicians Position Paper,* 163 ANN. INT. MED. 787, app. (2015) ("Limited access to care is not an issue specific to rural communities; underserved patients in urban areas have the same risks as rural patients if they lack primary or specialty care . . . .").

[32] *See* DIV. OF SERVS. FOR AGING & ADULTS WITH PHYSICAL DISABILITIES, DEL. HEALTH & SOC. SERVS., DELAWARE STATE PLAN ON AGING: OCTOBER 1, 2012 TO SEPTEMBER 30, 2016 (2012), www.dhss.delaware.gov/dsaapd/files/state_plan_on_aging_12_15.pdf (telehealth services will improve the lives of older persons and persons with disabilities "by allowing persons to receive some medical care at home, or in other more convenient settings").

[33] *See* Press Release, Delaware Health and Social Services & Office of Governor Markell, Delaware Medicaid Program to Reimburse for Telemedicine-Delivered Services Beginning July 1 (June 27, 2012), http://news.delaware.gov/2012/06/27/delaware-medicaid-program/. ("Telemedicine will improve access to

information and medical care," and lead "to better health outcomes for patients and reduced costs for hospitalizations and transportation." (quoting Gov. Jack Markell)).

[34] States that receive federal Medicaid funds are required to ensure transportation for Medicaid beneficiaries to and from medical appointments. *See* 42 C.F.R. § 431.53. The Delaware Medicaid & Medical Assistance Program pays for nonemergency transportation to covered services. *See Medical Transportation*, STATE OF DEL., http://www.dhss.delaware.gov/dhss/dmma/medical.html (last updated June 2, 2016).

[35] *See, e.g.*, Rolio et al., *supra* note 29, at 1213 ("A number of studies have demonstrated the utility of video consultations for the delivery of nutrition care either alone or as part of a multi-disciplinary team for chronic kidney disease, diabetes, weight management, and home parenteral nutrition . . . ."). Licensed Delaware dietitians/nutritionists assess individuals' specific nutritional needs and provide dietetic and nutrition therapy, including services such as counseling, education, medically prescribed diets, tube feedings, and specialized intravenous solutions. *See* DEL. CODE ANN. tit. 24, § 3802(2).

[36] *See* Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. No. 106-554, Dec. 21, 2000, Tit. 1, Subtit. A, § 105(d), 114 Stat. 2763A-472 (codified at 42 U.S.C. § 1395u(b)(18)(C)). Medicare pays for telehealth services provided by a physician or a practitioner described in 42 U.S.C. § 1395u(b)(18)(C)). *See* 42 U.S.C. § 1395m(m)(1).

[37] Medical nutrition therapy services are not on the *statutory* list of Medicare-covered telehealth services. *See* 42 U.S.C. § 1395m(m)(4)(F). However, regulatory changes expanded the list of covered services to include individual medical nutrition therapy in 2006, and group medical nutrition services in 2011. *See* 42 C.F.R. § 410.78(b) (2006); 42 C.F.R. § 410.78(b) (2011). *See also* Matlin Gilman & Jeff Stensland, *Telehealth and Medicare: Payment Policy, Current Use, and Prospects for Growth* 3 MEDICARE & MEDICAID RES. REV. E1, E6, E7 (2013) (describing the expansion of Medicare-covered telehealth services).

[38] *See, e.g.*, Dave Overson, *Nutrition Done Right from Afar at NMVAHCS*, N.M. VA HEALTH CARE SYS. (Sept. 28, 2015) (discussing a telenutrition program "that is improving the lives of countless New Mexico Veterans."); CAL. AREA OFFICE, INDIAN HEALTH SERV., TELENUTRITION GUIDELINES FOR CALIFORNIA TRIBAL AND URBAN INDIAN HEALTHCARE PROGRAMS 1 (2012), https://www.ihs.gov/california/tasks/sites/default/assets/File/HPDP-CAO_TeleNutrition_Guidelines.pdf ("As with other telehealth services, telenutrition can provide access and convenience of clinical services to communities unable to locally obtain these services. Telenutrition can help reduce travel, stress, and costs for patients and their family."); Press Release, *supra* note 33.

