Comments by the American Telemedicine Association
Before the Federal Trade Commission
Examining Health Care Competition

March 10, 2014

On behalf of the American Telemedicine Association (ATA), I am pleased to provide the Federal Trade Commission the following comments in response to your announced public workshop titled: "Examining Health Care Competition." Our comments focus on recent trends in telemedicine, its impact on competition and the effect of current regulations.

ATA, established over twenty years ago, is a membership-based, non-profit organization. Members in ATA include thousands of healthcare providers, administrators, government officials and academics from every state in the country. We also represent over 150 hospital and health systems and over 140 companies in the health, technology and telecommunications industries.

Telemedicine is an important part of the delivery of integrated care and prevention and can be practiced with the assurance of quality and safety for the public, allowing many health services to be delivered to anyone anywhere. The use of telemedicine, the provision of health services using telecommunications, offers many opportunities to improve the delivery of health care; however, the growth of telemedicine faces artificial barriers to competition. Some of these barriers are artifacts that predate the deployment of modern-day telecommunications, advancements in technology and experience. Other barriers are consciously created and some are encouraged or enabled. Just as innovation is blossoming in the way we delivery healthcare, so too must innovation occur in the way we regulate health care.

What is telemedicine?

Formally defined, telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status. Also referred to as telehealth, mobile health and connected care, telemedicine includes a growing variety of applications and services using two-way video, email, smart phones, wireless tools and other forms of telecommunications technology. Starting out over forty years ago with demonstrations of hospitals extending care to patients in remote areas, the use of telemedicine has spread rapidly and is now becoming integrated into the ongoing operations of hospitals, specialty departments, home- health agencies, private physician offices as well as consumer's homes and workplaces.

Telemedicine has experienced rapid growth because it offers four fundamental benefits:

1. **Improved Access** – For over forty years, telemedicine has been used to bring healthcare services to patients in distant locations. Not only does telemedicine improve access to patients, but it also allows physicians and health facilities to expand their reach beyond their own offices. Given the provider shortages throughout the world--in both rural and urban areas--telemedicine has a unique capacity to increase service to millions of new patients.
2. **Cost Efficiencies** – Reducing or containing the cost of healthcare is one of the most important reasons for funding and adopting telehealth technologies. Telemedicine has been shown to reduce the cost of healthcare and increase efficiency through better management of chronic diseases, shared health professional staffing, reduced travel times, and fewer or shorter hospital stays.
3. **Improved Quality** – Studies have consistently shown that the quality of healthcare services delivered via telemedicine is as good those given in traditional in-person consulations. In some specialties,

particularly in mental health and ICU care, telemedicine delivers a superior product, with greater outcomes and patient satisfaction.

4. **Consumer Empowerment** – Consumers want telemedicine. 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.

Telemedicine and competition

The growing use of telemedicine provides opportunities and challenges. Telemedicine can open up the healthcare market. It changes the paradigm of "going to the doctor" to allowing the doctor come to you. Patients no longer have to be limited to the healthcare services available locally. For the first time, providers can be accessed anywhere. When traveling or temporarily relocating, consumers can keep in touch with their own primary care doctor. Simple follow-up appointments need not always require going back to a provider's office. In additional to primary care doctors, specialists may also be accessed practically anywhere. Patients with chronic diseases can be monitored at home, work or wherever they are located.

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. Also, patient access to online health information may challenge the elevated status and self-image of local family doctors as patients come in equipped with their own information. 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.

Professional regulation of health care providers

Historically, health care providers have been licensed and regulated by individual states. There are 70 independent medical and osteopathic boards that oversee physician licenses and practices in the U.S. and territories. Hundreds of other state boards regulate allied health professions.

Each regulating body provides three types of regulatory oversight for professional services delivered to residents in each state. Each may vary from state to state:

1. Licensing professionals and levees its own licensing fees;
2. Scope-of-practice rules regarding what services can be provided by certain types of licensed professionals; and
3. Standard of care rules regarding normal accepted practices.

Historically, states have held a legitimate responsibility to assure that their citizens have the best possible access to the best possible comprehensive array of services to meet their individual needs, and that those services are evaluated for quality and safety. As such, given the challenges of modern 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.

