

Telemedicine and Small Physician Practices

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Thank you Chairman Collins, Ranking Member Hahn, and members of the Subcommittee. I am honored to have been invited to testify before you today on this important policy topic. My name is Megan McHugh, and I am a research assistant professor at Northwestern University, Feinberg School of Medicine. My research and teaching focus on federal health policy and the impact of policy changes on health care cost, quality, and access. The opinions that I will share today are my own, and not the University's.

My testimony is organized around three points:

1. By adopting telemedicine services, small physician practices may be better prepared to participate and succeed in new payment and delivery models, such as bundled payment.
2. Reimbursement and state licensing policies serve as barriers to the adoption of telemedicine by small practices.
3. Any policy that expands the use of telemedicine should be carefully monitored. While there is promising evidence about the value of telemedicine, the evidence is not conclusive (or easily accessible to physicians in small practices).

Telemedicine and New Payment and Delivery Models

There is widespread agreement that the traditional fee-for-service system, which pays providers for each visit, procedure, or test, is an obstacle to achieving the triple aim of better health care, better health, and lower cost.^{1,2} Researchers, health care advisory groups, and policy makers have called for public and private payers to move away from the fee-for-service system toward reimbursement models that reward providers for the quality of care delivered, cost consciousness, and patient satisfaction.³⁻⁵ As a result of these calls, the way in which physicians and hospitals are paid is beginning to change. For example, the Centers for Medicare and Medicaid Innovation (CMMI), created under the Affordable Care Act, launched a bundled payment initiative in which providers receive a fixed, negotiated fee covering a set of treatment services for an episode of care (e.g., hip replacement, stroke). Providers are also required to report quality data. The single, set payment per episode encourages providers to manage costs and integrate care, and the reporting requirements promote accountability for care quality.⁶ Similarly, the CMMI is supporting new models at the state level. The State of Oregon received a grant to reorganize its delivery system into coordinated care organizations (CCOs). CCOs are networks of different types of providers that have agreed to work together to manage the care of Medicaid enrollees financed by a single per-patient budget.

Telemedicine has an important place in these value-based purchasing models. Reimbursement is not contingent upon in-person services; instead, providers have the flexibility and the financial incentive to care for patients using the best means possible at the lowest cost. Several studies have shown that telemedicine costs less than in-person visits, and may reduce utilization of high-cost services. One study found that the availability of telemedicine videoconferencing after hours in nursing homes reduced hospital readmissions and led to approximately \$150,000 in Medicare savings per nursing home each year.⁷ Additionally, a primary care electronic consultation system that allowed iterative communication between a referring physician and specialist resulted in 20% fewer specialty referrals.⁸

Given the momentum towards value-based purchasing, small physician practices and hospitals would be well-served by exploring whether and how telemedicine could be used to support high-quality care at a reduced cost.

Challenges to the Adoption of Telemedicine by Small Practices

While there are several barriers to the adoption of telemedicine by small physician practices, the two that are arguably the most important and policy relevant are reimbursement and licensing.

Reimbursement

Medicare generally limits payment for telemedicine services to interactive audio and video telecommunications with real-time conversations where the originating sites are located in a rural area.⁹ As a result, telemedicine accounts for a very small portion of Medicare services. Only 369 providers had 10 or more Medicare telehealth consultations in 2009, and in 2011, Medicare payments for telemedicine totaled only \$6 million.^{10,11} Medicare's rather cautious policies related to reimbursement for telemedicine are magnified because private insurers often look to the Medicare program when crafting their own reimbursement policies.

However, through the rulemaking process, the Centers for Medicare and Medicaid Services (CMS) has been gradually expanding reimbursement for telemedicine. For example, CMS changed the geographic criteria for originating sites for calendar year 2014. Previously, payment for telemedicine services was limited to rural areas that were not located in a metropolitan statistical area (MSA). This year, payment for telemedicine services is also available in rural census tracts within MSAs, which will expand reimbursable telemedicine services to nearly 1 million rural Medicare beneficiaries. CMS also added coverage for complex chronic care services for patients with multiple chronic conditions, as well as transitional care management. Earlier this month, CMS proposed to add annual wellness visits, psychoanalysis, psychotherapy, and prolonged evaluation and management services to the list of covered services.

Although research on the impact of telemedicine on cost, quality, and access is promising, the evidence is not conclusive. As a result, I believe the gradual expansion of telemedicine coverage under Medicare is a sensible course of action, and one that will produce a slow but steady increase in the number of small practices that effectively and efficiently use telemedicine.

