



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

Office of Policy Planning
Bureau of Competition
Bureau of Economics

November 1, 2017

Director, Regulation Policy and Management (OOREG)
Department of Veterans Affairs
810 Vermont Ave., NW, Room 1063B
Washington, DC 20420

Re: RIN 2900-AQ06-Authority of Health Care Providers to Practice Telehealth

The staffs of the Federal Trade Commission's ("FTC") Office of Policy Planning, Bureau of Economics, and Bureau of Competition¹ (collectively, "FTC staff") appreciate the opportunity to respond to your request for comments on the Department of Veterans Affairs' ("VA") proposed rule entitled, "Authority of Health Care Providers to Practice Telehealth" ("Proposed Rule"). We write in support of the Proposed Rule, which would "clarify that VA health care providers may exercise their authority to provide care through the use of telehealth, notwithstanding any State laws, rules, or licensure, registration or certification requirements to the contrary."² Thus, if adopted, the Proposed Rule will ensure that VA telehealth providers may provide services to or from non-federal sites, such as a home, regardless of whether the provider is licensed in the state where the patient is located.

In recent years, FTC staff have had numerous opportunities to examine the impact of telehealth regulations on health care competition. Our findings reinforce the VA's view that the Proposed Rule would enable the use of telehealth to reach underserved areas and VA beneficiaries who are unable to travel, improving the ability of the VA to utilize its health care resources. Accordingly, we believe that the Proposed Rule would likely increase access to telehealth services, increase the supply of telehealth providers, increase the range of choices available to patients, improve health care outcomes, and reduce the VA's health care costs, thereby benefiting veterans.

The VA's rulemaking would also provide an important example to non-VA health care providers, state legislatures, employers, patients, and others of telehealth's potential benefits. The rulemaking may spur innovation among other health care providers and thereby promote competition and improve access to care, which will benefit consumers so long as providers are

held to the appropriate standard of care for the services they are providing remotely. Additionally, the Proposed Rule may afford a valuable opportunity to gather data and provide additional evidence for the VA and outside policymakers to assess the effects of telehealth expansion, thus benefitting VA patients and health care consumers generally.

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.³ Competition is at the core of America's economy,⁴ 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,⁵ research⁶ and advocacy.⁷ Many of our recent advocacy comments, including one to the VA, have addressed scope of practice and supervision requirements that may 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.⁸

The VA's Proposed Rule involves the intersection of two important and current FTC advocacy areas that directly affect many consumers: occupational licensing and telehealth. Since the late 1970s, the Commission and its staff have conducted economic and policy studies relating to licensing requirements for various occupations and professions,⁹ and submitted numerous advocacy comments to state and self-regulatory entities on competition policy and antitrust law issues relating to occupational regulation, including the regulation of health professions.¹⁰ Building on this work, in 2017 the FTC formed a new Economic Liberty Task Force ("ELTF") that has been examining a broad range of licensing issues, including occupational license portability.¹¹ On July 27, 2017, the ELTF held a roundtable, Streamlining Licensing Across State Lines: Initiatives to Enhance Occupational License Portability, to examine ways to mitigate the effects of state-based occupational licensing requirements that make it difficult for those licensed by one state to obtain a license in another state.¹² Barriers imposed by occupational licensing place particular burdens on telehealth – the use of telecommunications to provide health care services to remotely located patients – because of its intrinsic ability to enable providers to provide services across jurisdictional boundaries.

The impact of occupational licensing requirements on telehealth is also of great importance because of telehealth's 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.¹³ 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."¹⁴ 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 across state lines in the same manner as in-state physicians.¹⁵ FTC staff also recently commented on telehealth regulations proposed by three Delaware occupational licensing boards.¹⁶ The conclusions of the agencies' 2004 report and

these recent FTC staff comments, which support reduction of unjustified barriers to telehealth, underpin this comment.¹⁷