However, just as providers feel threatened, so too can regulators. State licensure fees bring in millions of dollars to state coffers in additional licensure fees from providers located in other states who wish to provide services to patients residing within state boundaries. Any move to provide licensing and regulation on a regional, national, or even reciprocal basis may present a challenge to the authority of the state-based regulating body.

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, such as remote reading of a MRI or patient emergencies.

In response, state regulators face both a legitimate feeling of responsibility to protect the citizens of their state as well as threats coming from this new competition. Since state boards are almost entirely composed of providers themselves, they may be subject to additional pressure from their colleagues to take action. As a result, 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.

A number of groups and members of ATA have raised serious concerns about the current approach to regulating healthcare providers. Among the concerns raised are:

- Growing demands and costs coupled with shortages of professionals have overwhelmed the ability of local providers to deliver health care. Using such tools as telemedicine and electronic health records, the burden of delivering quality, efficient and immediate care can be shared on regional and national levels.

- For patients, it limits and delays access to the best possible health care. It prohibits people from receiving critical, often life-saving, health services such as treatment for a rare disease that may be available to their neighbors living just across a state line. In life threatening conditions, a delay in time may be life threatening. In short, our fragmented licensing system restricts patient access and choice.

- It forces patients and their families to be transferred from their local community hospital to long distance health centers creating undue burdens on families and loss of support to patients. In some instances, the transfer of patients is not always without risk to a highly unstable patient.

- For patients, it blocks continued access to their established professionals because of seasonal travel, such as “snowbirds” or recent relocation to a new state for employment.

- For patients, their professional should be able to consult with an out-of-state specialist, or other colleague, without requiring the consulted doctor to also be licensed in the caller’s state. Change is also needed to accommodate a variety of service models featuring a team approach to providing and coordinating a patient’s care, such as a medical homes that serves a multi-state area.

- For health professionals, such requirements are costly and serve as a barrier to fair competition. Licensure costs professionals and the taxpayer hundreds of millions of dollars each year. Separate licensing is without justification for clinical services that do not require face-to-face interactions such as the interpretation of images or peer-to-peer consultations.

ATA's Position

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. Further, 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. It prohibits people from receiving critical, often life-saving health services that may be available to their neighbors living just across the state line.

This does not mean that ATA supports eliminating state-based regulation. In fact, ATA has stated repeatedly that it supports any approach to resolving the current problem with duplicate state licensure and regulations as long as the reform is accomplished without delay and with a specific timeline included for its implementation. While some groups have proposed national licensure, ATA has been outspoken in additional support of alternatives that preserve the ability of a state to regulate professionals, yet allow the safe efficient delivery of healthcare, regardless of location, across the U.S. These include state reciprocity through interstate compacts, uniform, state-based regulatory structures, and nationally recognized state licensing.

The largest concern regarding any state-based solution is whether such an approach will be completed in every state, across the nation in a timely manner. We note that the interstate nursing compact is now 15 years old and has only been adopted by 24 states, leaving a majority of nurses still in a single-state system.

One area ATA finds compelling is the "one state license" model as adopted by Congress for the U.S. Department of Defense. When the federal government evaluated these issues for the healthcare needs of military men and women, especially the millions returning from war-front service in Iraq and Afghanistan with physical and mental wounds, Congress found an innovative solution building on state licensure. This model would have an added benefit of eliminating redundant work and expenses for state licensing boards. Instead, a state may choose to require a professional to register to do business in that state, as is commonly used for other interstate commerce, and to investigate any possible patient complaints. Such a model should be considered for other federal healthcare programs (covering all agencies, health programs, and federally-funded health care sites). In particular, we support H.R. 2001 for patients of the U.S. Department of Veterans Affairs health and H.R. 3077 for Medicare beneficiaries. Also, such a model should be considered for interstate health commerce (under Clause 3 of Section 8 of Article I of the U.S. Constitution).

Regarding provider practice regulations, the expansion of telemedicine would be well served if the nation should move toward unified scope of practice regulations for all of health care. Achieving uniformity may be accomplished either through cooperative agreements among states or through federal standards, such as conditions of participation. At the same time, it should be noted that the care delivered via telemedicine should follow the same standards of as for in-person services.

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 duly qualified telemedicine professional.

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. Regardless, of the approach used, provisions must be included to assure ongoing patent safety. 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.

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