Members

Justin M. Senior, Chair
Secretary, Agency for Health Care Administration

Celeste Philip, MD, MPH
State Surgeon General & Secretary, Department of Health

Ernest Bertha, MD
Sunshine Health

Anne Burdick, MD
University of Miami, School of Medicine

Leslee Gross
Baptist Health South Florida

Darren Hay
Care Angel

Kim Landry, MD
Leon County EMS

William Manzie
Memorial Healthcare

Elizabeth Miller, CRNP
WellCare

Steven Selznick, DO
Selznick Consulting, CFP Physicians Group

Mike Smith
Florida State University, College of Medicine

Matthew Stanton
Cleveland Clinic

Monica Stynchula
REUNIONCare

Sarvam Terkonda, MD
Mayo Clinic

Agenda
October 17, 2017
9:00am – 12:00pm

Location: Capital City Office Complex
Betty Easley Conference Center
Room 152
4075 Esplande Way
Tallahassee, FL 32399

Teleconference: 1-877-309-2071
Attendee Access Code: 856-620-590
Webinar: Register Here GoToWebinar

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Organizer</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00 – 9:05</td>
<td>Welcome &amp; Introductions, Roll Call, Review &amp; Approval of Minutes</td>
<td>Chair Senior</td>
</tr>
<tr>
<td>9:05 – 10:00</td>
<td>Member Discussion – Report Review</td>
<td>Council Members</td>
</tr>
<tr>
<td>10:00 – 10:30</td>
<td>Member Discussion - Legislation</td>
<td>Senator Bean</td>
</tr>
<tr>
<td>10:30 – 11:00</td>
<td>Public Comments</td>
<td>Chair Senior</td>
</tr>
<tr>
<td>11:00 – 11:15</td>
<td>Break</td>
<td>Council Members</td>
</tr>
<tr>
<td>11:15 – 11:45</td>
<td>Member General Discussion</td>
<td>Council Members</td>
</tr>
<tr>
<td>11:45 – 12:00</td>
<td>Wrap Up &amp; Closing</td>
<td>Chair Senior</td>
</tr>
</tbody>
</table>

Meeting Materials and Information will be available at: [www.AHCA.myflorida.com/Telehealth](http://www.AHCA.myflorida.com/Telehealth)
Additional comments and information may also be sent to: [Telehealth@ahca.myflorida.com](mailto:Telehealth@ahca.myflorida.com)
Minutes
September 19, 2017
Telehealth Advisory Council
Agency for Health Care Administration

Members Present
Justin M. Senior, Chair
Dr. Ernest Bertha (virtual)
Dr. Anne Burdick
Leslee Gross (virtual)
Darren Hay (virtual)
Dr. Kim Landry
Elizabeth Miller
Dr. Steven Selznick (virtual)
Mike Smith
Matthew Stanton
Monica Stynchula
Dr. Sarvam Terkonda

Staff Present
Nikole Helvey
Pam King
Dana Watson

Guests Present
Please see Attachment A

Call to Order
Chair Senior called the meeting to order at 9:00 a.m.

Roll Call
Chair Senior welcomed the group and explained that due to the many health care related issues caused by Hurricane Irma, his presence would be intermittent, and Council member Mr. Mike Smith would Chair the meeting in his absence. Next, Chair Senior directed Ms. Helvey to call the roll. Ms. Helvey announced that a quorum was present.

Review and Approval of the Minutes
The Council reviewed the August 2017 meeting minutes. Dr. Burdick made the motion to approve the August 2017 minutes. Dr. Terkonda seconded the motion, which carried unanimously.

Member Discussion – Telehealth Legislation
Chair Senior told the Council that Senator Bean filed Senate Bill 280 (SB 280), on Telehealth, for the 2018 legislative session. He noted that the legislation included the Council’s agreed upon definition. Some of the Council members were concerned that Senator Bean filed the bill prior to the completion of the report. Chair Senior explained to the Council that SB 280 is the Senate’s first draft of the legislation and that it may be amendments at its referenced committee stops or on the Senate floor. He went on to explain that a member of the House of Representative would need to file a telehealth bill as well.

Member Discussion – Introduction
The Council members reviewed the Introduction section of the report and made suggestions to clarify parts of the section. Chair Senior began with the suggestion to use two words when referring to “health care”, the Council concurred.

The Council also made the following change to the introduction section of the report:

Second to the last sentence, second paragraph:
While these technologies offer promising solutions, the adoption and expansion of telehealth also presents specific challenges to facilities, professionals, payers, and other stakeholders.

In the third paragraph, first sentence:

The information presented to and reviewed by the Council demonstrates clear benefits from utilizing telehealth technology and the provision of not being limited by physical distance”.

**Member Discussion – Defining Telehealth**

The Council reviewed the definition of telehealth section. After discussion the recommendation was modified to read:

**To ensure clarity, the Council recommends a definition of telehealth should be included in statute and should be inclusive of six key components:**

1. Telehealth can be used for providing health care and public health services.
2. Telehealth includes synchronous and asynchronous modalities.
3. Practitioners treating Florida patients must be appropriately licensed in Florida or appropriately supervised by a licensed Florida health care practitioner as prescribed by law or rule.
4. Health care practitioners must treat within the scope of their practice.
5. Telehealth can be health care practitioner to health care practitioner or health care practitioner to patient.
6. There must be no limitations on geographic or place of service.

The Council suggests the following language as a clear definition of telehealth and replacement for telemedicine for Florida:

**Telehealth means the mode of providing health care and public health services through synchronous and asynchronous information and communication technology by a Florida licensed health care practitioner, within the scope of his or her (changed from their) practice, who is located at a site other than the site where a recipient (patient or licensed health care practitioner) is located.**

**Member Discussion – Health Insurance and Telehealth**

The Council members reviewed the Health Insurance and Telehealth section of the report. The Council suggested the following changes in the background section:

First sentence in the background section:

**Florida healthcare facilities and practitioners identify issues surrounding coverage and reimbursement as a primary policy barriers influencing the delivery and growth of telehealth services.**

Telehealth insurance coverage recommendation section, third sentence:

**…Florida’s legislature require Florida-licensed health insurance plans (excluding Medicare) provide coverage for health care services provided via telehealth if coverage is available for the same service when provided in person.”**

The Council discussed whether they should include a section on the value of telehealth. Ms. Gross noted she had documentation showing telehealth value. Mr. Hay reminded the Council they had determined at a previous meeting to be broad in regards to costs. The Council revisited the decision and requested that Ms. Gross provide documentation to staff for inclusion in the report.

Dr. Burdick suggested an additional edit to the background section in the fourth paragraph, last sentence, the Council concurred with the suggestion. The change is as follows:
States, including Florida, have flexibility to develop policy for their Medicaid programs and enjoy full authority to establish guidelines for coverage of employees through state employee group health insurance programs, worker’s compensation, and similar state-sponsored programs.

Mr. Stanton suggested using the language shared with the Council by Nathaniel Lacktman with Foley & Lardner (Foley) in a September 18, 2017 correspondence, in the insurance coverage recommendation section of the report. After much discussion, the Council agreed to change the recommendation language in the report as follows:

A health insurance policy issued, amended, or renewed on or after July 1, 2018, shall provide coverage for services (excluding Medicare) provided via telehealth to the same extent the services are covered if provided via in-person consultation or contact. An insurer shall not impose any additional conditions for coverage of services provided via telehealth.*

* The intent of this recommendation is to ensure appropriate insurance coverage for the use of telehealth in treating patients. Any legislative language developed should not require insurers to add additional service lines or specialties, mandate a fee-for-service arrangement, inhibit value based payment programs, or limit healthcare insurers and practitioners from negotiating contractual coverage terms.

Dr. Burdick requested the Council also consider another change to the insurance background section of the report. After discussion, the last sentence of the fifth paragraph was modified to read:

The integration of telehealth modalities into health care practitioner workflows can strongly support practitioners in meeting these goals.

Member Discussion – Telehealth Insurance Reimbursement

The Council discussed the issue of payment parity for services delivered via telehealth. Mr. Manzie voiced his concern that there was not more clarity in this section as to the Council’s recommendation to support payment parity. Ms. Helvey pointed out the report is divided into sections, which include background and recommendations. She noted the background in this section is intended to capture the discussions and thought process of the Council in making their ultimate determination on their recommendation of requiring payment parity. She noted the language in the recommendation section does clearly indicated the Council’s recommendation on reimbursement parity.

Ms. Miller commented that the language regarding payment parity would be controversial because health plans have different contracts with different practitioners, reimbursing at different rates, at their own discretion. Dr. Bertha agreed with Ms. Miller that the topic of reimbursement parity would be contentious. Dr. Bertha pointed out that the language in the Foley as language that may remove ambiguity. After more discussion, the Council agreed to slightly amended the Foley language for their recommendation. The following recommendation language was agreed upon for inclusion in the report:

For the purposes of health insurance coverage and payment (excluding Medicare plans), payment rates for services provided via telehealth shall be equivalent to the rates for comparable services provided via in-person consultation or contact contained in the participation agreement between the insurer and the healthcare practitioner.*

*The intent of this recommendation is to ensure appropriate insurance reimbursement for the use of telehealth in treating patients. Any legislative language developed should not require insurers to add additional service lines or specialties, mandate fee-for-service arrangements, inhibit value based payment programs, or limit healthcare insurers and practitioners from negotiating contractual coverage terms.

Dr. Burdick suggested modifying the last line of the background section. The Council agreed to the following change:
Council members acknowledge that planning and implementation of integrated telehealth strategies can assist practitioners in more efficiently and effectively meeting the foundational goals of value-based payment methodologies.

Mr. Smith told the audience members on the phone and in the room that the Agency received the “Foley & Lardner” correspondence on September 18, 2017, and the Council members were reviewing it for the first time. He said the document would be on the Telehealth Advisory Council meetings page after the meeting.

**Member Discussion – Medicare**

The Council modified the recommendation in this section to list the store-and-forward modalities before the remote monitoring. The recommendation is as follows.

*It is the consensus of the Council that the State of Florida support modifications to Medicare telehealth laws that would expand coverage to include store-and-forward modalities, as well as remote patient monitoring expand the types of health care practitioners covered; and revise or eliminate the existing geographic and place of service requirements.*

**Member Discussion – Medicaid**

The Council reviewed the background information and made the suggestion to amend the second sentence in the Medicaid background information with the following:

*This Medicaid rule does limit fee-for-service coverage to live video conferencing and pays the practitioner that provides the diagnosis only.*

In an attempt to draw a broader picture, Council members brought up the current Medicaid procurement. The staff quickly explained that the Agency is unable to discuss the procurement as the Agency is in a blackout period and is unable to discuss it.

The Council members discussed the last sentence of the recommendation. Ms. Miller explained that Medicaid currently pays and the sentence is not necessary. Dr. Bertha agreed with Ms. Miller to delete the sentence from the recommendation. However, Dr. Burdick suggested amending the sentence, rather than deleting it. The Council members wanted to wait for Chair Senior to return before making the recommendation. The Council revisited the Medicaid recommendation when Chair Senior was present. Once Chair Senior shared his thoughts, the Council agreed to delete the last sentence from the recommendation and modify the recommendation to read:

*The Council recommends the Agency modify the Medicaid telehealth fee-for-service rule to include coverage of store and forward and remote patient monitoring modalities in addition to the currently reimbursed live video conferencing modality.*

**Member Discussion – Insurance Network Adequacy**

The Council reviewed the Insurance Network Adequacy section of the report. Dr. Burdick suggested the Council to include information regarding states besides Colorado. Ms. King explained that Colorado is the only state to date that has laws regarding allowing insurers to count available telehealth services in meeting insurance network adequacy requirements specialties.
The Council discussed the best language to use in their recommendation for insurers to be able to include telehealth services as part of their network adequacy requirements. Using the language in the NAIC “Model Network Adequacy Act” (ACT) was discussed.

Chair Senior stated that Network Adequacy in Florida would really be associated with Medicaid and CHIP plans. He advised the Agency does have extensive Network Adequacy requirements for Medicaid health plans. Chair Senior stated that he would speak with the Agency legal team about the regulation of the Commercial plans and the expense of the added full time FTE to monitor network adequacy in every area of the state. Ms. Miller shared the regulation and monitoring that Medicaid plans currently have with the Council.

