"I am a student at Columbia University. However, this comment to the Federal Trade Commission reflects my own personal opinions. This is not representative of the views of Columbia University or the Trustees of Columbia University."

To: Federal Trade Commission
Re: Mainstreaming Telemedicine

Executive Summary

Telemedicine, the use of communication technology for medical purposes, is a growing field, but perhaps growing too slowly. It has been proven to reduce cost and improve access to healthcare while maintaining the same quality of care of an in-person visit. Telemedicine is especially useful to people who live great distances from the services they need as it can connect them to the quality care they previously did not have access to. However, there are obstacles to the growth of telemedicine. There are burdensome licensing requirements to treat a patient in another state, restrictive coverage of telemedicine services, and large start-up fees for the provider to invest in the technology. Each issue should be addressed before telemedicine can be fully mainstreamed, but the problem of incomplete coverage for telemedicine services underlies them all. Before doctors will apply for licenses or invest in the technology, they need to be assured that they will be reimbursed for the services they provide. For this reason, Congress should amend the Benefits Improvement and Protection Act to make coverage more inclusive for people who live outside of metropolitan areas.

Background

Between 2008 and 2030, the U.S population is projected to grow by 20%. This growth will be accompanied by an increase in chronic diseases and health care costs and a shortage of licensed healthcare professionals. As the demand for health care increases and the supply of providers decreases, the health care industry must find other ways to provide care to a growing and more demanding population (Hein 4). Telemedicine can solve this problem by providing better patient access to physicians services at a lower cost.

According to the American Telemedicine Association (ATA), telemedicine is defined as the exchange of medical information through electronic communication in order to improve a patient's health. Examples of telemedicine include video conferencing, smart phone use, and email among others. The uses of telemedicine can be divided into three categories: store- and-forward, remote monitoring, and interactive services. Store-and-forward technology frees a patient and doctor from having to be present at the same time. The patient may send medical information to the doctor for assessment at a different time. Remote monitoring technology allows a patient to receive medical attention from home through monitoring devices that transmit real time medical data to physicians. Finally, interactive technology allows doctors and patients to communicate in real time from remote locations.

This technology saves time and money by reducing unnecessary physician and ER visits and increases patient access to medical care. Currently, the ATA estimates the home monitoring sector to be valued at 600 million and the entire telemedicine field to grow 56% over five years. (Hein 4) However, the regulations and incentives governing telemedicine make its widespread implementation difficult.

Laws governing licensing and credentialing of physicians practicing telemedicine differ from state. Navigating these policies can be confusing and vague and can act as a disincentive for physicians to treat patients in other states. Each state is granted the authority to determine a physician's ability to practice medicine in that state and each state has different requirements for granting a license. Telemedicine complicates the licensing requirements. Some states require that the physician have a license in the state where the doctor resides and others require that the license be in the state where the patient resides. Some health care facilities also require that physicians get credentials at the site of

their patient. Credentialing is the process of being evaluated by the off-site facility (where the patient is) for license and competence qualifications. Applying for credentials consists of extensive paperwork for the physician, often duplicating the work he/she had to do to get credentials in the facility he/she physically works in. The process can take a long time and may even require two separate applications, one from the Joint Commission and one from the Centers for Medicaid and Medicare Services. (Licensure 15)

The reimbursement policies governing telemedicine are also piecemeal with Medicare, Medicaid and private insurance policies existing under different laws . Reimbursement for Medicaid is at the discretion of each state, 45 of which have decided to implement some form reimbursement. The reimbursement is extremely variable as each state can decide what services to cover. This decision is based on such variables as quality of equipment and location of provider (Medicare Reimbursement 13). Medicare reimbursement for telemedicine is federally mandated, but limited. Coverage depends on location of the patient and type of service rendered. The patient must be at a health facility that is in a Health Professional Shortage Area and the service must usually be rendered with patient and provider both present, as in a live teleconference. However, some use of store-and-forward technology is reimbursed. (Telehealth reimbursement 16)As of 2012, 13 states require private health insurance companies to reimburse telemedicine care. However, the states don't require that the services be reimbursed at the same rate as an in-person service(More States 17). This very fragmented nature of telemedicine coverage is restricting its integration into mainstream physician care.

A third issue preventing the widespread availability of telemedicine is that the costs to develop and purchase the technology falls on the hospital and physicians while the financial benefit goes to the insurer and payer. Currently, the financial benefit to hospitals of providing telemedicine is unclear (LeRouge 14). Cost and revenue information is vague which creates a vicious cycle where lack of information on hospital costs leads to insurer hesitancy to cover services which makes hospital costs and benefits even more difficult to estimate (LeRouge14). Costs of equipment and communication incurred by hospitals from technology maintenance, may not justify the benefit (LeRouge 14).