II. Current Regulatory Framework and the VA's Proposed Rule

Under current law, VA health care practitioners who work within the Veterans Health Administration (“VHA”) must be licensed, registered or certified in a state to be eligible for employment and to practice within the VA system.¹⁸ Practitioners working within the scope of their federal duties need not be licensed in the particular state where employed by the VA.¹⁹ However, because current VA licensing law does not address telehealth, state requirements that telehealth providers be licensed in the state where the patient is located create legal ambiguity for VA telehealth providers.²⁰

States deem the practice of medicine and other health professions to occur where the patient is located; for this reason, they generally require full in-state licensure of out-of-state providers, including those providing telehealth services.²¹ Practicing without a license is prohibited by state statute and subject to civil or criminal penalties.²² Thus, as the VA has explained, state laws and regulations that require licensure of telehealth providers licensed in another state, and with no exception for VA employees, inhibit VA employees from delivering telehealth services to beneficiaries in states in which they are not licensed.²³ For these reasons, the VA has limited the expansion of telehealth services that do not take place entirely on federal property, as is the case when a beneficiary receives services at home or when the VA provider is delivering telehealth care from his or her home.²⁴

The VA's Proposed Rule would eliminate these barriers by preempting “State licensure, registration, and certification laws, rules, regulations, or requirements to the extent such State laws conflict with the ability of VA health care providers to engage in the practice of telehealth while acting within the scope of their VA employment.”²⁵ Thus, the Proposed Rule would allow VA health care practitioners to provide telehealth services to beneficiaries regardless of whether the practitioner and patient are located in different states, or on non-federal property such as a home. By doing so, the Proposed Rule would allow VA health care providers the flexibility to furnish telehealth care in various ways without fear of adverse actions by the states, which could jeopardize providers' credentials and subject them to various types of penalties.²⁶

III. Likely Competitive Impact of the VA's Proposed Rule

FTC staff believes the Proposed Rule will likely benefit both VA beneficiaries and non-VA health care consumers. Telehealth often increases the supply of practitioners, extends the reach of practitioners to new locations, or both. By doing so, telehealth can enhance price and non-price competition, reduce transportation expenditures, and improve access to quality care.²⁷ Many health care professionals and expert bodies support the increased use of telehealth to address health care access challenges arising from an aging population, health care workforce shortages, and geographic and other maldistributions of providers that can lead to shortages in both rural and urban areas.²⁸

A. The VA's Telehealth Program

The ability of telehealth to expand access to health care services, address provider supply issues, and reduce costs has made telehealth a key element in the VA's ongoing efforts to ensure that all beneficiaries have access to convenient, high-quality mental health care, specialty care, and general clinical care. Indeed, the VA is a leader in the development and use of telehealth to expand access to health care.²⁹ In FY 2016, the VA provided 2.17 million episodes of care via telehealth, serving more than 702,000 veterans, of whom 45 percent lived in rural communities. To put these numbers in perspective, 12 percent of the veteran patient population received some form of telehealth care in FY 2016.³⁰

The VA provides telehealth services in a variety of fields, focusing on areas of high priority for veterans in which providers are able to meet the appropriate standard of care without being physically in the same place as the patient. Mental health care that could reduce veteran suicide is the highest clinical priority for the VA, and is readily provided by audio-video telehealth services because it does not require physical interaction. Telehealth is also particularly well suited for specific mental health conditions, such as anxiety and agoraphobia, that make it difficult for the patient to leave the house to obtain care.³¹ The VA also relies on telehealth in screening for diabetic retinopathy, which affects approximately 20 percent of veterans and is the leading cause of blindness in working adults in the United States.³² Other areas in which the VA provides telehealth services include teleaudiology,³³ telecardiology, teleneurology, teleamputation care, teledermatology, teleICU, and telepathology.³⁴

Currently, many VA telehealth encounters link a practitioner at a VA medical center with a patient at a community outpatient clinic where a trained assistant uses specialized equipment;³⁵ however, for some services such as mental health care, either the patient or the provider (or both) may be at home. In FY 2000, the VA began a home telehealth program to promote self-management of complex chronic conditions and expand non-institutional care for aging veterans.³⁶ Since FY 2012, the VA has expanded the use of clinical video telehealth to veterans at their homes, and is exploring the use of home telehealth to provide services in a number of specialty areas.³⁷