Chair Senior stated there needs to be a specific description of the parameters for when telehealth counts toward network adequacy. There was discussion about the formulation of network adequacy requirements and the need to ensure patients had treatment options.

Mr. Smith stated that the Council needed to give this section more consideration and would discuss it at the next Council meeting.

**Member Discussion - Health Practitioner Licensure & Telehealth**

The Council reviewed the Health Practitioner Licensure section of the report. Dr. Landry expressed concern about making a recommendation that may diminish consultation between physicians in separate jurisdictions. The Council discussed whether a section on physician consultation was needed in the report. They Council determined consultation between physicians was different than telehealth treatment and did not need to be included.

Council members reviewed the Interstate Licensure section. Dr. Burdick commented that she would like to see a figure with each compact including the states participating and the minimum number of participants required by each compact to “go-live.” It was clarified that an attachment with this information would be included in the report.

Ms. Gross asked Dr. Terkonda how the Florida Medical Association (FMA) feels about the compacts. He responded that he is not aware of any position statement that the FMA has on compacts, but that the Board of Medicine was supportive. Dr. Terkonda asked Ms. Mary Thomas representing the FMA to come forward and answer the Council’s questions. She stated that the FMA fully supports the compacts as long as the compact remains voluntary, so practitioners do not have to participate, and those practitioners will not feel negative affects due to their non-participation.

Dr. Landry suggested they clarify the section by including a provision stating, “practitioner to practitioner consultations are not considered telehealth.”

The Council reviewed the recommendation and modified it to read:

*In order to ensure the best care for Florida patients and maximize available resources and access to care, the Council recommends the following:*

1. **Maintain the requirement of Florida licensure for health practitioners providing patient care in Florida via telehealth. This recommendation requires no change to current regulations and does not inhibit the use of telehealth to treat patients.**

2. **The legislature adopt laws allowing participation in healthcare practitioner licensure compacts with equivalent or increased licensure requirements as Florida, when available and appropriate.**

**Member Discussion - Hurricane Response**

Chair Senior shared examples provided during the 2017 Hurricane season of how the use of telehealth, patients were provided care throughout the state. Ms. Gross commented that during the storm, the facilities were only concerned with treatment, not reimbursement. Chair Senior shared that the federal government provided many waivers to provide expanded care through Medicaid and Medicare during a state of emergency. He also stated that the main objective was providing good patient care.
Dr. Burdick suggested including a section on the state response to the hurricanes. Mr. Smith agreed and stated that Nemours experienced a large increase in the telehealth services during Irma since the issue is topical and the section can provide a favorable impression of telehealth services.

**Break 12:35 reconvene**

**Member Discussion- Telehealth Standards of Care**

The Council reviewed the Standards of Care section of the report. Mr. Smith read the current recommendation in the report and then read part of the Foley correspondence, which suggested the Council adopt the language from Texas statutes.

Mr. Manzie stated that he did not think the language pertaining to non-physician health care practitioners and unlicensed practice of medicine was necessary. He stated that they are already licensed and have a scope of practice to work within. Ms. King reminded the Council they had determined they should use the language because there were some practitioner types whose regulating boards do not currently have statutory rulemaking authority.

Mr. Smith directed the Council in a conversation regarding the standard of care provisions in SB 280 on Telehealth, by Senator Bean. There was much discussion about the current language in the Bill. The discussion included concerns the current language might insinuate providers are not required to do as much to provide treatment. There were also questions about sections of the Bill that spoke to unlicensed practice of medicine and non-physician practitioners.

Ms. Thomas, representing the Florida Medical Association told the Council that in the past, the FMA referred to telehealth services as being telemedicine, because physicians were practicing medicine. However, she stated that the FMA’s position has changed to refer to telehealth rather than telemedicine because all provider types can use it. Ms. Thomas also stated that the FMA does not like the language in the Practice Standards section of the bill, as it falls below the standards of practice. Dr. Landry commented that the words “evaluation sufficient to diagnose” are ambiguous and can cause confusion, leading to a lower standard of care. Ms. Stynchula agreed with Dr. Landry and stated she had concerns with the proposed Bill language and that the more precise the report can be regarding the standard of care, the better. Based on the discussion of the Bill, Mr. Stanton stated that the following should be included in the report as recommendation.

*The current standard of care shall remain the same regardless of whether a Florida licensed health care provider provides health care services in person or via telehealth.*

There was additional discussion about eliminating the recommendation to provide statutory authority to regulatory boards and council for establishing telehealth rules. Ms. Helvey stated that the Council did hear from other practitioner types that do not have statutory authority to write rules and Ms. Miller reminded the other Council members about the request from allied health providers. The Council asked for clarification on the rule making process and why statutory authority was needed.

Mr. Michael Moné, with Cardinal Health advised the Council that the boards and councils need specific authority to develop rules. He further noted the need to include some type of language in the report to provide authority for the boards and councils to establish needed rules. The Council and Mr. Moné discussed the recommendations for the standard of care section.

Mr. Smith asked Mr. Moné and Ms. King to draft language regarding standard of care for the Council’s consideration during a short recess.

**Break reconvene at 1:50 p.m.**

After discussion, the consensus of the Council was to include the following recommendations in the standard of care section of the report:
1. The Department of Health and health care regulatory boards continue to educate and raise awareness among licensees about their ability to utilize telehealth modalities as a means to treat patients when appropriate.
2. The Florida legislature authorize health care regulatory boards and councils specific statutory authority to develop standard of care and other rules necessary for implementation of telehealth. The telehealth standard of care shall be the same as the in-person standard of care.

**Member Discussion – Patient and Consumer Protections**

The Council reviewed the Patient and Consumer Protections background section of the report. The Council agreed to change the term “mechanism of care” to “modality of care.” The Council also modified the second sentence of the section to read:

*Patients should have confidence the standard of care they receive, whether delivered in-person or through telehealth will be the same.*

The consensus of the Council was to modify the last sentence of the background section to read:

*A practitioner who potentially bills inappropriately for services may be audited regardless of modality of care.*

**Member Discussion – Patient-Provider Relationships and Continuity of Care**

The Council reviewed the Patient-Provider Relationships and Continuity of Care section of the report. Mr. Hay likes the recommendation, but thinks the background section should include more data. Dr. Burdick suggested adding in positive statements to the background section. After much discussion, the consensus of the Council was to use the last line of the background section as the recommendation. The modified recommendation reads:

*The Council recommends the Florida legislature recognize the ability for practitioners and 12 patients to establish a relationship through telehealth in addition to encourage efforts for 13 ensuring patient care coordination among treating practitioners.*

**Member Discussion – Patient Consent**

The Council reviewed the Patient Consent background section of the report and changed the last sentence to read “…care delivery mechanism” to “delivery modality.” The Council agreed to change the recommendation to read:

*The Council recommends maintaining current consent laws in Florida. The Council notes that additional consent requirements will add unnecessary barriers for both practitioners and patients attempting to utilize telehealth services.*

The Council members discussed the different consent requirements their practices follow.

**Member Discussion - Telehealth and Prescribing**

The Council reviewed the Telehealth and Prescribing section of the report. Mr. Manzie inquired what the drug schedules meant. Dr. Landry explained the schedule and the potential for addiction. Ms. Stynchula and Ms. Miller asked about the ability for hospices and other specific healthcare providers’ ability to use telehealth for prescribing of controlled substances. Ms. King advised that the language the Council was recommending did include a provision for hospice care, in patient care for licensed facilities, behavioral health, and emergency care.

The consensus of the Council was to modify the recommendation to read:
The Council recommends the Florida legislature recognize the establishment of practitioner-24 patient relationships through telehealth as appropriate for treating patients, including the 25 prescribing of medications; with limited exceptions for prescribing of controlled substances.

Dr. Landry stated concerns about the abuse and addiction of controlled substances prescribed via telehealth. The Council requested staff to include language that would support the language found in the Boards of Medicine and Osteopathic Medicine telehealth rules regarding prescribing of controlled substances.

**Member Discussion – Technology**

The Council reviewed the Technology section of the report. Ms. Gross commented that the section has too much detailed. Mr. Stanton suggested reducing the length. He said the recommendations were fine, but too vague. The Council made following changes to the recommendations.

Noting diminishing technological barriers, the Council recommends:

1. The Agency identify existing resources for health information exchange; existing and potential solutions to expanding interoperability; and pathways to potential solutions.
2. Florida continue promotion of existing programs and services available to increase access to technology, access to broadband networks, and improved interoperability.
3. Education opportunities be offered by medical schools, health care institutions and allied health care practitioner associations related to the utilization to telehealth to treat patients. Educational opportunities should include training on technology system security and HIPAA and requirements needed to ensure the appropriate standard of care.

Mr. Hay stated the only recommendation he thinks is necessary would be “to encourage the Legislature to support the policy supporting interoperability.” He does not think the recommendation needs to be so prescriptive as it is currently written.

The Council discussed the Lifeline program and smart phone access provided to patients to use telehealth. Ms. Stynchula asked if Florida could increase the phone benefits to allow the use to access telehealth. Staff will research.

**Public Comments**

Jane Johnson, with the Florida Council for Community Mental Health asked the Council to include the use of telehealth when providing Mental Health services. She noted telehealth is very useful when treating pediatric and adolescent patients. She discussed the way telehealth can help with meeting network adequacy goals.

Michael Mone’ with Cardinal and Mary Thomas with the Florida Medical Association provided input and testimony during the member discussion portion of the meeting.

**Next Steps**

The Council directed Agency staff to make the agreed upon changes to the report and distribute it as soon as possible. The Council will hold a webinar on October 3, 2017, where the Council will make further recommendations for the report. The staff will make the changes and the Council will review and vote on the “Florida Telehealth Utilization and Accessibility” report.

**Adjournment**

There being no further discussion, the Telehealth Advisory Council adjourned at 3:10 p.m.
Attachment A

Interested Parties in attendance at the September 19, 2017
Telehealth Advisory Council Meeting

Doreen Barlu, AARP; Ben Browning, FACHC; Nathan Dunn, Florida Department of Health; Jessica Grace, Agency for Health Care Administration; Carolyn Grant, Cardinal Health; Joe Anne Hart, Florida Dental Association; William Hightower, Florida Osteopathic Medical Association; Joni Higgins, Bay Care; Jane Johnson, Florida Council for Community Mental Health; Michael Moné, Cardinal Health; Joy Ryan, Meenan, PA; Chris Snow, FLASHA; Mary Thomas, Florida Medical Association; Chris Hansen, Cardinal Health; Craig Hansen, Wellcare.
Minutes
October 3, 2017
Telehealth Advisory Council
Conference Call

Members Present
Justin M. Senior, Chair
Dr. Ernest Bertha (virtual)
Dr. Anne Burdick
Leslee Gross (virtual)
Darren Hay (virtual)
Dr. Kim Landry
Elizabeth Miller
Dr. Steven Selznick (virtual)
Mike Smith
Matthew Stanton
Monica Stynchula
Dr. Sarvam Terkonda

Staff Present
Pam King
Dana Watson

Guests Present
Please see Attachment A

Call to Order
Chair Senior called the meeting to order at 12:00 p.m.

Roll Call
Chair Senior welcomed the group and directed Ms. King to call the roll. Ms. King announced that a quorum was present.

Member Discussion – Report Review
The Telehealth Advisory Council (Council) met via conference call and made changes to the report, as reflected in the attached DRAFT report. (Attachment B)

Next Steps
Chair Senior directed Agency staff to make the suggested edits to the report. The Council will meet on Tuesday, October 17, 2017 from 9:00 a.m. to 12:00 p.m. at the Capital City Office Complex, Betty Easley Conference Center, Room 152, 4075 Esplande Way, Tallahassee, FL 32399. The Council will make necessary final edits and vote on the final product.