Evidence

To find information on the three barriers discussed in this paper, I used websites from experts in the field. For example, to find the current reimbursement policy for telemedicine, I used the Center for Telehealth and e-Health Law's website. To find information about the current licensing environment, I used the Telehealth Resource Center website. These are both respected, nonpartisan organizations dedicated to explaining and disseminating telemedicine issues. To find information on telehealth in general such as its current and projected use, I used data healthcare consulting firms and the American Telemedicine Association.

Problem

The issues of licensing, reimbursement, and cost are issues of supply. They are obstructing additional avenues of receiving care, and therefore preventing competition. Without unobstructed access to telemedicine, healthcare access will remain difficult and prices will continue to rise. Removing these barriers can reduce cost and improve access. According to the American Telemedicine Association, the purpose of telemedicine is to save time, money, and lives. The issues of licensing, reimbursement, and cost have become problems because they are preventing telemedicine from achieving its goals.

Options

In order begin simplifying the licensure process and making it easier for physicians to practice telemedicine, Congress could amend title XVIII of the Social Security Act. Title XVIII covers freedom of healthcare choice and states, "any individual entitled to insurance benefits under this title may obtain

health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services." This declaration can serve as the basis to make providing care easier across state lines. House Bill 3077, the TELE-MED Act of 2013, attempts to make it legal for a Medicare provider licensed in one state to legally treat a patient in another state without getting re-licensed. This would be an immensely simplified licensing structure compared to the current licensing regulations. The time, effort, and confusion that act as obstacles in the current system of re-licensing would be completely eliminated for Medicare providers. A disadvantage of this option is the long timeline inherent to the policy making process and the slight chance that a new regulation will make it past all the veto points involved. However, since the proposed regulation only has implications for Medicare providers, this can be seen as an incremental change in the licensing process which may have a greater chance of gaining Congressional support. (More States 17)

Another way to expand the use of telemedicine would be to address reimbursement disparities which inhibit patients from taking full advantage of telemedicine services. Although the Benefits Improvement and Protection Act expanded coverage delimited by the Social Security Act, one central guideline remained severely constricted—reimbursement was still dependent on the location of the patient. Insurance only covered residents outside of Metropolitan Statistical Areas (MSA). Rural residents are an important beneficiary of telemedicine as it allows them to receive quality care that is not available in their area. The issue is that this designation may categorize a resident living an hour or more outside of a city as still living in an MSA. The patient must also live in a health professional shortage area (HPSA) which is defined as having a shortage of primary medical, dental, or mental health providers. This reimbursement restriction penalizes those living in an HPSA who seek treatment from a profession outside of these three. BIPA expanded coverage in 2000 and should be further amended to be even more inclusive of those seeking care. One advantage to this strategy is that having been passed before, Congress will be softened up to a more inclusionary reimbursement structure. (Hughes 19)

The start-up costs to hospitals of investing in the necessary technology can be prohibitive in the uptake of telemedicine. In the current environment, the case may be that doctors have to pay for the costs of new technology while being unable to bill for the services (due to reimbursement issues) provided with this technology. Hospitals and doctors must be provided with some financial incentive to invest in these technologies. A payment structure should be instituted where an increase in the provision of telemedicine results in an increase in provider salary. Modeled off the pay-for-performance payment structure, a better performance would be equivalent to more telemedicine provided. More compensation would incentivize initiating a telemedicine program. The disadvantage of this option is that it may lead to "telemedicine mills" where quality of services is sacrificed for quantity.

<u>Recommendation</u>

The most deeply rooted issue preventing the mainstreaming of telemedicine, is the lack of insurance for it. If doctors are not compensated for their services, they will likely not seek licenses or initiate telemedicine programs in their hospitals and health care facilities. This is most important issue to solve. A coverage expansion was passed in 2000 which bodes well for the legislations passage in the future. After its passage, it is highly feasible that a coverage expansion based on location could be implemented. The financial costs involved in, perhaps, calculating the mileage of a residence to a hospital would not be high nor would it be time intensive. The bill would likely have to pass through the House Appropriations Committee meaning that Chairman, Hal Rogers, would have to lead it through. Although the intensive process around re-licensing and the issue of start-up costs for doctors do represent obstructions to the increase in telemedicine supply, these are issues that should be solved second to expanding coverage.

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