UNIVERSITY of VIRGINIA HEALTH SYSTEM

Center for Telehealth | Office of Telemedicine

COMMENTS OF THE UNIVERSITY OF VIRGINIA HEALTH SYSTEM

"FACILITATING THE COMPETITIVE PROMISE OF TELEMEDICINE"

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Submitted April 29, 2015

IN RESPONSE TO FEDERAL TRADE COMMISSION AND

U.S. DEPARTMENT OF JUSTICE ANTITRUST DIVISION

"EXAMINING HEALTH CARE COMPETITION" WORKSHOP

Held February 24-25, 2015, Washington D.C.

"FACILITATING THE COMPETITIVE PROMISE OF TELEMEDICINE"

COMPETITION LAWS AND THE HEALTH CARE MARKETPLACE

Executive Summary

The antitrust laws seek to protect against the exercise of market power that diminishes consumer choice or undermines competition. As the Federal Trade Commission and Department of Justice Antitrust Division have emphasized, competition in health care markets benefits consumers because it helps contain costs, improve quality, and encourage innovation. The University of Virginia Health System applauds the Federal Trade Commission and Department of Justice Antitrust Division for conducting this workshop and appreciates the opportunity to submit its views.

As demand for health care services and physician shortages increase, and as America's health care system transitions from volume-based to value-based care delivery models, telemedicine is uniquely positioned to enhance competition and access to high quality medical care. However, structural barriers continue to limit telemedicine. Ensuring equivalent reimbursement rates for telehealth services, eliminating originating site restrictions, and expanding distant site provider eligibility under Medicare will help telemedicine obtain its pro-competitive promise during a period of greater integration among some health care providers.

Telemedicine Defined

For purposes of these comments, "telemedicine" has the same meaning as that contained in 42 CFR 410.78 (2014). Specifically, telemedicine is defined as the use of medical information exchanged via interactive telecommunications to improve a patient's clinical health status. An interactive telecommunications system is defined as "multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system." *See id*. Because quality and patient safety remain critical priorities, the practice of telephone-only healthcare services is excluded from the definition of telemedicine.

Telemedicine Expands Consumer Choice, Enhances Patient Care, and Improves Efficiency at a Time of Increasing Demand for U.S. Medical Services

As reflected in the more than 50 year growth of connected healthcare services in the United States, telemedicine provides opportunities to expand consumer choice, improve quality and broaden access to care at often reduced costs with enhanced efficiency. Advances in healthcare technology innovation, an increasingly robust broadband and wireless communications infrastructure, and the imperatives of healthcare reform have set the stage for greater integration of telemedicine. The broad geographic reach of telemedicine enhances patient care access, expands consumer choice and results in cost-saving efficiencies.

According to the most recent estimate of the Association of American Medical College's Center for Workforce Studies, by 2025 the projected shortfall of physicians nationwide range from 46,100 to 90,400. Projected shortfalls in primary care will range between 12,500 and 31,100, while the shortfalls in non-primary care physicians will range from 28,200 to 63,700 by 2025. The Congressional Budget Office estimates that once fully implemented, the Patient Protection and Affordable Care Act will provide health insurance coverage to 26 million additional Americans. However, expanded health insurance does not guarantee timely access to care if demand for services outstrips the supply of medical service providers. Telemedicine mitigates workforce shortages and supports inter-professional models of care delivery via different technology platforms to include live interactive videoconferencing formats, store and forward applications, m-Health tools and through the use of remote patient monitoring tools.

Examples of Telehealth in Practice – Neurology, Neonatal Care, Diabetes Screening, and Hospital Admissions/Readmissions

Live interactive videoconferencing used in stroke systems of care provides timely access to acute stroke neurology evaluations and appropriate use of thrombolytic agents proven to reduce morbidity and mortality and cost of care for stroke victims. EMS providers using m-Health tools now can connect stroke patients with physicians en route to the hospital, sparing precious time when every moment counts in preserving brain function. When used to support women with high risk pregnancies, in particular those residing in geographic locations remote from centers with perinatal specialty care, telemedicine can reduce preterm deliveries, reduce infant mortality, and lower the cost of care both during the neonatal period and for a lifetime.