Adjournment
There being no further business to discuss, the Council adjourned at 2:20 p.m.
Attachment A

Interested Parties in attendance on the October 3, 2017

Telehealth Advisory Council Conference Call

Anna Baznik, IMPOWER Florida; Melanie Brown; Kathleen Brown-Blake, Moyle Law; Ben Browning, FACHC; Debi Dilling, SalusCare; Kimberly Driggers, Driggers Law; Nathan Dunn, Florida Department of Health; Paula Fenzau, SunCoast Center; Stefanie Fontaine, BridgeWay; Debby Gillespie, BridgeWay; Patricia Greene, NMetz, Husband, & Daughton; Joe Anne Hart, Florida Dental Association; Joni Higgins, BayCare; William Hightower, Florida Osteopathic Medical Association; Melissa Jakubowitz; Robert Kelly, Cummins; Jennifer Lloyd, Florida Senate; Douglas Manning, Dentaquest; James McFaddin, Southern Strategies; Shane Messer, Florida Council for Community Mental Health; Lindsay Newton, Devereux; Audrey Richards; Keri Riedel, SalusCare; Sheryl Rosin; Joy Ryan, Meenan Law; Sandra Schwemmer, Prestige Health Choice; Christine Sexton, News Service of Florida; Yolanda Siples, Florida House of Representatives; Kenyatta Smith, Agency for Health Care Administration; The Florida Channel; Rose Tuzik; Vicki A. Twogood, Florida Department of Financial Services; Melisa Urrutia, MBHCI Recovery Center; Megan Weiland, Florida Agency for Health Care Administration.
TELEHEALTH ADVISORY COUNCIL

Justin M. Senior, Chair
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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>6</td>
</tr>
<tr>
<td>Background</td>
<td>8</td>
</tr>
<tr>
<td>Introduction</td>
<td>9</td>
</tr>
<tr>
<td>Defining Telehealth</td>
<td>10</td>
</tr>
<tr>
<td>Recommendation(s):</td>
<td>11</td>
</tr>
<tr>
<td>Health Insurance and Telehealth</td>
<td>12</td>
</tr>
<tr>
<td>Telehealth Insurance Coverage</td>
<td>13</td>
</tr>
<tr>
<td>Recommendation(s):</td>
<td>14</td>
</tr>
<tr>
<td>Telehealth Insurance Reimbursement</td>
<td>14</td>
</tr>
<tr>
<td>Recommendation(s):</td>
<td>16</td>
</tr>
<tr>
<td>Medicare</td>
<td>16</td>
</tr>
<tr>
<td>Recommendation(s):</td>
<td>17</td>
</tr>
<tr>
<td>Medicaid</td>
<td>17</td>
</tr>
<tr>
<td>Recommendation(s):</td>
<td>17</td>
</tr>
<tr>
<td>Insurance Network Adequacy</td>
<td>17</td>
</tr>
<tr>
<td>Recommendation(s)</td>
<td>18</td>
</tr>
<tr>
<td>Health Practitioner Licensure and Telehealth</td>
<td>18</td>
</tr>
<tr>
<td>Interstate Licensure</td>
<td>18</td>
</tr>
<tr>
<td>Recommendation(s):</td>
<td>19</td>
</tr>
<tr>
<td>Telehealth Standards of Care</td>
<td>19</td>
</tr>
<tr>
<td>Recommendation(s):</td>
<td>20</td>
</tr>
<tr>
<td>Patient/Consumer Protection</td>
<td>21</td>
</tr>
<tr>
<td>Patient-Practitioner Relationships &amp; Continuity of Care</td>
<td>21</td>
</tr>
<tr>
<td>Recommendation(s):</td>
<td>22</td>
</tr>
<tr>
<td>Patient Consent</td>
<td>22</td>
</tr>
<tr>
<td>Recommendation(s):</td>
<td>23</td>
</tr>
<tr>
<td>Telehealth &amp; Prescribing</td>
<td>23</td>
</tr>
<tr>
<td>Recommendation(s):</td>
<td>23</td>
</tr>
<tr>
<td>Technology</td>
<td>24</td>
</tr>
<tr>
<td>Technology and Patient Access</td>
<td>24</td>
</tr>
<tr>
<td>Technology and Health care Facilities/Practitioners</td>
<td>25</td>
</tr>
<tr>
<td>Recommendation(s):</td>
<td>26</td>
</tr>
<tr>
<td>Conclusion</td>
<td>26</td>
</tr>
<tr>
<td>Glossary of Terms</td>
<td>27</td>
</tr>
<tr>
<td>Endnotes</td>
<td>28</td>
</tr>
</tbody>
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EXECUTIVE SUMMARY

Telehealth technology is currently being utilized to provide health care services nationally and in Florida. Telehealth technology can enable real-time communication between patients and health care practitioners (or between multiple practitioners) using live video conferencing; can securely store and forward clinical data to offsite locations for evaluation by specialists; and can support remote monitoring of patients’ chronic conditions. The United States Department of Health and Human Services notes that telehealth is not a type of health care service; but is rather a means or method used to deliver health care services.\(^1\)

Chapter 2016-240, Laws of Florida, created the Telehealth Advisory Council (Council) to make recommendations about telehealth services in Florida to the Governor and Legislature by October 31, 2017. The law designated the Secretary of the Agency for Health Care Administration (Agency) as the Council Chair, and designated the State Surgeon General & Secretary of the Department of Health (Department) as a member. The Agency’s Secretary and the Surgeon General appointed 13 Council members representing specific stakeholder groups.

This law also directed the Agency, the Department, and Office of Insurance Regulation to survey licensed health care facilities, practitioners, health insurers and Health Maintenance Organizations (HMOs); and to submit a report of survey and research findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 31, 2016. The Council charge was to review the survey and research findings and to develop this report of recommendations for the expansion of telehealth services in the state.

Note: Council would like a few sentences highlighting information from the Survey report added into this section.

Through surveys, research findings, formal testimony, and public comment, the Council has conducted an in-depth review of the current telehealth landscape in Florida. There are many successes from which to draw knowledge; there are also challenges that can be addressed. This report presents six topic areas where there are current opportunities to support expansion of telehealth in our state: defining telehealth, health insurance coverage, reimbursement for telehealth, health care practitioner licensure, patient/consumer protections, and technology.

Key findings and recommendations of the Telehealth Advisory Council include:
• **Defining Telehealth** - A clear, consistent definition for telehealth and/or telemedicine is needed. The Council recommends the state establish a definition for telehealth, which should replace the various definitions currently used in any applicable state statute or rule. Specific guidelines and a proposed definition are included in the report.

*Note: The Council would like Health Insurance Coverage & Reimbursement separated in the Executive Summary*

• **Health Insurance Coverage and Reimbursement** - Limited coverage and reimbursement of services provided via telehealth influence its delivery and growth. The Council notes a clear distinction between health insurance coverage parity and reimbursement parity for services provided via telehealth. Health care insurance coverage parity refers to health plans including benefits for services provided via telehealth to the same extent the plan covers the same services provided in-person, but is silent about payment. Health care insurance reimbursement parity refers to health plans paying health care facilities and practitioners for covered services at an equivalent rate whether the service is provided using telehealth or in person.

To stimulate greater adoption of telehealth and increase access to care, the Council recommends the Florida legislature take action to require Florida-licensed health insurance plans (excluding Medicare) provide coverage and reimbursement for health care services offered via telehealth, if coverage is available for the same service when provided in person. (The intent of this recommendation is not to limit insurers and practitioners from negotiating contractual coverage terms or entering into value based payment programs.)

The Council also recommends the Agency amend the Medicaid fee-for-service rule for telehealth to include coverage of additional modalities: store and forward and remote monitoring; and develop a model that would allow Medicaid Managed Care plans to incorporate telehealth offerings as a means to ensure provider network adequacy.

The Council encourages Florida to support modifications to Medicare telehealth guidelines that would expand coverage to additional modalities, provider types, and care settings.

• **Health Practitioner Licensure** - The responsibility to ensure patient protections and practitioner accountability lies within each state. To ensure the best possible care for Florida residents while maximizing access to care, the Council recommends health care practitioners be licensed in Florida prior to being allowed to provide care to a patient in Florida. The Council recommends the Florida Legislature enact laws to authorize participation in multi-state health care practitioner licensure compacts, when available and
appropriate, only if the compact includes eligibility requirements for licensure that are equal to or stronger than Florida’s existing requirements.

The Council also recommends a review of all of the state’s health care practitioner licensure laws to ensure that the associated health care regulatory boards and councils have been given adequate authority to develop rules and standards of care for telehealth services if needed.

- **Patient Protection** - The Council notes the importance of the patient-provider relationship in ensuring quality health care. The Council recommends the Florida Legislature recognize and allow the establishment of patient-provider relationships through telehealth; including for the purposes of prescribing and care coordination.

- **Technological Advances** - The Council notes that while technology-related limitations and costs have historically been barriers for practitioners interested in utilizing telehealth; those barriers will continue to decrease as technology evolves and market forces drive cost reductions.

The Council members would like to thank the Florida Legislature for the opportunity to study and provide insight on these issues; and look forward to continuing the great work that is already underway toward ensuring Floridians have access to the best possible health care. It is the hope of the Council that these recommendations provide a solid foundation for future telehealth development in our state.

**BACKGROUND**

Chapter 2016-240, Laws of Florida, created the Telehealth Advisory Council (Council) to make recommendations to the Florida Governor and Legislature about telehealth. The law designated the Secretary of the Agency for Health Care Administration (Agency) as the Council Chair and the State Surgeon General (or designee) as a member. The Agency’s Secretary and the Surgeon General were then directed to appoint thirteen Council members representing specific facility, practitioner, and stakeholder groups. The Council was charged to review survey and research findings and to employ that information to develop recommendations to increase the use and accessibility of services provided via telehealth in the state.
The law also directed the Agency, the Florida Department of Health, and the Florida Office of Insurance Regulation to survey health care facilities, licensed practitioners, insurance plans, and Health Maintenance Organizations (HMOs) regarding availability, utilization, and coverage of telehealth services in the state. The Agency was designated to compile the survey and research findings; and to submit a report of those findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 31, 2016. (Attachment 1)

The Council is required to submit its report of recommendations to the Governor, Senate President, and the House Speaker by October 31, 2017. This Telehealth Advisory Council report of recommendations represents the members’ findings from detailed discussions and deliberations during the course of ten (10) public meetings hosted in various regions of the state. The Council received input via formal presentations from approximately 30 individual practitioners, stakeholders, and national experts (Attachment 2) as well as numerous public comments, the Florida telehealth survey results, and national and state research compiled by members and Agency staff. All meeting information, including the speaker presentations, survey results, and research materials, have been archived on a dedicated Council website for reference as needed. This report, when viewed in its electronic format, contains direct links to source information or meeting materials when appropriate.

INTRODUCTION

The United States, including Florida, is experiencing a shortage of health care practitioners to serve a growing and aging population. Data from the U.S. Health Resources and Services Administration (HRSA) Bureau of Health Workforce indicated there were 615 federally designated Health Professional Shortage Areas (HPSAs) within the state for primary care, dental care, and mental health therapists in June 2014. More recent data from the bureau shows the number of HPSAs in Florida grew to 623 by December of 2016.ii The Florida Department of HealthHRSA has projected a need for 3,060 additional primary care physicians in the state by 2025.iii The existing and emerging deficits in the physician and health care workforce is a driver of innovation as the industry explores new strategies to extend the reach
of existing health care practitioners. The adoption and use of telehealth technology is one strategy that is gaining momentum nationally to help address these workforce deficiencies.

The United States Department of Health and Human Services notes that telehealth is not a type of health care service; it is a means or method used to deliver health care. The standard of care for providing health services should not alter based on the mode of delivery. Telehealth services can enable real-time (synchronous) communication between patients and health care practitioners through video conferencing; facilitate the storage and forwarding (asynchronous) of clinical data to offsite location for evaluation by specialist health care practitioner teams; and support remote monitoring of patient’s chronic conditions via sensors and monitoring equipment/devices. Telehealth technology is evolving into wearable and even implantable devices that detect information such as EKG readings. While these technologies offer promising solutions, the adoption and expansion of telehealth also presents specific challenges to facilities, practitioners, payers, and other health care stakeholders. The intent of this report is to address the specific challenges the Florida Report on Telehealth Utilization and Accessibility identifies and through stakeholder testimony and research provided to the Council. The report presents six specific areas with identifiable obstacles for the expansion of telehealth: the definition of telehealth, health insurance coverage, reimbursement for telehealth, health practitioner licensure, patient/consumer protection, and technology.