Studies have confirmed that the VA's existing telehealth services have expanded veterans' access to care, improved health outcomes, and reduced costs for the VA and travel time for beneficiaries. The use of telehealth improves access to care by allowing the VA to reach veterans who might otherwise not receive treatment, and by improving screening of veterans for conditions that require treatment.³⁸ While some studies show that improved access to care results in higher short-term costs, the identification and treatment of serious conditions not only improves beneficiaries' health outcomes and quality of life,³⁹ but also reduces long-term costs by reducing hospitalizations and treatment of advanced disease.⁴⁰ VA telehealth programs also reduce the travel costs incurred by the VA, which typically reimburses beneficiaries for travel to VA facilities or pays to send practitioners to remote locations. Savings from reduced travel costs may be substantial, resulting in immediate savings for the VA and large reductions in beneficiaries' travel time.⁴¹

B. Likely Effects of the VA's Proposed Rule

1. Effects Within the VA System

By ensuring that the VA can provide telehealth services regardless of the location of the provider or patient, the Proposed Rule will allow the VA to expand its telehealth services beyond what it is already doing successfully, thereby further improving access, innovation, and quality, and further reducing costs. In particular, the Proposed Rule would eliminate concerns relating to VA telehealth practitioners who provide services to patients located in states in which they are not licensed, when either the provider, the patient, or both are not on federal property. This flexibility is critical to the VA's ability to enhance the reach of practitioners affiliated with VA Medical Centers ("VAMCs"). The VA has 168 VAMCs and at least one in every state, but 16 states, the District of Columbia, and Puerto Rico have only one VAMC.⁴² Especially in large rural states, telehealth is a highly effective means of improving health care delivery by expanding patients' access to both out-of-state and in-state practitioners.⁴³ Because telehealth services are not intrinsically limited by jurisdiction, elimination of out-of-state licensure requirements, and any other legal impediments to interstate practice, would help the VA more efficiently allocate its health care resources, consistent with appropriate standards of care.⁴⁴

State requirements for licensure of out-of-state telehealth providers have inhibited the expansion of critical VA home-based telehealth services, which have great potential to improve access and health care outcomes for beneficiaries who are unable to travel or are located in rural and underserved areas.⁴⁵ If adopted, the Proposed Rule would allow the VA to lift its current hold on the expansion of many high-priority home telehealth services that can be provided safely and effectively.⁴⁶ For example, patients in need of mental health care experience benefits from home telehealth far beyond convenience, choice, and elimination of travel time. Because of the nature of their conditions, many are simply unable to leave the house or make even a short trip to obtain care.⁴⁷ Similarly, the ability to manage complex chronic conditions via home telehealth may allow veterans to stay in their homes and avoid institutional care, such as at a nursing home.⁴⁸ Moreover, these significant benefits for veterans would come at reduced costs to the VA, not only through avoidance of short-term travel reimbursements, but also because better access to care improves long term health outcomes.

In addition to alleviating local workforce imbalances within the VA system and expanding care to and from non-federal locations, the Proposed Rule has the potential to expand the supply of VA telehealth providers by making it easier to fill existing job vacancies and by improving retention of current employees. For example, the VA has been unable to fill multiple vacancies for telemental health psychiatrists. A number have either left the VA system or refused to provide telehealth services because of concerns about possible adverse actions by states in which they are not licensed or whose requirements are inconsistent with VA protocols or policies.⁴⁹ The Proposed Rule would improve the ability of the VA to compete more effectively to hire qualified providers and to expand critical telehealth programs that involve interstate telehealth services provided to or from a home.

