ALLIANCE for CONNECTED CARE

May 27, 2025

Abigail Slater
Assistant Attorney General
Antitrust Division
U.S. Department of Justice
950 Pennsylvania Avenue NW
Washington D.C. 20530

RE: Alliance for Connected Care Response to the Anticompetitive Regulations Task Force RFI

Dear Ms. Slater:

Our health care system is deeply impacted by anticompetitive practices. The Alliance for Connected Care (the "Alliance") outlines four areas where we hope the Department of Justice Task Force will focus to improve care for patients, and ease the burden for providers.

The Alliance is dedicated to improving access to care through the reduction of policy, legal, and regulatory barriers to the adoption of telemedicine and remote patient monitoring. Our members are leading health care and technology organizations from across the spectrum, representing health systems, healthy payers, technology innovators, and patient and provider groups, including many types of clinician specialty and patient advocacy groups who wish to better utilize the opportunities created virtual care.

Issue I: Licensure Portability for Health Care Providers

State licensing boards are comprised of practitioners in the field they are regulating, which can lead to decisions that benefit their profession over the public good. Our current system of state-by-state licenses is stifling the ability of providers to consult with and treat Americans wherever they may be, exacerbating our workforce maldistribution issues and forcing Americans to drive to appointments that could be done virtually.

Digital technology is giving health care professionals new tools to deliver care to patients in addition to giving patients new access to care. Provider shortages are associated with delayed health care usage, reduced continuity of care, higher health care costs, worse prognoses, less adherence to care plans, and increased travel. In addition to being a tool to address such barriers, telehealth plays an important role in supplementing and strengthening clinician networks available to patients. Telehealth can be leveraged to strengthen the delivery system by providing highly specialized services in areas where clinicians with these skills are not available to consumers.

The problem with unleashing new technology, such as telehealth, is state lines are still artificial barriers to care. The Federal Trade Commission (FTC) has a history of taking on this issue (Appendix A), but little has changed. You have the opportunity to make real progress that will give millions of Americans the opportunity to seek care from qualified providers no matter where they are in the country.

On December 14, 2020, then-President Donald Trump signed an Executive Order on Increasing Economic and Geographic Mobility. It was meant to alleviate overly burdensome occupational licensing requirements that impede job creation and slow economic growth. Since then, we have made little

progress. Patients and providers would greatly benefit from the active involvement of the FTC in solving this problem.

The Problem

Anticompetitive state licensing practices impact all medical provider types. One example is physicians. They attend nationally accredited medical schools, complete nationally accredited residency programs, take the US Medical Licensing Exam, and pass a national FBI background check. Yet, if they want to practice, they must be licensed in every state where their patients are located. This involves widely varying processes, which makes the licensure pathway time consuming and expensive. On average, the cost of the application is between $500-$1,000 and the wait times can be up to four months.

After an outcry in 2014-2015, and a successful Supreme Court Case, the Federation of State Medical Boards (FSMB) set up the Federation Credentials Verification Service to help streamline the licensing process. State medical boards did not succumb to pressure for state licensure reciprocity, but they did agree to make the process easier. The problem is there is a fee of $400 on top of the cost of the state license, some states require additional documentation to be submitted directly to the state, the process adds time to an already lengthy process, and providers can not use the same background check for multiple states.

State licensing boards earn revenue from processing out-of-state licenses. Licensure reciprocity reduces the incoming fees, thereby leaving the boards with revenue shortfalls. This, plus the potential influx of out of state providers competing with state-based providers and the loss of full control over who is practicing in their states, has resulted in resistance from medical boards to mutual recognition of state licenses.

State licensing boards often argue that the system should remain the same because of patient safety. As a result of the flexibilities of the pandemic that permitted the widespread practice of medicine across state lines, we now have evidence that allowing cross-state licensure does not risk new harm to patients. One study found that patients who received out-of-state telemedicine care received the same care. The patients that used out-of-state telemedicine visits were those that lived near state borders or in rural communities, receiving primary care services and mental health treatment.