Licensing

While state borders may be irrelevant to the delivery of quality care via telemedicine, they do present an important legal barrier. In most instances, physicians are limited to practicing in states where they are licensed. Telemedicine practice is regulated at the state level by state medical boards, which are given authority by state legislatures. Some state medical boards require telemedicine providers practicing across state lines to have a valid state license in the state where the patient is located.¹² Those who support requirements for physicians to be licensed in the same state as their patients, including the American Medical Association, argue that easing state licensure could compromise patient

safety. For example, state regulators may have no power to conduct an investigation of an out-of-state provider if a patient is harmed. Obtaining an additional state license to practice telemedicine typically costs between \$200 and \$600 per state, and the administrative and time burdens are substantial. These burdens may be greater for small practices, which are less likely to have support staff who can help navigate this process.

My personal opinion is that the current medical licensure system is inadequate to address the growing practice of telemedicine. There are several alternative models that could be considered, though each presents challenges. For example, federal licensure and regulation would inevitably raise federalism concerns as professional licensure has historically been a state power. Another option is an interstate agreement that would grant privileges in all participating states, provided that the physician has a valid license in at least one of the participating states. However, when this approach was attempted by the nursing profession, only half the states adopted the interstate agreement.¹³

Notably, decisions by state medical boards may come under greater scrutiny with the Supreme Court scheduled to hear oral arguments in the case of *North Carolina State Board of Dental Examiners v. FTC*. The board, overseeing the practice of dentistry, sent cease-and-desist letters to unlicensed practitioners who removed stains from teeth. The Federal Trade Commission accused the board of illegally excluding non-dentists from the teeth-whitening market. While this conflict involves a dental board, the outcome could have repercussions for how states regulate medical practice. The court will consider whether a regulatory board whose members have a financial interest in the industry it is charged with regulating can define practice to reduce competition.

Evidence on the Impact of Telemedicine

The academic literature on the impact of telemedicine is voluminous and still growing. Overall, the evidence suggests that telemedicine can improve access to care and the value of care. Here are just two examples:

- The Veterans Health Administration has a national home telehealth monitoring program that provides routine care, care management, and case management services to veterans with chronic illness through remote monitoring. Patient satisfaction levels are high (greater than 85 percent), the program facilitated independent living, and it reduced hospital days by 40 percent.^{14,15}
- Using store-and-forward teledermatology (where a referring physician uploads a patient history and images of a skin lesion to a secure site for a consulting dermatologist to review), dermatologists at Kaiser Permanente in San Diego were able to handle 50 percent more cases compared to face-to-face visits.¹⁵ Other research has shown that teledermatology consults are just as accurate as in-person consults. Store-and-forward teledermatology consults reduce in-person clinic appointments by 25 percent, and real-time teledermatology consults reduce clinic appointments by 50 percent. Satisfaction among patients, referring clinicians, and dermatologists is high.¹⁶

However, evidence of the impact of telemedicine is not entirely consistent. For example, one study found that physicians were more likely to prescribe antibiotics when the visits occurred via telemedicine, suggesting that telemedicine may result in a more conservative care plan, which could have unintended consequences, such as antibiotic resistance.¹⁷ A randomized controlled trial found that telemonitoring for frail older adults did not reduce hospitalizations or emergency department visits, and was associated with greater mortality.¹⁸ In a recent compilation of systematic reviews on telemedicine, twenty reviews concluded that telemedicine was effective, 19 were less confident about the effectiveness of telemedicine but noted its potential, and 22 concluded that its effectiveness was limited or inconsistent.¹⁹

Clearly, there is a need for continued research in this area. Additionally, there are two other issues concerning research that should be addressed. First, many studies of the effectiveness of telemedicine have been conducted within hospitals or large physician practices affiliated with health systems. As a result, our understanding of the impact of telemedicine among small, independent practices is much more limited. Second, information about the impact of telemedicine is typically published in the academic literature, which is not easily accessible to leaders of small practices. This limits physicians' ability to make informed decisions about whether or not to adopt telemedicine.

Despite the gaps and inconsistencies in the evidence, I believe that telemedicine holds great potential to expand access, improve care, and reduce cost. This past year, my colleagues and I at Northwestern University designed a new model for primary care in partnership with a private foundation. Our model incorporates telemedicine, reflecting our belief that telemedicine can not only improve the value of health care, but also improve patient and provider satisfaction, and potentially make the practice of primary care more attractive to physicians. We are currently developing an implementation plan for the adoption of this primary care model by small physician practices.

Conclusion

In conclusion, telemedicine is an important tool for small practices as payers transition away from the fee-for-service model. State and federal policy makers have the ability to facilitate the adoption of telemedicine through policies related to reimbursement and licensing, but expansion should be coupled with oversight to monitor impact.

Again, I would like to thank you for allowing me to appear before you today and share my opinions on this topic. I would be happy to take your questions.

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