FTC staff recognize that state licensure requirements for health care professionals are intended to protect patients. Such restrictions should, however, be narrowly tailored to address legitimate health and safety issues. 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

In this case, the VA's proposal to preempt state laws and regulations would ensure that a VA health care practitioner can provide telehealth in reliance on a single state license, as is already the case with respect to in-person services. The VA proposal is similar to the Department of Defense telehealth preemption law, which allows its health care professionals licensed in one state to practice "at any location in . . . the United States, regardless of where such health-care professional or the patient are located, so long as the practice is within the scope of the authorized Federal duties."⁵¹ Most health boards, national associations of health boards, and other organizations surveyed by the VA fully support the Proposed Rule, and have raised no health or safety concerns about it.⁵²

2. Effects Outside the VA System

The VA's leadership and foresight on telehealth will send an important signal to all U.S. health care stakeholders regarding the likely benefits of reducing licensing-related barriers to telehealth practice and provide an opportunity to assess additional empirical evidence regarding telehealth. For these reasons, the Proposed Rule may influence broader policy considerations relating to the adoption of telehealth, leading to helpful changes in provider services markets outside the VA system. If so, the Proposed Rule may help to bring the benefits of increased provider competition and expanded telehealth availability to many U.S. citizens and permanent residents, not just VA beneficiaries.

IV. Conclusion

We commend the VA for its proposal to reduce state licensure-related barriers to the provision of telehealth services. By clarifying that VA health care providers can provide telehealth services to or from non-federal sites regardless of whether the provider is licensed in the state where the patient is located, the Proposed Rule is likely to enhance the VA's supply of telehealth providers, improve access to services in rural and underserved locations, expand health care options for patients for whom travel is a particular challenge, improve health outcomes, and reduce the VA's costs. To the extent that the Proposed Rule generates additional support for reducing barriers to telehealth practice and thereby spurs additional competition among health care providers outside the VA system, we believe these benefits would extend to private health care markets as well. For these reasons, we support the Proposed Rule, which should benefit VA beneficiaries – including many of our nation's most vulnerable veterans – as well as non-VA health care consumers.

Thank you for the opportunity to provide our views. We appreciate your consideration.

Respectfully submitted,

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¹ This letter expresses the views of staff in 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 authorized us to submit these comments.

² Authority of Health Care Providers to Practice Telehealth, 82 Fed. Reg. 45,756, 45,757 (proposed Oct. 2, 2017) (to be codified at 38 C.F.R. pt. 17).

³ Federal Trade Commission Act, 15 U.S.C. § 45.

⁴ 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.”).

⁵ See generally MARKUS H. MEIER ET AL., FTC, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS (2017), https://www.ftc.gov/system/files/attachments/competition-policy-guidance/overview_health_care_january_2017.pdf.

⁶ 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>.

⁷ 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 [“APRNs”] (2014), https://www.ftc.gov/system/files/documents/advocacy_documents/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf (presenting an overview of FTC staff comments regarding

APRNs, and an in depth analysis of the competitive effects of statutes and rules governing APRN scope of practice and supervision).

⁸ See, e.g., Comment from FTC Staff to the Dep't of Veterans Affairs (July 25, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/comment-staff-ftc-office-policy-planning-bureau-competition-bureau-economics-department-veterans/v160013_staff_comment_department_of_veterans_affairs.pdf (supporting proposed rule that would allow APRNs to provide services required by the VA without the oversight of a physician); Comment from FTC Staff to the Iowa Dep't of Public Health (Dec. 20, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-professional-licensure-division-iowa-department-public-health-regarding-proposed/v170002_ftc_staff_comment_to_iowa_dept_of_public_health_12-21-16.pdf (regarding the appropriate level of supervision of physician assistants). Most FTC staff competition advocacy comments have focused on proposed state-level changes to statutes and rules. See, e.g., FTC STAFF, POLICY PERSPECTIVES, *supra* note 7.

⁹ See, e.g., CAROLYN COX & SUSAN FOSTER, BUREAU OF ECON., FED. TRADE COMM'N, THE COSTS AND BENEFITS OF OCCUPATIONAL REGULATION (1990), http://www.ramblemuse.com/articles/cox_foster.pdf.

¹⁰ Many of these advocacy comments can be found at FTC, Advocacy Filings, <http://www.ftc.gov/policy/advocacy/advocacy-filings>.