The information presented to and reviewed by the Council demonstrates clear benefits from utilizing telehealth technology and the provision of virtual health services. There remain significant opportunities to increase access and enhance the quality of services provided to vulnerable populations, especially in isolated communities, both rural and urban.

**DEFINING TELEHEALTH**

The Council heard testimony from numerous stakeholders on a broad array of telehealth applications. The value and utility of telehealth crosses most health service disciplines including but not limited to primary medical care, specialty care, chronic disease management, behavioral health, physical and occupational therapies, speech therapy, pharmacy, and home health.

The American Telemedicine Association uses the terms telemedicine and telehealth interchangeably. The United States Department of Health and Human Services uses the term telemedicine as a specific reference to the practice of medicine and telehealth as an
encompassing term inclusive of the broader scope of health care. Experts and stakeholders expressed the need for a clear definition of telehealth. Health care practitioners indicated the need for a definition that will clarify the use of technological modalities as a viable way to treat patients within their scope of practice. Health plans noted the need for clarity in the allowable modes of telehealth for coverage and reimbursement purposes.

**RECOMMENDATION(S):**

There are several definitions for “telemedicine” in Florida regulations, but none for “telehealth”. Although the terms telemedicine and telehealth are commonly used interchangeably, the term telehealth denotes the depth and range of the uses and modalities. The Council determined the need for a broad definition of telehealth in order to provide clarity on acceptable uses of current technology for treating patients, without becoming a barrier to technological innovations in the future.

To ensure clarity, the Council recommends that a definition of telehealth should be included in statute and inclusive of six key components:

1. Telehealth can be used for providing health care and public health services
2. Telehealth includes synchronous and asynchronous transmission modalities
3. Practitioners treating Florida patients must be appropriately licensed in Florida or appropriately supervised by a licensed Florida health care practitioner as prescribed by law or rule
4. Health care practitioners must treat within the scope of their practice
5. Telehealth can be between health care practitioner to health care practitioner and/or health care practitioner to patient
6. There must be no limitations on geographic location or place of service

The Council offers the following language as a definition of telehealth and replacement for existing telehealth and telemedicine definitions in Florida statutes and rules:

Telehealth means is defined as the mode of providing health care and public health services through synchronous and asynchronous information and communication technology by a Florida licensed health care practitioner, within the scope of his or her practice, who is located at a site other than the site where a recipient (patient or licensed health care practitioner) is located.
Florida health care facilities and practitioners identify issues surrounding coverage and reimbursement as a primary policy barriers influencing the delivery and growth of telehealth services. xi Health care facilities and practitioners have reported through surveys and testimony to the Council a lack of adequate coverage and reimbursement for health care services provided using telehealth technologies. Some stakeholders have expressed hesitancy to invest in telehealth programs, citing that without some assurance regarding reimbursement they are unable to determine a positive Return-On-Investment (ROI). xii Confirming these reports from health care practitioners, outside of Medicaid, a majority of Florida’s licensed health insurers indicated in their response to the state’s Telehealth Utilization and Accessibility survey they offer only extremely limited coverage, if any coverage, for telehealth services. xiii Among Florida insurers that do cover telehealth, coverage is typically limited to specific circumstances and methodologies or require special coding. xiv Note: The Council would like to use specific data from the Survey Report.

There is a national paradigm shift among private and public payers toward quality and performance-based payment models, which serves as a driver to increase telehealth utilization. These value-based payment arrangements incentivize health care practitioners to achieve the triple aim of increasing access to health care services for all persons, providing the highest possible quality of care, and minimizing costs. The integration of telehealth modalities into health care practitioner workflows can strongly support practitioners in meeting these goals.

Add in statistics on coverage parity

Executive leaders from the American Telemedicine Association and the Center for Connected Health Policy, the nation’s federally funded national telehealth policy resource center, presented information to the Council during April 2017. As of September 2017, both organizations’ websites indicate thirty-four (34) states and the District of Columbia have established health insurance coverage parity laws to address gaps in coverage for telehealth services. xv According to a report published in August from the Center for Connected Health Policy, only three (3) of the states with telehealth coverage parity laws explicitly mandate reimbursement parity. xvi In some states the coverage and reimbursement parity laws apply varyingly to private and in other states public payer plans in each state where they exist. Note: the Council would like sentence reworded Some states limit coverage and reimbursement based on modality and/or location.
The Council members have emphasized the importance of establishing a clear distinction between telehealth insurance *coverage parity* and *reimbursement parity*. The Council recognizes telehealth coverage parity as a requirement of health plans to include benefits for services provided via telehealth, when possible and appropriate, to the same extent the plan covers the same services provided in-person. Coverage parity is silent regarding the amount of payment for telehealth services. Telehealth reimbursement parity is a requirement of health plans to pay health care facilities and practitioners for covered telehealth services at an equivalent rate as the in-person reimbursement for the same service.

Policies governing the nation’s primary public health care programs, Medicare and Medicaid, also play a key role in shaping Florida’s telehealth landscape. These Federal programs strongly influence how states are able to serve senior and vulnerable populations, including patients who are dually eligible for both Medicare and Medicaid. There are efforts underway among members of Congress to modify current Medicare payment guidelines to support the expanded use of telehealth services nationally. States, including Florida, have flexibility to develop policy for their Medicaid programs and enjoy full authority to establish guidelines for coverage of employees through state employee group health insurance programs, worker’s compensation, and similar state-sponsored programs.

Coverage of telehealth services, whether voluntary or required, has also led to new discussions around network adequacy requirements among health insurers and their stakeholders. The National Association of Insurance Commissioners (NAIC) has developed a *Managed Care Network Adequacy Model Act* as a guide for state lawmakers for evaluating insurers’ provider networks. This model includes potential uses for telehealth in meeting a state’s network adequacy requirements. If adopted, these measures offer a valuable benefit and incentive for health plans to cover telehealth services.

**Telehealth Insurance Coverage**

*Many* health care facilities and licensed health practitioners have implemented successful telehealth programs and have reported real benefits in terms of cost savings, quality outcomes, and customer satisfaction. Others have been more reluctant to move toward the use of innovative technologies without stronger assurance that a return on their investment is achievable. One approach taken by some states to provide such assurance is through implementing laws requiring insurers to cover health services offered through telehealth when possible and appropriate, known as coverage parity. Coverage parity for telehealth services does not require health plans to provide any new service lines or specialties, and is intended to
ensure patients have options for how they may be seen by health care practitioners, including in-person or virtually.

**RECOMMENDATION(S):**

In order to increase access and use of telehealth in Florida, there must be an increase in health care practitioners offering services via telehealth. The limited or lack of reimbursement for telehealth service stifles the expansion of the use of this modality to treat patients. The Council recommends that the Florida's legislature require Florida-licensed health insurance plans (excluding Medicare) provide coverage for health care services provided via telehealth if coverage is available for the same service when provided in person.

The Council offers the following language for inclusion in Florida statutes:

*A health insurance policy issued, amended, or renewed on or after July 1, 2018, shall provide coverage for services (excluding Medicare) provided via telehealth to the same extent the services are covered if provided via in-person consultation evaluation and management or contact. An insurer shall not impose any additional conditions for coverage of services provided via telehealth.*

* The intent of this recommendation is to ensure appropriate insurance coverage for the use of telehealth in treating patients. Any legislative language developed should not require insurers to add additional service lines or specialties, mandate a fee-for-service arrangement, inhibit value-based payment programs, or limit health care insurers and practitioners from negotiating contractual coverage terms.

**Telehealth Insurance Reimbursement**

Telehealth reimbursement parity is the requirement of health plans to pay health care practitioners and facilities for covered telehealth services at an equivalent rate as the in-person reimbursement for the same service. The Council received a great deal of input from health care practitioners, health care facilities, payers, and stakeholders through research findings, survey data, and direct testimony regarding reimbursement for telehealth services. Reimbursement parity is a complex issue that must be considered from a variety of perspectives. Practitioners, for example, contend adequate funding of telehealth through
reimbursement parity will serve to stimulate greater adoption of telehealth, which would increase access to care and reduce overall health care spending over time. Conversely, some payers and researchers predict that enhanced access through telehealth will increase utilization, which would result in increased spending under traditional fee-for-service payment models. Others suggest a time-limited requirement for reimbursement parity would stimulate telehealth use until value-based payment models more fully mature to better support telehealth as a quality enhancement and cost reduction strategy. State policymakers must also consider whether forced reimbursement parity stifles adversely affects individual practitioner’s ability to competitively promote their telehealth programs to payers and other stakeholders separately from their in-person services.

The Council recognizes that the current and evolving national paradigm shift toward quality and performance-based health care payment models has significant potential to drive greater market use of telehealth. The U.S. Center for Medicare and Medicaid Services (CMS) is a primary driver of health care policy nationally and has launched a variety of value-based programs over recent years designed to reward health care practitioners for more favorable outcomes and restrict reimbursement for services resulting in less favorable outcomes and/or higher costs. Those CMS programs include:

- Hospital Value-Based Purchasing Program (HVBP)
- Hospital Readmission Reduction Program (HRR)
- Value Modifier Program (aka: Physician Value-Based Modifier or PVBM)
- Hospital Acquired Conditions Program (HAC)
- End-Stage Renal Disease Quality Initiative Program (ESRD)
- Skilled Nursing Facility Value-Based Program (SNFVBP)
- Home Health Value-Based Program (HHVBP)

An increasing number of private and commercial health plans have adopted similar strategies to contain costs and improve care outcomes among their provider networks. Council members acknowledge that planning and implementation of integrated telehealth strategies can assist
practitioners in more efficiently and effectively meeting the foundational goals of value-based payment methodologies.

**RECOMMENDATION(S):**

In order to stimulate greater adoption of telehealth and increase access to care, the Council recommends the Florida legislature require Florida licensed health insurance plans (excluding Medicare plans) to provide reimbursement parity for covered health care services provided via telehealth.

The Council offers the following language for inclusion in Florida statutes:

*For the purposes of health insurance coverage and payment (excluding Medicare plans), payment rates for services provided via telehealth shall be equivalent to the rates for comparable services provided via in-person consultation or contact contained in the participation agreement between the insurer and the health care practitioner.*

*The intent of this recommendation is to ensure appropriate insurance reimbursement for the use of telehealth in treating patients. Any legislative language developed should not require insurers to add additional service lines or specialties, mandate fee-for-service arrangements, inhibit value based payment programs, or limit health care insurers and practitioners from negotiating contractual coverage terms.

**Medicare**

Although Medicare is a federal program, Medicare laws and regulations often influence how states are able to serve vulnerable populations, including patients who are dually eligible under both the Medicare and Medicaid programs. There are many caveats governing telehealth coverage under current Medicare payment guidelines, including strict requirements for the geographic location and care setting of patients and limitations to specific technological modalities. The United States Congress is currently considering several bills that would expand or modify Medicare telehealth policy. One example is the [Medicare Telehealth Parity Act](https://www.congress.gov/bill/117th-congress/house-bill/1485), a bipartisan effort that would incrementally expand Medicare coverage for telehealth to include allied health care practitioners such as physical therapists, occupational therapists, audiologists, speech-language pathologists, and others; would allow a wider variety of telehealth modalities to be covered; and would expand the list of qualifying geographic locations. The Council finds the current Medicare policies related to telehealth coverage and reimbursement to be a
significantly limiting factor to growth and innovation, and supports congressional efforts to expand coverage and reimbursement of telehealth in Medicare.

RECOMMENDATION(S):

**It is the consensus of the Council recommends that** the State of Florida support modifications to Medicare telehealth laws that would expand coverage to include store and forward modalities as well as remote patient monitoring; expand the types of health care practitioners covered; and revise or eliminate the existing geographic and place of service requirements.

