UNITED STATES OF AMERICA

FEDERAL TRADE COMMISSION

Baltimore, MD 21244-1850

Attention: **CMS-1744-IFC, Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Emergency**

of Economics, Bureau of Competition, and Office of the General Counsel

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appreciate the opportunity to respond to your request for comments on the Interim Final Rule with Comment Period entitled *Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency* ([2] The IFC aims to give flexibility, such as an increased ability to use telehealth, to individuals and entities that provide services to Medicare beneficiaries. The IFC therefore may enable these service providers to respond more effectively to the serious public health threats posed by the pandemic.

Public and private reimbursement laws and policies frequently are cited as impeding the development and widespread use of telehealth services. By limiting entry of telehealth

access to care and choice of practitioner, especially in areas where there is a shortage of healthcare professionals and at times outside normal business hours. Reducing restrictions on Medicare reimbursement for telehealth services is especially important, not only to enhance the use of telehealth to care for Medicare beneficiaries, but also to encourage private payers to expand the use of telehealth. Reducing or eliminating restrictions on reimbursement of telehealth services could potentially enhance competition, improve access and quality, and decrease health care costs in both the public and private sectors.

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payment requirements for telehealth and communication technology-based services

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 $ P H U L F D ¶ V [6] and the FTC's mission. 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] Many of our recent advocacy comments have addressed

FTC staff support CMS as it reduces restrictions on Medicare reimbursement of telehealth services during this public health emergency, thus mitigating the exposure risk of patients and health care professionals. This comment provides a competition perspective on Medicare payment of telehealth services both during and after the public health emergency. In SDUWLFXODU ZH FRQVLGHU WKH six categories: 1) eliminating originating site and geographic requirements, thus allowing telehealth services to be provided to patients at any location, including the home; 2) expanding the types of services that may be furnished by telehealth; 3) providing for access to therapy services furnished by providers who are not statutorily authorized telehealth providers; 4) expanding the use of telehealth telecommunication modalities, including audio-only telephone; 5) allowing CTBS for new as well as established patients DQG DOORZLQJ GLUHFW VXSHUYLVLRQ UH ³LQFLGHQW WR´ ELOOLQJ UXOHV WR EH FDUULHG RXW YLD

A. Allowing Telehealth Services to be Provided to Patients at Any Location, Including the Home

:H VXSSRUW &06¶V XVH RI LWV ZDLYHU DXWKRULW\ WR VHUYLFHV SURYLGHG WR SDWLHQWV LQ DQ\ ORFDWLRQ LQFOXGLQJ this public health emergency.[20] This temporarily eliminates a major and longstanding barrier to providers of telehealth services.[21] Ordinarily, Medicare's fee-for-service program pays providers for telehealth services only when patients are located at certain types of health care facilities ³RULJLQDWLQJ VLWHV´[22] and the facilities must be located in rural areas with a shortage of health professionals.[23] Therefore, Medicare does not reimburse for telehealth services furnished to a patient at a residence, or in a metropolitan area. By restricting reimbursement, Medicare reduces the supply of providers, access to telehealth services, and competition at such locations.

Allowing reimbursement of telehealth services in the home, in any geographic area, will greatly increase the ability to provide care safely during the pandemic. To mitigate exposure risk from COVID-19, the greatest need for telehealth services may be in densely populated urban areas where COVID-19 cases are common.[24] As a result of shelter-in-place orders, both uninfected and infected patients are often at their homes or other residences.[25] By allowing telehealth services to be provided to patients anywhere, including at their residences, the waiver allows more patients to receive services without jeopardizing their health or the health of the professionals who provide care.[26]

Although the public health emergency necessitated immediate removal of the geographic and originating site requirements, longstanding and broad support for eliminating these requirements existed before the pandemic.[27] These requirements preclude reimbursement for services provided to urban beneficiaries with limited access to in-person care because of mobility, economic, or other barriers, as well as rural populations who may live far from an authorized originating site. The requirements inhibit entry of telehealth providers and limit SDWLHQWV¶ access to and choice of provider. Accordingly, the requirements could limit competition among practitioners, potentially reducing the quality and amount of care and increasing its costs.

For these reasons, we strongly support suspending these requirements during the public health emergency, and we urge CMS to consider whether they should be permanently eliminated. Doing so would be consistent with the DGPLQLVWUDWLRQ¶V report, Reforming $PHULFD¶V +HDOWKFDUH 6\VWHP 7KURXJK &KRLFH DQG &RP which recommends that

³ &RQJUHVV VKRXOG FRQVLGHU SURSRVDOV PRGLI\LQJ JHRJ requirements in Medicare fee-for-service that restrict the availability of telehealth services to 0HGLFDUH EHQHILFLDULHV LQ WKHLU[28] Experience during the LQ PRVW pandemic with reimbursing telehealth services not subject to originating site and geographic location requirements should be helpful in evaluating whether it would also be beneficial to eliminate these requirements permanently after the emergency ends.