According to the American Telemedicine Association, this year, more than 15 million Americans will receive medical services remotely, including 120,000 stroke patients seen by neurologists and 500,000 Intensive Care Unit patients monitored remotely by an intensivist. Store and forward telemedicine services such as those used for screening of diabetic patients for retinopathy, the number one cause of blindness in working adults, offers community based access to screening. When the standard of care requires that every diabetic patient undergo an annual eye exam, provider shortages and geographic and other socio-demographic disparities limit access, but are easily mitigated through retinal screening programs using tele-ophthalmology tools.

Telemedicine and remote patient monitoring have been proven to reduce hospital readmissions of patients with congestive heart failure, acute myocardial infarction, chronic obstructive pulmonary disease, and pneumonia, improving outcomes and lowering the cost of care. Remote patient monitoring has been demonstrated to improve chronic disease management in home and workplace settings. In short, telemedicine has a clear and demonstrated track record improving access to patient care, increasing patient choice, reducing costs, and advancing healthcare competition.

RECOMMENDATIONS TO FURTHER ADVANCE THE PROCOMPETITIVE PROMISE OF TELEMEDICINE

In order to fully realize the potential of telemedicine to enhance patient care while reducing costs, a number of public policy imperatives must be addressed.

Reimbursement Models Must Eliminate Arbitrary Disparities Between Telemedicine and In-Person Medical Care

To date, reimbursement for telemedicine services takes place via a diverse number of methodologies, including limited fee for service coverage by Medicare (attributable to significant statutory originating site restrictions and eligible distant site providers), by some private payers, by state Medicaid programs (generally as a result of state mandates), through contracted services, self-pay, and hospital investments to defray readmissions penalties. Currently, 23 states and the District of Columbia have enacted parity reimbursement statutes. Simply put, in order to more fully realize telemedicine's procompetitive potential telemedicine providers must be reimbursed at rates equivalent to physically present providers.

Medicare Reimbursement Parity

In 2013, nationwide, Medicare reimbursed less than $12 million in telemedicine claims for both originating site and distant site providers. These low reimbursement levels are attributable to statutory impediments that limit reimbursement for telemedicine services to location and types of originating sites (rural only), and eligible providers. Hospitals, clinics, skilled nursing facilities and patient homes located in urban areas are *not* eligible originating sites and thus ineligible for Medicare reimbursement. Medicare Shared Savings Program Accountable Care Organizations (ACOs) must conform to these same originating site restrictions for payment. This disparity places telemedicine programs at a competitive disadvantage despite its procompetitive attributes and "Triple Aim" track record of improving patient care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.

Recently signed into law after passing both chambers with large bipartisan majorities, H.R. 2, the *Medicare Access and CHIP Reauthorization Act of 2015*, provides the following: "Nothing in the provisions of, or amendments made by, this title shall be construed as precluding an alternative payment model or a qualifying APM participant (as those terms are defined in section 1833(z) of the Social Security Act, as added by paragraph (1)) from furnishing a telemedicine service for which payment is not made under section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m))."

While laudable, this language is more aspirational than practical; more hortatory than mandatory. In order for telemedicine to more formally realize its procompetitive potential, we support efforts to encourage or mandate adoption of alternative payment models that require that telemedicine services receive equivalent compensation under section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)). We also recommend eliminating originating site restrictions and expanding eligible distant site providers to any Medicare provider. Leveling the playing field in this manner will accelerate advances in the provision of telemedicine in a manner that enhances patient care, encourages greater population management, reduces costs, and advances the competitive goals of the Patient Protection and Affordable Care Act.