¹¹ See, e.g., *Occupational Licensing: Regulation and Competition: Hearing Before the Subcomm. on Regulatory Reform, Commercial and Antitrust Law of the H. Comm. on the Judiciary*, 115th Cong. 1, 3, 6-7 (2017) (statement of Maureen K. Ohlhausen, Acting Chairman, Federal Trade Commission), https://www.ftc.gov/system/files/documents/public_statements/1253073/house_testimony_licensing_and_rbi_act_sept_2017_vote.pdf.

¹² See FTC, Streamlining Licensing Across State Lines: Initiatives to Enhance Occupational License Portability (event web page), <https://www.ftc.gov/news-events/events-calendar/2017/07/streamlining-licensing-across-state-lines-initiatives-enhance>.

¹³ See FTC & U.S. DEP'T OF JUSTICE, *supra* note 6, ch. 2, at 30 (2004) (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.

¹⁴ FTC & U.S. DEP'T OF JUSTICE, *supra* note 6, Executive Summary at 23.

¹⁵ 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).

¹⁶ See Comment from FTC Staff to the Delaware Bd. of Speech/Language Pathologists, Audiologists & Hearing Aid Dispensers (Nov. 29, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-delaware-board-speech/language-pathologists-audiologists-hearing-aid-dispensers-regarding-its-proposed-revisions-its/161130_ftc_dealers_final_.pdf; 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); and Comment from FTC Staff to the Delaware Board of Dietetics/Nutrition (Aug. 16, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-delaware-board-dietetics/nutrition-regarding-its-proposed-telehealth-regulation/staff_comment_delaware_diet_telehealth_signed.pdf.

¹⁷ 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 13.

¹⁸ See 38 U.S.C. § 7402(b) (setting for the qualifications for appointment as a VHA physician, dentist, nurse, podiatrist, optometrist, pharmacist, psychologist, social worker, marriage and family therapist, mental health counselor, chiropractor, or other health care provider).

¹⁹ See, e.g., 20 Reasons Nurses Love Working for the Veterans Health Administration 37 (2017), https://www.vacareers.va.gov/assets/common/print/Nurse_20Reasons.pdf (“VA offers federal supremacy for nursing licensure, making your specific state license valid in all 50 states and other VA territories.”); Jana Cason & Janice A. Brannon, *Telehealth Regulatory and Legal Considerations: Frequently Asked Questions*, 3 INT. J. TELEREHAB. 15, 16 (2011), <https://telerehab.pitt.edu/ojs/index.php/Telerehab/article/view/6077> (practitioners can practice on the basis of a single state license when the practitioner and patient are located on federal property). See generally Dep’t of Veterans Affairs, Federal Supremacy and Nursing Scope of Practice, Op. VA Gen. Counsel (May 23, 2011), (“without Congressional consent, States may not regulate or control the activities of employees who are acting within the scope of their employment.”).

²⁰ See Authority of Health Care Providers to Practice Telehealth, 82 Fed. Reg. at 45,757 (state legislation and regulations that restrict the practice of interstate telehealth discourage providers from providing telehealth services and create “legal ambiguity and unacceptable State licensing risk”).

²¹ See, e.g., Eric M. Fish, Shiri A. Hickman, & Humayun J. Chaudhry, 10 SCITECH LAWYER (2014), http://www.americanbar.org/content/dam/aba/publications/scitech_lawyer/2014/spring/state_licensure_regulations_evolve_to_meet_demands_modern_medical_practice.authcheckdam.pdf (“Fifty-seven state medical and osteopathic boards and the District of Columbia Board of Medicine now require physicians engaging in telemedicine to be licensed in the state in which the patient is located.”); LYNN D. FLEISHER & JAMES C. DECHENE, TELEMEDICINE AND E-HEALTH LAW § 1.02[2] (2014) (“A large number of states require out-of-state telemedicine physicians to obtain a full, unrestricted medical license in order to ‘see’ patients in the state via telemedicine.”).

²² AMERICAN MEDICAL ASSOCIATION, COUNCIL ON MEDICAL EDUCATION, REPORT 6-A-10, TELEMEDICINE AND MEDICAL LICENSURE 1-2 (2010).