The Benefits of Breaking Down State Barriers

During the Public Health Emergency of 2020-2022, governors across the country used emergency authority to waive some aspect(s) of state licensure requirements to facilitate greater patient access to care. This included credentialing, licensure, and supervision/cooperation requirements. Doing so allowed licensed medical professionals more flexibility to treat patients in other states when there were pressing needs or specialized expertise not available where they lived. In New Jersey, its waiver program expanded provider pools, creating access to a supply of mental health providers during the pandemic.

A study by the University of Michigan found that the number of out-of-state telehealth services from the first quarter to the fourth quarter of 2020 increased by 572 percent, and that a higher percentage of out-of-state telehealth users lived in rural areas (28 percent). Additionally, 64 percent of out-of-state telehealth visits occurred between a patient and clinician in a bordering state. The study suggested that the majority of out-of-state telehealth is used for continuity of care rather than acquisition of new

patients. Another study found similar results. A report from the Cicero Institute reviewed Florida and Idaho's approaches to out-of-state telehealth care and found that there were no cases that resulted in disciplinary action for an out-of-state provider offering services via telehealth in these states.

FTC's History on the Issue

We appreciate the Federal Trade Commission's long-standing work to reform occupational licensing regulations, removing anticompetitive practices. In particular, the FTC investigated options to enhance occupational license portability in 2017, which acknowledged that individual state licensing regulations reduced access to critical services, like telehealth, or increased prices to ordinary consumers. The FTC's Economic Liberty Task Force held a roundtable, which examined ways to mitigate the negative effects of state-based occupational licensing requirements. Key policy options included:

- **Mutual recognition of a single state license can pose a lower barrier to cross-state practice** than expedited licensure and could be more effective in enhancing cross-state competition and improving access to services.
- **Expedited licensure could ease provider relocation** to another state.

The Alliance for Connected Care and its members have advocated for a federal solution to interstate licensure. There is a clear need for a federal solution to decrease anticompetitive barriers in providing care across state lines to ensure consumers have access to care. The Alliance recommends a national framework for interstate licensure using a policy of mutual recognition, which would allow patients to receive care beyond their state boards, and allow qualified health care providers already licensed in a U.S. state or territory to treat patients without the costly and time-consuming burden associated with purchasing and renewing multiple state licenses.

The Alliance has worked with Congress in requesting funds appropriated to FTC to conduct a report on license portability and health care competition, building on its 2017 Economic Liberty Task Force to investigate and act on unnecessary occupational licensing restrictions that impeded economic mobility.[1] We believe that to better understand the impact of license portability on health care competition, the FTC needs to continue its ongoing workstream on this issue and examine the anti-competitive practices of licensing boards that impede access to care.

Competition is at the core of America's economy and vigorous competition among providers utilizing telehealth in an open marketplace gives consumers the benefits of lower prices, higher quality products and services, and increased innovation. License portability benefits both providers practicing across state lines, as well as consumers who seek better access to services. The DOJ Task Force has an opportunity to utilize the FTC's work to remove anticompetitive and burdensome licensure requirements for health care providers.

Issue II: Anticompetitive Proposal at the Drug Enforcement Administration (DEA)

[1] *In the Senate Financial Services and General Government Appropriations Bill of 2024 report language, the Committee indicated that it believed the temporary licensure flexibilities enacted during the COVID-19 pandemic offered a unique opportunity to continue past FTC research into the effect of occupational licensure on health care competition and directed the FTC to draft a report on interstate licensure portability and health care competition.*

In January, the DEA released a proposed regulation that would significantly curtail telehealth and the practice of medicine when a controlled substance is required for treatment. Controlled substances are clinically appropriate for many forms of care offered through telehealth, with mental health treatments being disproportionately impacted. This proposal directly contradicts policy efforts to increase economic efficiency and encourage health care competition across state lines.

While not directly stated in this rule, there continues to be a misconception that telemedicine is separate and different from in-person care – when it is the same care, just provided through a different modality. We note that some policy voices, such as the authors of Project 2025, have called for actions to legally define the locus of service as where the provider is located during the telehealth visit, rather than where the patient is. Pursuing this definition would encourage greater competition in the market, allowing telehealth services when they are an appropriate form of care delivery.