Medicaid Uniformity and Reimbursement Parity

Jointly funded by the state and federal governments, Medicaid provides medical services for qualifying low income citizens or legal permanent residents. Nearly every state Medicaid program covers *some* telemedicine services, but no two state Medicaid program policies are aligned. While state participation in Medicaid is voluntary, the federal government exercises considerable discretion in determining eligibility for the receipt of federal Medicaid support. In order to ensure telemedicine

providers are accorded the reimbursement parity that will enhance competition and consumer choice, we recommend the adoption of a uniform national reimbursement model for the provision of Medicaid services.

The Center for Medicare and Medicaid Innovation has funded initiatives that include the development of bundled and other alternative payment models, including through the State Innovation Model grants. While these efforts show early promise, they remain in their development stage. Maintaining highly disparate, volume-driven and inefficient payment methodologies restrains further integration of telemedicine. As a result, we strongly endorse prompt adoption of modern, quality-driven reimbursement models that affirm the potential of telemedicine to enhance patient access, quality and outcomes, improve population health management, and reduce costs.

Alternatives to Traditional Fee-for-Service Payment Models, Clinical Integration, and Telemedicine

In remarks delivered at the FTC/DOJ Examining Healthcare Competition Workshop on February 24-25, 2014, Chairwoman Edith Ramirez reiterated the view that the goals of the antitrust laws and those of the Patient Protection and Affordable Care Act are fully consistent. Chairwoman Ramirez stated that accountable care organizations (ACOs), alternative payment models, and clinical integration may improve quality and patient outcomes. Bill Baer, Assistant Attorney General for Antitrust, also expressed commitment to rigorous antitrust enforcement in health care markets. "Because health care is fundamental to our lives," he said, "we share an interest in maintaining and fostering competitive markets that will keep prices in check, improve quality and spur innovation."

The shift from traditional fee-for-service payment models toward alternative payment models predicated upon quality, patient outcomes and enhanced population management has facilitated partnerships, joint ventures and clinical integration among health care providers. As federal antitrust enforcement authorities have emphasized, vertical consolidation and provider arrangements that that limit competition will continue to receive scrutiny. Given its broad reach, accessibility, and substitutability across relevant product and geographic markets, telemedicine is uniquely situated to countervail the anticompetitive potential associated with these arrangements. In other words, telemedicine offsets potential anticompetitive risks associated with enhanced market power exercised by clinically-integrated entities operating in the post-Affordable Care Act health care marketplace. As a result, the FTC and Antitrust Division of the Department of Justice should take affirmative steps to eliminate arbitrary barriers to the practice of telemedicine.

Additional Efforts to Encourage Healthcare Competition

The Federation of State Medical Boards ("FSMB") recently adopted a model compact licensure process in a good faith effort to facilitate interstate medical practice, including via telemedicine. The FSMB should be commended for this important, procompetitive effort. The FSMB model compact requires the participation of seven states; to date, six states have adopted legislation to facilitate the accelerated licensure process. If this compact becomes operational, it promises to help reduce significant delays and administrative burdens facing practitioners wishing to obtain a license to practice medicine – or to treat a patient physically present in –another state. This development would expand consumer choice and encourage precisely the type of competition that has been at the forefront of recent antitrust enforcement efforts in the health care marketplace.

CONCLUSION

Telemedicine increases competition and consumer choice and permits patients to receive high quality care that might otherwise be unavailable. As we transition from volume-based to value-based care delivery models, reduction of unnecessary barriers to telehealth practice will increase competition, improve access, and lower health care costs. Ensuring equivalent reimbursement rates for telehealth services, eliminating originating site restrictions, expanding distant site provider eligibility under Medicare, and ensuring that state licensure laws do not discriminate against these services will help further realize the pro-competitive potential of telemedicine. Moreover, telemedicine' s uniquely broad product and geographic scope in relevant health care markets serve as an expedient to greater competition during a period of greater concentration and integration among health care providers.

Thank you for the opportunity to submit our views. Should you have any questions concerning this submission, please do not hesitate to contact Karen Rheuban, M.D., Medical Director, Office of Telemedicine, Director, Center for Telehealth, and Senior Associate Dean for Continuing Medical Education and External Affairs, University of Virginia Health System, at (434) 924-2481 or ksr5g@virginia.edu.