²³ See Authority of Health Care Providers to Practice Telehealth, 82 Fed. Reg. at 45,761 (“The primary barrier to the expansion of VA’s telehealth program is that States’ licensing boards have placed explicit restrictions on the use of telehealth in their States and have not made exceptions for VA providers, which ultimately inhibits VA providers from delivering VA health care to beneficiaries. Five of the States with the largest veteran populations, California, Texas, Florida, New York, and Ohio, have enacted laws and rules that restrict health care providers’ ability to practice telehealth across State lines.”). Compare *id.* at 45,759-60 (discussing licensure exemptions for VA health practitioners provided by the Rhode Island Board of Licensure & Discipline and the Utah Occupations and Professions Licensing Act).

²⁴ See *id.* at 45,757, 45,761 (“To protect VA health care providers from potential adverse actions by States, many VA medical centers (“VAMC”) are currently not expanding some critical telehealth services if the health care service is provided outside Federal property”); Cason & Brannon, *supra* note 19, at 16 (VA practitioners’ privilege to provide telehealth services in states other than their state of licensure does “not extend[] to services provided off federal property”).

²⁵ Authority of Health Care Providers to Practice Telehealth, 82 Fed. Reg. at 45,757.

²⁶ See *id.* at 45,761.

²⁷ See, e.g., Comment from FTC Staff to Steve Thompson, *supra* note 15.

²⁸ See generally 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”); 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.”); 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 . . .”).

²⁹ See, e.g., Authority of Health Care Providers to Practice Telehealth, 82 Fed. Reg. at 45,757; John Wennergren et al., *Implementation of Clinical Video (CVT) within a VA Medical Center is Cost Effective and Well Received by Veterans*, 5 INT’L J. CLIN. MED. 711, 714 (2014), http://file.scirp.org/Html/11-2100844_47385.htm (the VA is ahead of many private institutions and health care organizations with regard to the implementation of innovations and “the wide dissemination and integration of telehealth in clinical practice”).

³⁰ See Authority of Health Care Providers to Practice Telehealth, 82 Fed. Reg. at 45,758.

³¹ See *id.* at 45,758; Adam Darkins, *U.S. Department of Veterans Affairs*, in INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, *THE ROLE OF TELEHEALTH IN AN EVOLVING HEALTH CARE ENVIRONMENT: WORKSHOP SUMMARY* 99, 101, 103 (National Academies Press 2012) [hereinafter Darkins, *U.S. Department of Veterans Affairs*]; Leslie A. Morland, *Telemedicine: A Cost-Reducing Means of Delivering Psychotherapy to Rural Combat Veterans with PTSD*, 19 TELEMED. & EHEALTH 754 (2013).

³² See Joel E. Chasan et al., *Effect of a Teleretinal Screening Program on Eye Care Use and Resources*, 132 JAMA OPHTH. 1045, 1046-1050 (2014) (“[e]arly detection and treatment of diabetic eye disease” through the VA diabetic teleretinal screening program “lead to a reduction in moderate to severe visual loss . . .”); Eser Kirkizlar et al., *Evaluation of Telemedicine for Screening of Diabetic Retinopathy in the Veterans Health Administration*, 120 OPHTHAL. 2604, 2605-09 (2013).

³³ See Chad Gladden et al., *Tele-audiology: Expanding Access to Hearing Care and Enhancing Patient Connectivity*, 26 J. AM. ACAD. AUDIOLOGY 792, 793, 795-96 (2015) (describing hearing aid fitting and programming by the VA). See also COMMITTEE ON ACCESSIBLE AND AFFORDABLE HEARING HEALTH CARE FOR ADULTS, NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE, *HEARING HEALTH CARE FOR ADULTS: PRIORITIES FOR IMPROVING ACCESS AND AFFORDABILITY* 125 (Dan G. Blazer et al. eds., 2016) (“One of the leading users of tele-audiology services is the VA, which serves a large number of patients who live outside urban areas and far from VA medical centers[.]”).