**Medicaid**

The Florida Medicaid fee-for-service rules were updated in June 2016 to expand the availability of telehealth reimbursement to a broader array of licensed health care practitioners. This Medicaid rule *does* limit fee-for-service coverage to live video conferencing and pays *only* the practitioner that provides the diagnosis and management only. The vast majority of Florida Medicaid beneficiaries, however, are enrolled in managed care. Florida’s Medicaid Managed Care plans are authorized to cover telehealth services with greater flexibility, although there is no state mandate for coverage. Based on survey responses from Florida licensed health plans and HMOs, coverage for telehealth is currently greatest among Florida Medicaid Managed Care plans and Affordable Care Act Exchange Plans. The Council members and multiple stakeholders acknowledged Florida Medicaid for its support of the expanded use of telehealth within the Statewide Medicaid Managed Care program, as well as its continued efforts to modify administrative rules governing the Medicaid Fee-for-Service program to support the use of telehealth.

RECOMMENDATION(S):

The Council recommends the Agency modify the Medicaid telehealth fee-for-service rule to include coverage of *store and forward and remote patient monitoring* modalities in addition to the currently reimbursed live video conferencing modality.

**Insurance Network Adequacy**
The National Association of Insurance Commissioners (NAIC) defines network adequacy as “a health plan’s ability to deliver the benefits promised by providing reasonable access to a sufficient number of in-network primary care and specialty physicians, as well as all health care services included under the terms of the contract.” Network adequacy minimum requirements are established to ensure consumers have access to needed care without unreasonable delay. In Florida network adequacy is required for Medicaid Managed Care and Children Health Insurance Program plans.

The NAIC has developed a Health Benefit Plan Network Access and Adequacy Model Act for use by states in developing laws around this issue. The model includes provisions allowing health care practitioners who offer services via telehealth to be included in the plan network for purposes of network adequacy. At the time of this report, Colorado is the only state allowing insurers to count available telehealth services in meeting network adequacy requirements for certain specialties.

**RECOMMENDATION(S):**

The Council recommends the Agency develop a model that would allow Medicaid Managed Care plans to utilize telehealth for the purpose of meeting network adequacy.

**HEALTH PRACTITIONER LICENSURE AND TELEHEALTH**

Each state bears the responsibility for assuring patient protections and practitioner accountability. In order to ensure adequate protections and enforcement, Florida’s practitioners, stakeholders, and payers provided strong testimony to the Council encouraging a requirement that all health care practitioners providing care to Florida residents using telehealth be licensed in Florida, regardless of where the health practitioner is physically located.

**Interstate Licensure**

To ensure patient protection and health care practitioner accountability, the Council recommends practitioners be licensed in the state in which the patient resides. The Council acknowledges time and expense burdens associated with attaining licensure in multiple states as a potential barrier to expanding health care practitioners’ use of telehealth. One opportunity
to address this challenge is through the establishment of interstate licensure compacts. Nine (9) licensed health care professions currently have or are developing interstate compacts involving multiple states (Attachment 3), including Florida’s current licensure compact for nursing as adopted by the Florida legislature in 2016xxiv.

Licensure compacts are established when a certain number of states enact the same legislation, intended to streamline administrative processes without undercutting the specific licensure requirements of any participating state. It is important to note that compacts may actually increase the eligibility requirements for licensure in some cases. Practitioner participation in a compact is voluntary, and each state maintains jurisdiction over all practitioners providing care to patients within its borders. Compact provisions vary from profession to profession and include distinct requirements and provisions for differing professions. The Federation of State Medical Boards’ (FSMB) Interstate Medical Licensure Compact creates an expedited process for eligible physicians to apply for licensure in compact states.xxv The Nurse Licensure Compact creates a multi-state license similar to a driver’s license, where the initial licensing state and other compact participating states all recognize the license.xxvi Florida’s current licensure compact for nursing was adopted by the Florida legislature in 2016. Although, different in implementation, the intent is to provide a less onerous process for practitioners seeking licenses in multiple states while maintaining the high standards of Florida licensure.

RECOMMENDATION(S):

In order to ensure the best care for Florida patients and maximize available resources and access to care, the Council recommends the following:

1. Maintain the requirement of Florida licensure for health practitioners providing patient care in Florida via telehealth. This recommendation requires no change to current regulations and does not inhibit the use of telehealth to treat patients.
2. The legislature adopt laws allowing participation in health care practitioner licensure compacts with equivalent or increased licensure requirements as Florida, when available and appropriate.

Telehealth Standards of Care

It is imperative that Florida licensed practitioners understand and comply with established standards of care whether treating patients in person or through telehealth. The Florida
Department of Health (Department), which is responsible for the licensure and regulation of the more than 800,000 health practitioners in the state, provided information to the Council clarifying that current rules are not intended to preclude Florida licensed practitioners from using telehealth within their authorized scope of practice and established standards of care. The Department is working to increase awareness and education among licensed health practitioners regarding their ability to use telehealth within their practices. The Department recognizes telehealth as a modality for providing health services, as opposed to a separate service, meaning they note the use of telehealth technology by Florida licensed health care practitioners for the purpose of providing patient care within the state of Florida is not precluded by Florida law. State’s established standards of care developed by each regulatory health care board are applicable whether care is provided in person or using telehealth.

Note: the Department of Health will have their General Counsel provide input on this section.

A number of stakeholders, primarily ancillary health care practitioners (i.e. Physical Therapists, Occupational Therapists, Audiologists, Speech-Language Pathologists, etc.), have indicated a need for specific statutory authority to develop telehealth practice standards related to telehealth, similar to the authority given to Boards of Medicine and Osteopathic Medicine. Other stakeholders deem the use of the general standard of care provisions in regulation rule as sufficient for practitioner oversight.

RECOMMENDATION(S):

The Council acknowledges Florida’s current standards of care as sufficient for general regulatory oversight of patient care; and recognizes each health care regulatory board has direct authority for establishing appropriate standards based on knowledge and insight for their respective practitioners.

To ensure clarity for Florida licensed health care practitioners and stakeholders regarding the ability to use telehealth as a modality of care, the Council recommends:

1. The Department of Health and health care regulatory boards and councils continue to educate and raise awareness among licensees about their ability to utilize telehealth modalities as a means to treat patients when appropriate.
2. The Florida legislature authorize health care regulatory boards and councils’ specific statutory authority to develop standards of care and permit rules necessary for the
implementation of telehealth. The telehealth standard of care shall be the same as the in-person standard of care.

Note: the Department of Health will have their General Counsel provide input on this section.

The Council offers the following language for inclusion in Florida statutes:

The telehealth standard of care shall be the same as the in-person standard of care. The health care regulatory boards and councils’ may establish standards of practice and permit rules necessary for implementation of telehealth.

**PATIENT/CONSUMER PROTECTION**

Health care practitioners’ responsibilities to patients are the same no matter regardless which modality of care is used. Patients should have confidence the standard of care they receive, whether delivered in-person or through telehealth will be the same. Patients should expect competent, confidential care and to receive accurate, timely, and complete information so that they may make informed decisions about their care.

Health care practitioners and stakeholders also have a responsibility to manage risks related to fraud and abuse in the delivery of health care services. There is no known evidence suggesting a higher risk of abuse or fraud involving telehealth over any other modality of care delivery. A practitioner who potentially bills inappropriately for services may be audited regardless of modality of care.

Patient-Practitioner Relationships & Continuity of Care

Patient-practitioner relationships are key to improved health care. All states recognize the ability for a patient-practitioner relationship to be established via telehealth, with varying laws. The Florida Boards of Medicine and Osteopathic Medicine regulations support the ability for physicians to establish a patient-practitioner relationship through telehealth. This is significant for patients living in isolated communities or with mobility issues who face challenges in establishing and maintaining a relationship with a health care practitioner through in-person visits. The use of telehealth expands the ability for patients and practitioners to develop establish and facilitate regular visits and follow-up care. Telehealth, in some instances, can assist practitioners in discovering new insights about patients by allowing them to observe
and interact with patients in the home setting.

The use of telehealth, however, does not diminish issues related to coordination of care among multiple practitioners. Ideally, when a patient receives care, information is integrated into coordinated Electronic Health Records (EHRs) or similar systems and made available to other practitioners providing treatments or services to the patient. There is some concern among practitioners and payers regarding the potential for care fragmentation or service duplication when patients seek or receive care outside of established provider networks and medical home. Similar to visits that occur in non-network urgent care centers, non-network direct to patient telehealth services could result in episodic care without the information ever being shared with the patient’s primary care provider or health plan - creating health care information silos. There are, however, federal and state initiatives to assist in sharing of patient health information.

Note: Add in reference that denotes types of federal and state initiatives

RECOMMENDATION(S):

The Council recommends the Florida legislature recognize the ability for practitioners and patients to establish a relationship through telehealth in addition to encourage efforts for ensuring patient care coordination among treating practitioners.

The Council offers the following language for inclusion in Florida statutes:

A health care practitioner-patient relationship may be established through telehealth.

Patient Consent

Prior to providing health care services, practitioners are required to ensure patients (or legal proxies) are aware of the specific benefits, risks, and alternative courses of action they may take for their care; and must receive and document patient consent. This is typically achieved through an informed consent, which also relates to practitioner liability and legal exposure. In the case of telehealth, it may be particularly beneficial for patients to know the potential risks, and to understand that a condition or treatment may require a practitioner to defer to in-person services. Section 766.103, Florida Statutes, governs the provision of medical consent for treatment and is applicable regardless of the care delivery modality.
RECOMMENDATION(S):

The Council recommends maintaining current consent laws in Florida. The Council notes that additional consent requirements will add unnecessary barriers for both practitioners and patients attempting to utilize telehealth services.

Telehealth & Prescribing

Many medical conditions and procedures require prescription medications as a component of the treatment plan. Both federal and state law governs appropriate prescribing, in particular the prescribing of controlled substances. The Ryan Haight Online Pharmacy Consumer Protection Act (Ryan Haight Act) is a federal law that provides guidelines for the prescribing of controlled substances through the internet. This federal regulation prohibits the prescribing of a controlled substance based solely on answering a questionnaire. The Ryan Haight Act affirmatively recognizes telehealth as a viable means of creating a treating practitioner-patient relationship, when specified standards are met, for the purpose of prescribing controlled substances. This federal regulation prohibits the prescribing of a controlled substance based solely on answering a questionnaire.

In Florida, medical doctors (allopathic and osteopathic), dentists, podiatrists, and some advanced registered nurses and physician assistants can prescribe controlled substances. Section 456.42, Florida Statutes, provides requirements for prescribing of controlled substances. The Florida Medical Boards’ rules on telehealth, additionally, prohibit the prescribing of controlled substances without an in-person visit – with the limited exceptions of treating of psychiatric disorders in an outpatient setting, treating patients in a licensed health care facility, and treating patients in an emergency medical situation. These rules also specify requirements needed to ensure a complete record for any prescriptions. Scope of practice laws provide additional boundaries for prescribing controlled substances when delivering care.

RECOMMENDATION(S)

The Council recommends the Florida legislature recognize the establishment of practitioner-patient relationships through telehealth as appropriate for treating patients, including the prescribing of medications; with limited exceptions for prescribing of controlled substances.
The Council offers the following language for inclusion in Florida statutes:

Health care practitioners, authorized by law, may prescribe medications via telehealth to treat a patient as is deemed appropriate to meet the standard of care established by his or her respective health care regulatory board or council. The prescribing of controlled substances through telehealth should be limited to the treatment of psychiatric disorders and emergency medical services. This should not prohibit an authorized, health care practitioner from ordering a controlled substance for an inpatient at a facility licensed under chapter 395, F.S. or a patient of a hospice licensed under chapter 400, F.S.

TECHNOLOGY

Telehealth is an increasingly accessible tool for both practitioners and patients due to innovation in the current health care technology market. Health care practitioners have noted some remaining technological barriers to effective telehealth implementations. Primary examples include limited access to technology and internet connectivity in isolated communities, equipment costs, and challenges related to interoperability with other health care systems.