B. Expanding the Types of Services that May be Furnished by Telehealth

We also support the expansion of the types of Medicare reimbursable telehealth services set forth in the IFC. By improving access to telehealth services and providers, patients, practitioners, and the Medicare program should benefit 2 U G L Q D U L O \ from this flexibility. Current program restricts these services that can be provided via telehealth. The statute limits reimbursable W H O H K H D O W K V H U Y L F H V W R ³ S U R I H V V L R Q D O F R Q V[29] X O W D W L which has resulted in a relatively short and narrow list of reimbursable telehealth services.[30] The Secretary of the U.S. Department of Health and Human Services + + 6 ´ K R Z H Y H U P D \ authorize additional services as warranted.[31]

To mitigate the risks of COVID-19 exposure for both patients and health care professionals, CMS has authorized more than 80 additional types of telehealth services during this public health emergency, including emergency department visits, initial nursing facility and discharge visits, intensive care unit services, and home visits.[32] CMS does not consider the newly authorized services to be similar to the original, statutorily authorized services. Indeed, under normal procedures, CMS probably would not approve these procedures for reimbursement without a clinical study demonstrating patient benefit.[33] But, in the face of this public health emergency where exposure risks are significant, CMS authorized the use of telehealth for these services.[34]

This vast expansion of the types of reimbursable services eliminates a major restriction on telehealth care and allows telehealth services to be provided in new and innovative ways that could improve triage, diagnosis, and treatment of COVID-19 patients. It also will reduce the coronavirus exposure risks of non-COVID-19 patients and health care professionals.[35] Without this expansion of reimbursable telehealth services, it could be difficult or impossible to provide many of the newly authorized services safely. By allowing practitioners to provide services remotely, especially in areas of need that are far away, the change likely increases E H Q H I L F L D U L H V access to needed care during the public health crisis. The change also could

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practitioners as authorized Medicare telehealth services providers. We believe this will enhance the supply of and access to therapy services.

Therapy practitioners are able to provide many services to patients through telehealth. For example, speech-language pathologists can screen and treat students using telepractice, and audiologists can carry out diagnostic hearing assessments and hearing aid programming remotely.[38] Physical therapists, occupational therapists, speech-language pathologists, audiologists, and others provide telerehabilitation care, which helps patients with stroke, head and spinal injury, neurological disorders, and other diseases regain everyday skills and maintain quality of life. In fact, telerehabilitation has the advantage of allowing the therapist to tailor care WR WKH SDWLHQW¶V KRPH RU UHVLGHQFH

Although the IFC sets forth two approaches to improvin

D. Telehealth Telecommunication Modalities, Including Audio-Only Telephone

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reimbursable telehealth services that may be provided by audio-only telephone.[48] Although not
prohibited by statute, services provided by audio-only telephone are not ordinarily reimbursable

need for a risky in- population of Medicare

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More generally, by excluding reimbursement for services provided to new patients who care from direct-to-consumer (which typically provide care around-the-clock, using practitioners located anywhere, often -person provider.[61] By excluding such distant providers of telecommunication-based services, and may be unnecessary to protect consumers. oners in traditional office settings from providing CTBS to new patients.

As discussed in a number of FTC staff advocacy comments, in-person examination requirements prevent licensed health care providers from providing telehealth care that they otherwise would deem appropriate. Such restrictions potentially reduce competition, innovation, consumer choice, and the

state supervision requirements. In the many states that allow APRNs and PAs to practice with less stringent supervision, this change would directly benefit healthcare consumers.

Unduly restrictigs0 0 0 12dethcare consumers.

nurse practitioners (NPs), other registered nurses, and physician assistants (PAs) to practice to[78]

Similarly, in changing the required level of supervision for hospital outpatient therapeutic

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in rural hospitals where there may be insufficient staff to furnish direct supervision. Moreover, in

therapeutic services, regardless of whether the minimum level of supervision required under the[79]

operates in
addition to any state supervision or collaboration requirements. Most state requirements were

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to provide care safely to Medicare beneficiaries, and to support and enhance the vast expansion of telehealth care that is already underway.

supra note 17 -
Bryan L. Burke et al., American Academy of Pediatrics, *Telemedicine: Pediatric Applications*, 136 PEDIATRICS
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[20] On March 17, 2020, CMS announced the temporary expansion of telehealth services pursuant to waiver authority added under the Social Security Act

services by Med

Home-Based Telerehabilitation vs In-Clinic Therapy for Adults After Stroke: A Randomized Clinical Trial, 76 JAMA NEUROL. 1079, 1080
effective means to provide rehabilitation therapy and improve patient outcomes after stroke and may be useful for

[40] *See* IFC, 85 Fed. Reg. at 19,239-40.

[41] *See id*. at 19,239 (90 percent of the time therapy services are furnished by therapy professionals, such as physical therapists, occupational therapists and speech-language pathologists).

[42] *See id*. at 19,243- es include those furnished to new or established patients that the occupational therapist, physical therapist, and speech-language pathologist practitioner is currently treating under a

[43] *See id*. at 19,244-45 (these services can only be billed when there has not been a related service within the past 7 days and the service does not lead to a related service or procedure within the next 24 hours). *See also* Letter 2
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[50] See IFC, 85 Fed. Reg. at 19,243 (amending 42 C.F.R. § 410.78(a)(3) by adding (a)(3)(i), defining "interactive telecommunications system" for the duration of the PHE).

[51] See, e.g., MONICA ANDERSON, MOBILE TECHNOLS5p9(II 56tMnD (E)]TJ ET Q q 0 0 612 792 re W* n BT 0 g /TT0 1 Tf 10.02 0 0 10.32 1T0 .02

[84] See CHOICE & COMPETITION REPORT, supra note 21, at 36(