³⁴ See Darkins, *U.S. Department of Veterans Affairs*, *supra* note 31, at 99, 101; Adam Darkins, *Perspective: The Growth of Telehealth Services in the Veterans Health Administration Between 1994 and 2014: A Study in the Diffusion of Innovation*, 20 TELEMED. & E-HEALTH 761, 763, 765, 766 (2014) [hereinafter Darkins, *Perspective*].

³⁵ See, e.g., Chasan et al., *supra* note 32, at 1046; Kirkizlar et al., *supra* note 32, at 2605; Gladden et al., *supra* note 33, at 793, 795 (Telepractice encounters typically link a practitioner at a VA medical center with a patient at a community outpatient clinic, where a trained assistant is available to set up specialized equipment that the practitioner operates remotely.); Wennergren et al., *supra* note 29, at 712 (describing the use of clinical video telemedicine to link patients at community clinics with VA medical centers).

³⁶ See Adam Darkins et al., *Case Study: Reduced Cost and Mortality Using Home Telehealth to Promote Self-Management of Complex Chronic Conditions: A Retrospective Matched Cohort Study of 4,999 Veteran Patients*, 21 TELEMED. & E-HEALTH (2015).

³⁷ See, e.g., COMMITTEE ON ACCESSIBLE AND AFFORDABLE HEARING HEALTH CARE FOR ADULTS, NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE, *supra* note 33, at 125 (The VA is exploring “home hearing tests, the scanning and transmission of ear canal images, and the programming of hearing aids in the home through smartphones or tablet computers.”); Darkins, *U.S. Department of Veterans Affairs*, *supra* note 31, at 99, 100; Darkins, *Perspective*, *supra* note 34, at 765 (describing FY 2012 VHA pilot of clinical video telehealth to the home).

³⁸ See, e.g., Darkins, *U.S. Department of Veterans Affairs*, *supra* note 31, at 99, 100 (the reasons for doing telehealth at the VA “include reducing costs, increasing quality, and improving access”); Morland, *supra* note 31, at 754-55 (“The delivery of mental health services via [clinical videoteleconferencing] enables Veterans who would not normally receive these services access to empirically based treatments”). About 40-50% of veterans are unable to access needed psychology services to treat posttraumatic stress disorder because they reside in geographically remote locations or because they have not been screened for the condition. See Morland, *supra* note 31, at 754-55.

³⁹ See, e.g., Darkins, *U.S. Department of Veterans Affairs*, *supra* note 31, at 99, 102-103 (“Outcomes assessments show reductions in bed days for home telehealth programs (53 percent) and clinical video telehealth for mental

health care (25 percent).”). In FY 2011, the VA’s telemental health programs resulted in a 30 percent reduction in hospital admissions. *See id.* at 103.

⁴⁰ *See* Chasan et al., *supra* note 32, at 1046-1050 (VHA diabetic teleretinal screening program increased specialty workload and use of resources including appointments, procedures, spectacles, medication, rehabilitation, and surgery, but “[e]arly detection and treatment of diabetic eye disease lead to a reduction in moderate to severe visual loss and may save the federal government hundreds of millions of dollars.”); Adam Darkins et al., *supra* note 36, at 70 (mortality of patients in the telehealth home monitoring program for self-management of complex chronic conditions was 9.8%, compared to 16.58% among those not in the program; pharmacy expenditures for telehealth program participants were higher than for non-participants, but reduced ER visits and hospitalizations contributed to substantial VA cost savings for participants); Kirkizlar et al., *supra* note 32, at 2605-09 (“A 3-fold increase in the yearly maintenance cost and a 10-fold increase in the setup cost still result in the conclusion that teleretinal screening is cost-effective . . .”).

⁴¹ *See, e.g.,* Darkins, *U.S. Department of Veterans Affairs*, *supra* note 31, at 99, 103 (cost savings from \$1,238 to \$1,999 per annum per patient); Morland, *supra* note 31, at 757-58 (“mental health services provided via telemedicine were vastly less expensive [for the VA] than services provided via the traditional in-person mode, which required therapists to fly from the VA medical center to outlying VA satellite clinics, with no drop-off in clinical efficacy”); Wennergren et al., *supra* note 29, at 711 (from 2011-2014, the use of clinical video telemedicine saved reduced veteran travel by 770,075 miles, and saved the government \$331,132 in reimbursement costs).