Technology and Patient Access
Many health services can be provided virtually through less expensive mobile devices such as smartphones. A vast majority of the United States population now has a cellphone including 92% of adults with an income of less than $30,000 a year. The Florida Public Service Commission operates and administers the federal LIFELINE program in Florida, which provides free or discounted mobile phones (including smartphones) to individuals who are eligible and

ALLIED HEALTH PRACTITIONERS USE TELEHEALTH TO EXPAND REACH

Allied health practitioners in Florida including physical therapists, audiologists, and speech-language pathologists are discovering the benefits of using telehealth to provide services to their patients. Physical therapists are using telehealth to help in the rehabilitation of veterans. Tele-rehabilitation has been shown to provide more rehabilitation sessions to veterans in rural communities resulting in significant patient function improvement, and unanimous satisfaction by participants.* Audiologists use telehealth for assessment, education, cochlear implant and hearing aid programing, rehabilitation, and neurosurgical monitoring. Speech-Language Pathologists attribute successes in working with children at schools to the flexibility telehealth provides. They also note the significant role telehealth plays in the rehabilitation of stroke patients both at home and in long-term care facilities. Allied health practitioners tout telehealth for improving access, reducing travel fatigue in frail patients, and assisting with care coordination.**
enrolled in certain social services programs. Several of Florida’s Medicaid Managed Care plans promote LIFELINE services to their members in order to support health care management through access to internet-based services. Approximately ten percent of American adults are “smartphone-only” internet users – meaning they own a smartphone and do not have traditional broadband service at home.

Florida has been very successful in implementing broadband connections throughout the state and is considered one of the top ten “most connected states” by Broadband Now, a national organization that compiles data from the Federal Communications Commission (FCC), the U.S. Census Bureau, broadband providers, resellers, IP-verified customers and other sources. Currently, over 97% of Floridians have access to wireline services and 100% have access to mobile broadband services. A small segment of the population in Florida, about 600,000 individuals, have access to the internet through mobile broadband only. Mobile broadband allows individuals to access the internet from their mobile devices. Telephone and data service providers, however, typically set limits on the amount of data a user can consume. These limits can inhibit some individuals from using their devices to receive health services via telehealth due to the additional costs imposed by telephone and data service providers for exceeding data limits.

Technology and Health care Facilities/Practitioners

Florida health care practitioners and facilities specifically identified the cost of equipment needed to treat patients using telehealth as a barrier. The growing telehealth and technology markets indicate ongoing reductions in cost. Additionally, research and stakeholder input suggests that telehealth technology is available at varying price points. The Council is supportive of reimbursement parity for telehealth services as a strategy to address return on investment (ROI) for initial costs. Federal grant funding programs are available to support the implementation of telehealth programs. Information about the availability of funding and resources to assist practitioners is available through the federally funded Regional Telehealth Resource Centers. The Southeastern Telehealth Resource Center provides resources and guidance to practitioners in Florida for implementing and expanding telehealth services.

A bipartisan focus group conducted by Health Affairs and the national Bipartisan Policy Center identified the lack of interoperability between electronic health record systems and medical devices as a barrier to telehealth expansion. Florida health care facilities also indicated through survey responses that a lack of interoperability between practitioners is a barrier to development and implementation of telehealth programs. The challenges related to
interoperability between health care practitioners’ data systems, include a lack of interoperability between telehealth technology and electronic health record (EHR) platforms. Technology vendors and health care organizations are working to improve systems’ interoperability through implementations that support data exchange, such as the national eHealthExchange and Carequality. The eHealthExchange is a growing network of exchange partners, health information organizations and federal Agencies such as the Veteran’s Administration and Social Security Administration Disability Determination, who securely share clinical information using a standardized approach. Carequality is advancing EHR interoperability by brokering agreements among health information technology vendors to implement a framework for point-to-point health information exchange. In Florida, the Agency provides governance for the statewide Health Information Exchange (HIE) program, which promotes interoperability and offers services that allow sharing of patient information between health care practitioners when needed.

RECOMMENDATION(S):

The Council notes that technology-related barriers for practitioners will continue to decrease as technological advances and market forces drive cost reductions. Barriers remain related to interoperability of health care information systems. The Council recommends:

1. The Agency identify existing resources for health information exchange; existing and potential solutions to expanding interoperability and pathways to potential solutions.
2. The Agency continue promotion of existing programs and services available to increase access to technology, access to broadband networks, and improved interoperability.
3. Medical schools and health care associations provide information and educational opportunities related to the utilization to telehealth to treat patients

CONCLUSION

The Council heard testimony from almost 100 individuals representing the full spectrum of telehealth stakeholders and, reviewed hundreds of articles, studies, and reports. The information obtained from stakeholders and documentation supports the benefits of expanding the use of telehealth for treating patients, especially patients both in isolated rural and urban communities. The information provided also supports the need for policy modifications in order to remove barriers for expanding telehealth use. The Council’s recommendations found in this report are viable solutions to overcoming identified barriers for telehealth expansion and access.
GLOSSARY OF TERMS

Asynchronous Modalities

Broadband Connections

Children Health Insurance Plan

Controlled Substances

Coverage Parity

Dually-Eligible

Emergency Medical Situation

Episodic Care

Exchange Partners

Fee-for-service Payment Models

Florida's Statewide Medicaid Managed Care

Health Care Practitioner

Health Insurance Parity

Facilities

Healthcare Payers

Healthcare Practitioners

Healthcare Regulatory Board

Healthcare Stakeholders

Healthcare Technology

Informed Consent

Insurer Provider Networks

Interoperability

Isolated Communities

Mobile broadband providers

Mobile broadband services

Mobile device

Modality
Network Adequacy
Patient Consent
Performance-based Payment Models
Psychiatric Disorders
Public Health Care Programs
Regulatory Oversight
Reimbursement Parity
Remote Patient Monitoring
Scope of Practice
Standards of Care
Store-and-Forward
Store-and-Forward Modalities
Synchronous Modalities
Value-based Payment

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Board of Medicine Rule 64B8-9.0141 Standards for Telemedicine, Florida Administrative Code and Board of Osteopathic Medicine Rule 64B15-14.0081, Florida Administrative Code


Board of Medicine Rule 64B8-9.0141 Standards for Telemedicine, Florida Administrative Code and Board of Osteopathic Medicine Rule 64B15-14.0081, Florida Administrative Code


Expanding Florida’s Use and Accessibility of Telehealth
October 31, 2017
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Sarvam P. TerKonda, MD
Mayo Clinic
# TABLE OF CONTENTS

1. **Executive Summary** .................................................................................................................. 3
2. **Background** ................................................................................................................................. 6
3. **Introduction** ................................................................................................................................ 7
4. **Defining Telehealth** .................................................................................................................... 8
   - Recommendation(s): .................................................................................................................. 8
5. **Health Insurance and Telehealth** ............................................................................................... 9
   - Telehealth Insurance Coverage ............................................................................................... 11
     - Recommendation(s): ........................................................................................................... 11
   - Telehealth Insurance Reimbursement .................................................................................... 12
     - Recommendation(s): ........................................................................................................... 13
6. **Medicare** ................................................................................................................................... 13
   - Recommendation(s): ........................................................................................................... 14
7. **Medicaid** .................................................................................................................................... 14
   - Recommendation(s): ........................................................................................................... 14
8. **Insurance Network Adequacy** ................................................................................................... 15
   - Recommendation(s): ........................................................................................................... 15
9. **Health Practitioner Licensure and Telehealth** ........................................................................ 15
   - Interstate Licensure ............................................................................................................... 15
     - Recommendation(s): ........................................................................................................... 16
   - Telehealth Standards of Care ................................................................................................ 16
     - Recommendation(s): ........................................................................................................... 17
10. **Patient/Consumer Protection** ................................................................................................ 17
    - Patient-Practitioner Relationships & Continuity of Care ......................................................... 18
      - Recommendation(s): ........................................................................................................... 19
    - Patient Consent .................................................................................................................... 19
      - Recommendation(s): ........................................................................................................... 19
    - Telehealth & Prescribing ....................................................................................................... 19
      - Recommendation(s): ........................................................................................................... 20
11. **Technology** ............................................................................................................................... 21
    - Technology and Patient Access ............................................................................................. 21
    - Technology and Health care Facilities/Practitioners .............................................................. 22
      - Recommendation(s): ........................................................................................................... 22
12. **Conclusion** ............................................................................................................................... 23
13. **Glossary of Terms** .................................................................................................................... 24
14. **Endnotes** .................................................................................................................................... 25
EXECUTIVE SUMMARY

Telehealth technology is currently being utilized to provide health care services nationally and in Florida. Telehealth technology can enable real-time communication between patients and health care practitioners (or between multiple practitioners) using live video conferencing; can securely store-and-forward clinical data to offsite locations for evaluation by health care practitioners; and can support remote monitoring of patients’ conditions. The United States Department of Health and Human Services notes that telehealth is not a type of health care service; but is rather a means or method used to deliver health care services.¹

Chapter 2016-240, Laws of Florida, created the Telehealth Advisory Council (Council) to make recommendations about telehealth services in Florida to the Governor and Legislature by October 31, 2017. The law designated the Secretary of the Agency for Health Care Administration (Agency) as the Council Chair, and designated the State Surgeon General & Secretary of the Department of Health (Department) as a member. The Agency’s Secretary and the Surgeon General appointed thirteen (13) Council members representing specific stakeholder groups.

This law also directed the Agency, the Department, and the Office of Insurance Regulation to survey licensed health care facilities, practitioners, health insurers, and Health Maintenance Organizations (HMOs); and to submit a report of survey and research findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 31, 2016. The survey results highlighted several barriers to implementation including the lack of a clear definition, financial obstacles, interoperability concerns, and a lack of detailed knowledge about telehealth services.² The Council’s charge was to review the survey and research findings and to develop this report of recommendations for the expansion of telehealth services in Florida.

Through surveys, research findings, formal testimony, and public comment, the Council has conducted an in-depth review of the current telehealth landscape in Florida. There are many successes from which to draw knowledge; there are also challenges that can be addressed. This report presents six (6) topic areas where there are current opportunities to support expansion of telehealth in our state: defining telehealth, health insurance coverage, reimbursement for telehealth, health care practitioner licensure, patient/consumer protections, and technology.
Key findings and recommendations of the Telehealth Advisory Council include:

- **Defining Telehealth** - A clear, consistent definition for telehealth and/or telemedicine is needed. The Council recommends the state establish a definition for telehealth, which should replace the various definitions currently used in any applicable state statute or rule. Specific guidelines and a proposed definition are included in the report.

- **Health Insurance** - Coverage and reimbursement of services provided via telehealth influence its delivery and growth. The Council notes a clear distinction between health insurance [coverage parity](#) and [reimbursement parity](#) for services provided via telehealth.

- **Health Insurance Coverage** - Health care insurance coverage parity refers to health plans including benefits for services provided via telehealth to the same extent the plan covers the same services provided in-person, but is silent about payment. In order to increase access and use of telehealth, the Council recommends the Florida legislature require Florida-licensed health insurance plans provide coverage for healthcare services provided via telehealth, if coverage is available for the same service when provided in-person. (The intent of this recommendation is not to limit insurers and practitioners from negotiating contractual coverage terms or entering into value-based payment programs.)

- **Health Insurance Reimbursement** - Health care insurance reimbursement parity refers to health plans paying health care facilities and practitioners for covered services at an equivalent rate whether the service is provided using telehealth or in-person. In order to stimulate adoption of telehealth and increase access to care, the Council recommends the Florida legislature require Florida licensed health insurance plans (excluding Medicare plans) to provide reimbursement parity for covered healthcare services provided via telehealth. (The intent of this recommendation is not to require insurers to add additional service lines or specialties, mandate fee-for-service arrangements, inhibit value based payment programs, or limit healthcare insurers and practitioners from negotiating contractual coverage terms.)

The Council also recommends the Agency amend the Medicaid fee-for-service rule for telehealth to include coverage of [store-and-forward](#) and remote monitoring; and develop a model that would allow Medicaid Managed Care plans to incorporate telehealth offerings as a means to ensure provider network adequacy.