[39] *See supra* notes 24 and 25 and accompanying text.

[40] *See supra* note 26 and accompanying text.

[41] Although we take no position on the telemedicine policies of the Federation of State Medical Boards ("FSMB") and the American College of Physicians ("ACP"), we note that under both policies, a physician-patient relationship can be established during a telemedicine encounter. *See* FED'N OF STATE MED. BDS., MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE 5 (2014), https://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/FSMB_Telemedicine_Policy.pdf (the physician-patient relationship to "be established using telemedicine technologies so long as the standard of care is met."); Daniel & Sulmasy, *supra* note 31, at 787-88, App. (ACP takes the position that "a telemedicine encounter itself can establish a patient-physician relationship," so long as the physician meets "the standard of care required for an in-person visit"). Occupational therapy organizations and practitioners have taken similar positions, concluding that telehealth may be used throughout the course of care – including for evaluation, intervention, and monitoring – when practitioners are held to existing professional standards of care. *See* Comment from FTC Staff to the Delaware Board of Occupational Therapy Practice, *supra* note 14, at note 38.

[42] *See* Comment from FTC Staff to Steve Thompson, *supra* note 13.

[43] *See, e.g.*, *id.* (describing the 2014 adoption by the Alaska State Legislature of a law allowing in-state Alaska licensed physicians to provide telehealth services without an in-person physical examination, and advocating the adoption of provisions in Senate Bill 74 that would allow out-of-state physicians to provide telehealth services in the same manner); *Bill History/Action for 29th Legislature: SB 74*, ALASKA STATE LEGISLATURE,

http://www.akleg.gov/basis/get_bill.asp?session=29&bill=sb++74 (last updated July 15, 2016) (noting adoption of Alaska SB 74, which eliminated an in-person physical examination requirement for Alaska licensed physicians located out of state); FTC Staff Comment to the Delaware Board of Occupational Therapy Practice, *supra* note 14, at note 22 (in-person evaluation requirement in the 2015 version of a proposed regulation was eliminated); Ala. State Bd. of Med. Examiners, Certification of Emergency Rules: Emergency Repeal of Chapter 540-X-15 (Aug. 25, 2015), http://www.albme.org/Documents/Rules/Temp/540-X-15ER%20repealed.pdf (repeal of telemedicine rules requiring an in-person physical examination or a telehealth evaluation with the patient at an established medical site in light of their potential antitrust implications).

[44] *See supra* note 21 and accompanying text.

[45] *See* 42 U.S.C. § 1395x(vv)(1). We express no opinion on whether a referral should be required for nutrition services; rather, we note that pursuant to a referral, dietitians/nutritionists may receive health information obviating any need for an in-person evaluation that might otherwise exist.

[46] *See, e.g.*, *Referring Patients to an RDN*, ACAD. OF NUTRITION & DIETETICS, http://www.eatrightpro.org/resource/about-us/what-is-an-rdn-and-dtr/work-with-an-rdn-or-dtr/referring-patients-to-an-rdn (discussing referral requirements in Medicare, private insurance, and state law).

[47] *See* 16 DEL. ADMIN. CODE § 3201-6.5.3 (2016) (Nutritional assessments at skilled and intermediate care nursing facilities).

[48] *See* Rolio et al., *supra* note 29, at 1213, 1218, 1220 (describing techniques for the collection, evaluation, and interpretation of information in a virtual nutrition assessment).

[49] Proposed Regulation, *supra* note 2, § 3800-9.2.4.1.

[50] *See* FTC STAFF, POLICY PERSPECTIVES, *supra* note 9. *See also* THE WHITE HOUSE, OCCUPATIONAL LICENSING: A FRAMEWORK FOR POLICYMAKERS 30 (2015), https://www.whitehouse.gov/sites/default/files/docs/licensing_report_final_nonembargo.pdf (excessively stringent restrictions on the services that a practitioner can provide may limit the supply of labor, restrict competition, restrict access to services, and increase the price of services).