We believe DEA needs the health care operations expertise of CMS to publish a rule that focuses on its core role of preventing the diversion of controlled substances, without creating unworkable restrictions on the practice of medicine. As an example, the January proposal included a requirement for a telehealth provider to offer a large portion of their care in-person – which is not a workable solution for most telehealth providers. Not only would this limit telehealth, but it would dramatically increase regulatory documentation burdens on all practitioners.

Issue III: Burdensome Reporting of Home Addresses of Medicare Providers

An important issue we want to bring to your attention is the issue of reporting home addresses by telehealth providers. Under § 424.505, the Centers for Medicare & Medicaid Services (CMS) requires Medicare providers to include their home addresses as a practice location in order to receive payment for covered Medicare items or services that were necessary for a Medicare beneficiary. Under this provider location reporting requirement, CMS requires Medicare providers to report their home address if the provider renders telehealth services from their homes. This requirement is unnecessary and stifles use of telehealth services as it creates privacy and administrative concerns for providers. Current CMS allowance for practitioners to render telehealth services from a location (such as their home) without creating and reporting as an additional billing location will end on December 31, 2025.

In an informal survey of Alliance members, the impact of this policy ending would be profound. Differentiating and reporting home addresses on billing and enrollment forms would result in a 40-times increase in the number of billing addresses tracked and reported to CMS by a health system. Multiple health systems estimated the resulting operational costs of this change at approximately $1 million in labor.[2]

Additionally, allowing practitioners the privilege to practice without the restriction of where there are located would allow practitioners to easily move across state lines, encouraging greater mobility of health care service providers. CMS now has a chance to leverage its active reform of the Provider Enrollment, Chain and Ownership System (PECOS) to make system-wide changes that facilitate a modernized system

[2] *A system reported that it would take their operations staff around 6 hours of work per provider, per year, to add and maintain an average of three billing addresses per telehealth provider. For a health system with more than 3,300 telehealth clinicians, that results in more than 20,000 hours of additional staff work per year. Another system found similar estimates, with more than 4,500 telehealth clinicians resulting in approximately 27,000 staff hours of additional staff work per year.*

that reflects the real-world usage of telehealth services and increase competition. We urge the DOJ to review the home reporting requirement and its impact on reducing competition if the policy were to end. We stand ready to work with you to ensure the new system works well for virtual providers.

Issue IV: Removing Antiquated Restrictions Not Relevant for Modern Connected Care

When telehealth access was created for Medicare beneficiaries, Congress drafted 1834(m) of the Act, which created the unintended consequence of limiting telehealth access to only certain populations. CFR § 410.78, which implements 1834(m), propels requirements that have become a barrier to accessing health care services via telehealth in today's modern day connected care. Under the first Trump Administration, President Trump allowed for expanded telehealth flexibilities. Since then, expanded telehealth has created new opportunities for services where telehealth and virtual care are used to more efficiently bring care to patients and enhance program integrity.

One provision of regulation includes the in-person mandate. The Alliance and its members strongly believe that an in-person requirement is never the right guardrail for a telehealth service. Requiring an in-person visit constrains telehealth from helping individuals that are homebound, have transportation challenges, live in underserved areas, etc. This creates a perversion of the Medicare payment system by reducing access for those who need it most, while allowing access for others. This in-person mandate limits the opportunities for providers to practice telehealth, restricting Medicare beneficiaries to only in-person care.

Health care providers and patients should be allowed to determine and choose telehealth services when it is safe and appropriate, including when there has not been a prior in-person visit. We understand that the DOJ will have to work with Congress to remove the anticompetitive provisions on virtual care. We strongly encourage the DOJ to work with Congress in modernizing Medicare telehealth services, empowering the market.

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The Alliance for Connected Care greatly appreciates the DOJ for considering the removal of these anticompetitive regulations that stiffly access to innovative virtual care tools like telehealth and RPM for Medicare beneficiaries. If you have any questions or would like to hear from Alliance member experts on these topics, please contact rikki.cheung@connectwithcare.org.

Sincerely,

Chris Adamec
Executive Director
Alliance for Connected Care