The Council encourages Florida to support modifications to Medicare telehealth guidelines that would expand coverage to additional modalities, practitioner types, and care settings.
• **Health Practitioner Licensure** - The responsibility to ensure patient protections and practitioner accountability lies within each state. To ensure the best possible care for Florida residents while maximizing access to care, the Council recommends health care practitioners be licensed in Florida prior to being allowed to provide care to a patient in Florida. The Council recommends the Florida Legislature enact laws to authorize participation in multi-state health care practitioner licensure compacts, when available and appropriate, only if the compact includes eligibility requirements for licensure that are equal to or stronger than Florida’s existing requirements.

The Council also recommends a review of all of the state’s health care practitioner licensure laws to ensure that the associated health care regulatory boards and councils have been given adequate authority to develop rules and standards of care for telehealth services if needed.

• **Patient Protection** - The Council notes the importance of the patient-practitioner relationship in ensuring quality health care. The Council recommends the Florida Legislature recognize and allow the establishment of patient-practitioner relationships through telehealth; including for the purposes of prescribing and care coordination.

• **Technological Advances** - The Council notes that while technology-related limitations and costs have historically been barriers for practitioners interested in utilizing telehealth; those barriers will continue to decrease as technology evolves and market forces drive cost reductions.

The Council members would like to thank the Florida Legislature for the opportunity to study and provide insight on these issues; and look forward to continuing the great work that is already underway toward ensuring Floridians have access to the best possible health care. It is the hope of the Council that these recommendations provide a solid foundation for future telehealth development in our state.
BACKGROUND

Chapter 2016-240, Laws of Florida, created the Telehealth Advisory Council (Council) to make recommendations to the Florida Governor and Legislature about telehealth. The law designated the Secretary of the Agency for Health Care Administration (Agency) as the Council Chair and the State Surgeon General (or designee) as a member. The Agency’s Secretary and the Surgeon General were then directed to appoint thirteen Council members representing specific facility, practitioner, and stakeholder groups. The Council was charged to review survey and research findings and to employ that information to develop recommendations to increase the use and accessibility of services provided via telehealth in the state.

The law also directed the Agency, the Florida Department of Health, and the Florida Office of Insurance Regulation to survey health care facilities, licensed practitioners, insurance plans, and Health Maintenance Organizations (HMOs) regarding availability, utilization, and coverage of telehealth services in the state. The Agency was designated to compile the survey and research findings; and to submit a report of those findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 31, 2016. (Attachment 1)

The Council is required to submit its report of recommendations to the Governor, Senate President, and the House Speaker by October 31, 2017. This Telehealth Advisory Council report of recommendations represents the members’ findings from detailed discussions and deliberations during the course of ten (10) public meetings hosted in various regions of the state. The Council received input via formal presentations from approximately 30 individual practitioners, stakeholders, and national experts (Attachment 2), as well as numerous public comments, the Florida telehealth survey results, and national and state research compiled by members and Agency staff. All meeting information, including the speaker presentations, survey results, and research materials, have been archived on a dedicated Council website for reference as needed. This report, when viewed in its electronic format, contains direct links to source information or meeting materials when appropriate.
INTRODUCTION

The United States, including Florida, is experiencing a shortage of health care practitioners to serve a growing and aging population. Data from the U.S. Health Resources and Services Administration (HRSA) Bureau of Health Workforce indicated there were 615 federally designated Health Professional Shortage Areas (HPSAs) within the state for primary care, dental care, and mental health therapists in June 2014. More recent data from the HRSA shows the number of HPSAs in Florida grew to 623 by December of 2016. HRSA has projected a need for 3,060 additional primary care physicians in the state by 2025. The existing and emerging deficits in the physician and health care workforce is a driver of innovation as the industry explores new strategies to extend the reach of existing health care practitioners. The adoption and use of telehealth technology is one strategy that is gaining momentum nationally to help address these workforce deficiencies.

The United States Department of Health and Human Services notes that telehealth is not a type of health care service; it is a means or method used to deliver health care. The standard of care for providing health services should not change based on the mode of delivery. Telehealth services can enable real-time (synchronous modality) communication between patients and health care practitioners through video conferencing; facilitate the storage and forwarding (asynchronous modality) of clinical data to offsite locations for evaluation by health care practitioner teams; and support remote monitoring of patient’s conditions via sensors and monitoring devices. Telehealth technology is evolving into wearable and implantable devices that detect information such as EKG readings. While these technologies offer promising solutions, the adoption and expansion of telehealth also presents specific challenges to facilities, practitioners, payers, and other health care stakeholders. The intent of this report is to address the specific challenges the Florida Report on Telehealth Utilization and Accessibility identifies and through stakeholder testimony and research provided to the Council. The report presents six (6) specific areas with identifiable obstacles for the expansion of telehealth: the definition of telehealth received national attention for its use in assisting patients in Texas and Florida after the devastating damage from Hurricanes Harvey and Irma respectively. Direct to patient telehealth vendors and hospitals waived costs and expanded the services they offer via telehealth in order to ensure patients received needed care before, during, and after the storms. Florida Hospital and Nemours Children’s Hospital are examples of two hospital systems offering free care via telehealth during Hurricane Irma in Florida. Both of these hospital systems saw a significant increase in telehealth usage from September 8 – 10. Nemours indicates an 800% increase in telehealth volume during this time.*

*Miller, N. Telemedicine Interest Spikes During Hurricane Irma. Orlando Sentinel. Sep. 27. 17.
of telehealth, health insurance coverage, reimbursement for telehealth, health practitioner licensure, patient/consumer protection, and technology.

The information presented to and reviewed by the Council demonstrates clear benefits from utilizing telehealth technology and the provision of virtual health services. There remain significant opportunities to increase access and enhance the quality of services provided to vulnerable populations, especially in isolated communities, both rural and urban.

DEFINING TELEHEALTH

The Council heard testimony from numerous stakeholders on a broad array of telehealth applications. The value and utility of telehealth crosses most health service disciplines including but not limited to primary medical care, specialty care, disease management, behavioral health, physical and occupational therapies, speech therapy, pharmacy, and home health.

The American Telemedicine Association uses the terms telemedicine and telehealth interchangeably. The United States Department of Health and Human Services uses the term telemedicine as a specific reference to the practice of medicine and telehealth as an encompassing term inclusive of the broader scope of health care. Experts and stakeholders expressed the need for a clear definition of telehealth. Health care practitioners indicated the need for a definition that will clarify the use of technological modalities as a viable way to treat patients within their scope of practice. Health plans noted the need for clarity in the allowable modes of telehealth for coverage and reimbursement purposes.

RECOMMENDATION(S):

There are several definitions for “telemedicine” in Florida regulations, but none for “telehealth”. Although the terms telemedicine and telehealth are commonly used interchangeably, the term telehealth denotes the depth and range of the uses and modalities. The Council determined the need for a broad definition of telehealth in order to provide clarity on acceptable uses of current technology for treating patients, without becoming a barrier to technological innovations in the future.

To ensure clarity, the Council recommends that a definition of telehealth should be included in statute and inclusive of six (6) key components:

1. Telehealth can be used for providing health care and public health services
2. Telehealth includes synchronous and asynchronous transmission modalities
3. Practitioners treating Florida patients must be appropriately licensed in Florida or appropriately supervised by a licensed Florida health care practitioner as prescribed by law or rule.

4. Health care practitioners must treat within the scope of their practice.

5. Telehealth can be between health care practitioner to health care practitioner and health care practitioner to patient.

6. There must be no limitations on geographic location or place of service.

The Council offers the following language as a definition of telehealth and replacement for existing telehealth and telemedicine definitions in Florida statutes and rules:

**Telehealth is defined as the mode of providing health care and public health services through synchronous and asynchronous information and communication technology by a Florida licensed health care practitioner, within the scope of his or her practice, who is located at a site other than the site where a recipient (patient or licensed health care practitioner) is located.**

**HEALTH INSURANCE AND TELEHEALTH**

Florida health care facilities and practitioners identify issues surrounding coverage and reimbursement as primary policy barriers influencing the delivery and growth of telehealth services. Health care facilities and practitioners have reported through surveys and testimony to the Council a lack of adequate coverage and reimbursement for health care services provided using telehealth technologies. Of practitioners surveyed, 59% of those using telehealth identified lack of health insurance reimbursement as a barrier to using telehealth. 63% of practitioners that stopped offering telehealth services identified lack of health insurance reimbursement as a barrier. Health care facilities also ranked lack of insurance reimbursement as the greatest barrier to using telehealth. Some stakeholders have expressed hesitancy to invest in telehealth programs, citing that without some assurance regarding reimbursement they are unable to determine a positive Return-On-Investment (ROI). Confirming these reports from health care practitioners, outside of Medicaid, a majority of Florida’s licensed health insurers indicated in their response to the state’s Telehealth Utilization and Accessibility survey they offer only extremely limited coverage, if any coverage, for telehealth services.

There is a national paradigm shift among private and public payers toward quality and performance-based payment models, which serves as a driver to increase telehealth utilization. These value-based payment arrangements incentivize health care practitioners to achieve the triple aim of increasing access to health care services for all persons, providing the highest
possible quality of care, and minimizing costs. The integration of telehealth modalities into health care practitioner workflows can strongly support practitioners in meeting these goals.

Executive leaders from the American Telemedicine Association and the federally funded national telehealth policy resource center, the Center for Connected Health Policy, presented information to the Council during April 2017. As of September 2017, both organizations’ websites indicate thirty-four (34) states and the District of Columbia have established health insurance coverage parity laws to address gaps in coverage for telehealth services. The laws implemented in these states have some common features, but vary in details from state to state. Some states limit coverage and reimbursement based on modality and/or location. According to a report published in August from the Center for Connected Health Policy, only three (3) of the states with telehealth coverage parity laws explicitly mandate reimbursement parity.

The Council members have emphasized the importance of establishing a clear distinction between telehealth insurance coverage parity and reimbursement parity. The Council recognizes telehealth coverage parity as a requirement of health plans to include benefits for services provided via telehealth, when possible and appropriate, to the same extent the plan covers the same services provided in-person. Coverage parity is silent regarding the amount of payment for telehealth services. Telehealth reimbursement parity is a requirement of health plans to pay health care facilities and practitioners for covered telehealth services at an equivalent rate as the in-person reimbursement for the same service.

Policies governing the nation’s primary public health care programs, Medicare and Medicaid, also play a key role in shaping Florida’s telehealth landscape. These Federal programs strongly influence how states are able to serve senior and vulnerable populations, including patients who are dually eligible for both Medicare and Medicaid. There are efforts underway among members of Congress to modify current Medicare payment guidelines to support the expanded use of telehealth services nationally. States, including Florida, have flexibility to develop policy for their Medicaid programs and enjoy full authority to establish guidelines for coverage of employees through state employee group health insurance programs, worker’s compensation, and similar state-sponsored programs.

Coverage of telehealth services, whether voluntary or required, has also led to new discussions around network adequacy requirements among health insurers and their stakeholders. The National Association of Insurance Commissioners (NAIC) has developed a Managed Care Network Adequacy Model Act as a guide for state lawmakers for evaluating insurers’ provider networks. This model includes potential uses for telehealth in meeting a state’s network
adequacy requirements. If adopted, these measures offer a valuable benefit and incentive for health plans to cover telehealth services.

TELEHEALTH INSURANCE COVERAGE

Many health care facilities and licensed health practitioners have implemented successful telehealth programs and have reported benefits in terms of cost savings, quality outcomes, and customer satisfaction. Others have been more reluctant to move toward the use of innovative technologies without stronger assurance that a return on their investment is achievable. To provide such assurance, some states are implementing laws requiring insurers to cover health services offered through telehealth when possible and appropriate, known as coverage parity. Coverage parity for telehealth services does not require health plans to provide any new service lines or specialties, and is intended to ensure patients have options for how they may be seen by health care practitioners, including in-person or virtually.xvii

RECOMMENDATION(S):

In order to increase access and use of telehealth in Florida, there must be an increase in health care practitioners offering services via telehealth. The limited or lack of reimbursement for telehealth service stifles the expansion of the use of this modality to treat patients. The Council recommends that the Florida legislature require Florida-licensed health insurance plans (excluding Medicare) provide coverage for health care services provided via telehealth if coverage is available for the same service when provided in-person.