⁴² *See* Veterans Health Administration, Where do I get the care that I need?, <https://www.va.gov/health/findcare.asp>; Veterans Health Administration, Connect With Your Medical Center, <https://www.va.gov/health/vamc/>. Alaska, Connecticut, Delaware, the District of Columbia, Hawaii, Maine, Maryland, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, North Dakota, Puerto Rico, Utah, Vermont, and Wyoming have only one VAMC. The VA also has 1,053 outpatient clinics of varying complexity. *See id.*

⁴³ *See* Comment from FTC Staff to Steve Thompson, *supra* note 15.

⁴⁴ *See, e.g.,* Authority of Health Care Providers to Practice Telehealth, 82 Fed. Reg. at 45,757 (“By providing health care services by telehealth from one State to a beneficiary located in another State or within the same State, whether that beneficiary is located at a VA medical facility or in his or her own home, VA can use its limited health care resources most efficiently.”).

⁴⁵ *See supra* notes 24, 38-40 and accompanying text; Authority of Health Care Providers to Practice Telehealth, 82 Fed. Reg. at 45,758 (telehealth “would allow VA to reach underserved areas or beneficiaries who are unable to travel, improving health outcomes for beneficiaries”).

⁴⁶ *See supra* note 24 and accompanying text.

⁴⁷ *See, e.g.,* Authority of Health Care Providers to Practice Telehealth, 82 Fed. Reg. at 45,757 (“Telehealth enhances VA’s capacity to deliver essential and critical health care services to beneficiaries located in areas where health care providers may be unavailable or to beneficiaries who may be unable to travel to the nearest VA medical facility for care because of their medical conditions.”).

⁴⁸ *See* Adam Darkins et al., *supra* note 36, at 70, 74 (care coordination home telehealth “allows people to remain living independently in their own homes and local communities who would otherwise need long-term institutional care”).

⁴⁹ *See*, Authority of Health Care Providers to Practice Telehealth, 82 Fed. Reg. at 45,757, 45,758 (“If the health care providers were able to practice telehealth while working from VA-approved alternate worksites and still deliver the telehealth services where needed, the Charleston Telemental Hub would be able to fill its vacancies and retain needed health care professionals.”).

⁵⁰ *See* FTC STAFF, POLICY PERSPECTIVES, *supra* note 7. *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).

⁵¹ National Defense Authorization Act for Fiscal Year 2012 § 713, 10 U.S.C. § 1094(d)(1) (2016) (incorporating H.R. 1832, Servicemembers' Telemedicine and E-Health Portability Act of 2011). Unlike the provision at 10 U.S.C. § 1094(d)(2), however, the VA's Proposed Rule would not cover contractors. *See Authority of Health Care Providers to Practice Telehealth*, 82 Fed. Reg. at 45,758 ("A health care provider as defined in this regulation cannot be a VA-contracted employee. Contract health care providers would be required to adhere to their individual State license, registration, or certification requirements.") The VA could improve the effectiveness of its Proposed Rule by changing it at proposed 38 C.F.R. § 17.417(a)(2)(iv) so that VA-contracted employees would be included in the definition of "Health Care Provider," thus giving contracted employees authority to practice telehealth across state lines, regardless of whether the provider or patient is on federal property.

⁵² *See Authority of Health Care Providers to Practice Telehealth*, 82 Fed. Reg. at 45,759-60. Even the few that did not entirely support the VA's proposal appeared to do so more on legal grounds requiring licensure in the state where the patient is located, rather than because of health or safety concerns. Thus, the Pennsylvania State Board of Medicine cited the Interstate Medical Licensure Compact as requiring the physician to be under the jurisdiction of the state medical board of the state where the patient is located. The Michigan Department of Licensing and Regulatory Affairs explained that Michigan law does not require VA providers to hold a Michigan license when practicing in the scope of their official duties at a VA facility, but a license is required when delivering care to a beneficiary's home. *See id.* at 45,760.