The Council offers the following language for inclusion in Florida statutes:

A health insurance policy issued, amended, or renewed on or after July 1, 2018, shall provide coverage for services (excluding Medicare) provided via telehealth to the same extent the services are covered if provided via in-person evaluation and management. An insurer shall not impose any additional conditions for coverage of services provided via telehealth.*

* The intent of this recommendation is to ensure appropriate insurance coverage for the use of telehealth in treating patients. Any legislative language developed should not require insurers to add additional service lines or specialties, mandate a fee-for-service arrangement, inhibit value-based payment programs, or limit health care insurers and practitioners from negotiating contractual coverage terms.


**TELEHEALTH INSURANCE REIMBURSEMENT**

Telehealth **reimbursement parity** is the requirement of health plans to pay health care practitioners and facilities for covered telehealth services at an equivalent rate as the in-person reimbursement for the same service.

The Council received input from health care practitioners, health care facilities, payers, and stakeholders through research findings, survey data, and direct testimony regarding reimbursement for telehealth services. Reimbursement parity is a complex issue that must be considered from a variety of perspectives. Practitioners, for example, contend adequate funding of telehealth through reimbursement parity will serve to stimulate adoption of telehealth, which would increase access to care and reduce overall health care spending over time. Conversely, some payers and researchers predict that enhanced access through telehealth will increase utilization, which would result in increased spending under traditional fee-for-service payment models. Others suggest a time-limited requirement for reimbursement parity would stimulate telehealth use until value-based payment models more fully mature to better support telehealth as a quality enhancement and cost reduction strategy.

State policymakers must also consider whether reimbursement parity adversely affects individual practitioners’ ability to competitively promote their telehealth programs to payers and other stakeholders separately from their in-person services. The Council recognizes that the current and evolving national paradigm shift toward quality and performance-based health care payment models has significant potential to drive greater market use of telehealth. The U.S. Centers for Medicare and Medicaid Services (CMS) is a primary driver of health care policy nationally and has launched a variety of **value-based programs** over recent years designed to reward health care practitioners for more favorable outcomes and restrict reimbursement for services resulting in less favorable outcomes and/or higher costs. Those CMS programs include:

- Hospital Value-Based Purchasing Program (HVBP)
- Hospital Readmission Reduction Program (HRR)
- Value Modifier Program (aka: Physician Value-Based Modifier or PVBM)
- Hospital Acquired Conditions Program (HAC)
- End-Stage Renal Disease Quality Initiative Program (ESRD)

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**TELE-ICU SAVING LIVES AND COSTS**

Baptist Health South Florida is using telehealth in their Intensive Care Units (tele-ICU) to save patient lives and decrease care costs. Tele-ICU allows a physician to monitor several patients in these units at one time, 24 hours a day, seven days a week. Physicians visit with the patient via a video monitor on a regular basis, but can also visit any time there is an indicator something may be wrong. Baptist Health South Florida notes they have seen significant positive outcomes. Data over the past three years indicates decreased mortality due to tele-ICU as well as achieved savings of $49,721,400 in cost avoidance by reducing the number of days a patient needed ICU care.*

*Data provided by Baptist Health South Florida
• Skilled Nursing Facility Value-Based Program (SNFVBP)
• Home Health Value-Based Program (HHVBP)

An increasing number of private and commercial health plans have adopted similar strategies to contain costs and improve care outcomes among their provider networks. Council members acknowledge that planning and implementation of integrated telehealth strategies can assist practitioners in more efficiently and effectively meeting the foundational goals of value-based payment methodologies.

RECOMMENDATION(S):

In order to stimulate adoption of telehealth and increase access to care, the Council recommends the Florida legislature require Florida licensed health insurance plans (excluding Medicare plans) to provide reimbursement parity for covered health care services provided via telehealth.

The Council offers the following language for inclusion in Florida statutes:

For the purposes of health insurance coverage and payment (excluding Medicare plans), payment rates for services provided via telehealth shall be equivalent to the rates for comparable services provided via in-person consultation or contact contained in the participation agreement between the insurer and the health care practitioner.*

*The intent of this recommendation is to ensure appropriate insurance reimbursement for the use of telehealth in treating patients. Any legislative language developed should not require insurers to add additional service lines or specialties, mandate fee-for-service arrangements, inhibit value-based payment programs, or limit health care insurers and practitioners from negotiating contractual coverage terms.

MEDICARE

Although Medicare is a federal program, Medicare laws and regulations often influence how states are able to serve vulnerable populations, including patients who are dually eligible under both the Medicare and Medicaid programs. There are many caveats governing telehealth coverage under current Medicare payment guidelines, including strict requirements for the geographic location and care setting of patients and limitations to specific technological modalities. The United States Congress is currently considering several bills that would expand or modify Medicare telehealth policy. One example is the Medicare Telehealth Parity Act, a
bipartisan effort that would incrementally expand Medicare coverage for telehealth to include allied health care practitioners such as physical therapists, occupational therapists, audiologists, speech-language pathologists, and others; would allow a wider variety of telehealth modalities to be covered and would expand the list of qualifying geographic locations.\textsuperscript{xix} The Council finds the current Medicare policies related to telehealth coverage and reimbursement to be a significantly limiting factor to growth and innovation, and supports congressional efforts to expand coverage and reimbursement of telehealth in Medicare.

\textbf{RECOMMENDATION(S):}

The Council recommends the State of Florida support modifications to Medicare telehealth laws that would expand coverage to include \textit{store-and-forward modalities} as well as \textit{remote patient monitoring}; expand the types of health care practitioners covered; and revise or eliminate the existing geographic and place of service requirements.

\textbf{MEDICAID}

The Florida Medicaid fee-for-service rules were updated in June 2016 to expand the availability of telehealth reimbursement to a broader array of licensed health care practitioners. This Medicaid rule limits fee-for-service coverage to live video conferencing and pays only the practitioner that provides the diagnosis and management.\textsuperscript{xx} The vast majority of Florida Medicaid beneficiaries, however, are enrolled in managed care. Florida’s Medicaid Managed Care plans are authorized to cover telehealth services, although there is no state mandate for coverage. Based on survey responses from Florida licensed health plans and HMOs, coverage for telehealth is currently greatest among Florida Medicaid Managed Care Plans and Affordable Care Act Exchange Plans.\textsuperscript{xxi} The Council members and multiple stakeholders acknowledged Florida Medicaid for its support of the expanded use of telehealth within the Statewide Medicaid Managed Care program, as well as its continued efforts to modify administrative rules governing the Medicaid Fee-for-Service program to support the use of telehealth.

\textbf{RECOMMENDATION(S):}

The Council recommends the Agency modify the Medicaid telehealth fee-for-service rule to include coverage of \textit{store-and-forward} and \textit{remote patient monitoring} modalities in addition to the currently reimbursed live video conferencing modality.
INSURANCE NETWORK ADEQUACY

The National Association of Insurance Commissioners (NAIC) defines network adequacy as “a health plan’s ability to deliver the benefits promised by providing reasonable access to a sufficient number of in-network primary care and specialty physicians, as well as all health care services included under the terms of the contract.” Network adequacy minimum requirements are established to ensure consumers have access to needed care without unreasonable delay. In Florida, network adequacy is required for Medicaid Managed Care and Children Health Insurance Program plans.

The NAIC has developed a Health Benefit Plan Network Access and Adequacy Model Act for use by states in developing laws around this issue. The model includes provisions allowing health care practitioners who offer services via telehealth to be included in the plan network for purposes of network adequacy. At the time of this report, Colorado is the only state allowing insurers to count available telehealth services in meeting network adequacy requirements for certain specialties.

RECOMMENDATION(S):

The Council recommends the Agency develop a model that would allow Medicaid Managed Care plans to utilize telehealth for the purpose of meeting network adequacy.

HEALTH PRACTITIONER LICENSURE AND TELEHEALTH

Each state bears the responsibility for assuring patient protections and practitioner accountability. In order to ensure adequate protections and enforcement, Florida’s practitioners, stakeholders, and payers provided strong testimony to the Council encouraging a requirement that all health care practitioners providing care to Florida residents using telehealth be licensed in Florida, regardless of where the health practitioner is physically located.

INTERSTATE LICENSURE

To ensure patient protection and health care practitioner accountability, the Council recommends practitioners be licensed in the state in which the patient resides. The Council acknowledges time and expense burdens associated with attaining licensure in multiple states as a potential barrier to expanding health care practitioners’ use of telehealth. One opportunity to address this challenge is through the establishment of interstate licensure compacts. Nine (9)
licensed health care professions currently have or are developing interstate compacts involving multiple states (Attachment 3). xxiv

Licensure compacts are established when a certain number of states enact the same legislation, intended to streamline administrative processes without undercutting the specific licensure requirements of any participating state. It is important to note that compacts may actually increase the eligibility requirements for licensure in some cases. Practitioner participation in a compact is voluntary, and each state maintains jurisdiction over all practitioners providing care to patients within its borders. Compact provisions vary from profession to profession and include distinct requirements and provisions for differing professions. The Federation of State Medical Boards’ (FSMB) Interstate Medical Licensure Compact creates an expedited process for eligible physicians to apply for licensure in compact states. xxv The Nurse Licensure Compact creates a multi-state license similar to a driver’s license, where the initial licensing state and other compact participating states all recognize the license. xxvi Florida’s current licensure compact for nursing was adopted by the Florida legislature in 2016. Although, different in implementation, the intent is to provide a less onerous process for practitioners seeking licenses in multiple states while maintaining the high standards of Florida licensure.

RECOMMENDATION(S):

In order to ensure the best care for Florida patients and maximize available resources and access to care, the Council recommends the following:

1. Maintain the requirement of Florida licensure for health practitioners providing patient care in Florida via telehealth. This recommendation requires no change to current regulations and does not inhibit the use of telehealth to treat patients.
2. The legislature adopt laws allowing participation in health care practitioner licensure compacts with equivalent or increased licensure requirements as Florida, when available and appropriate.

TELEHEALTH STANDARDS OF CARE

It is imperative that Florida licensed practitioners understand and comply with established standards of care whether treating patients in-person or through telehealth. The Florida Department of Health (Department), which is responsible for the licensure and regulation of the more than 800,000 health practitioners in the state, provided information to the Council clarifying that current law does not preclude Florida licensed practitioners from using telehealth within their authorized scope of practice and established standards of care. The Department is
working to increase awareness and education among licensed health practitioners regarding their ability to use telehealth within their practices. The Department recognizes telehealth as a modality for providing health services.

A number of stakeholders, primarily ancillary health care practitioners (i.e. Physical Therapists, Occupational Therapists, Audiologists, Speech-Language Pathologists, etc.), indicated a need for specific statutory authority to develop telehealth practice standards related to telehealth, similar to the authority given to Boards of Medicine and Osteopathic Medicine. Other stakeholders deem the use of the general standard of care provisions in rule as sufficient for practitioner oversight.

RECOMMENDATION(S):

The Council acknowledges Florida’s current standards of care as sufficient for general regulatory oversight of patient care; and recognizes each health care regulatory board has direct authority for establishing appropriate standards based on knowledge and insight for their respective practitioners.

To ensure clarity for Florida licensed health care practitioners and stakeholders regarding the ability to use telehealth as a modality of care, the Council recommends:

1. The Department of Health and health care regulatory boards and councils continue to educate and raise awareness among licensees about their ability to utilize telehealth modalities as a means to treat patients when appropriate.

2. The Florida legislature authorize health care regulatory boards and councils’ specific statutory authority to develop standards of care and permit rules necessary for the implementation of telehealth. The telehealth standard of care shall be the same as the in-person standard of care.

The Council offers the following language for inclusion in Florida statutes:

The telehealth standard of care shall be the same as the in-person standard of care. The health care regulatory boards and councils’ may establish standards of practice and permit rules necessary for implementation of telehealth.

PATIENT/CONSUMER PROTECTION

Health care practitioners’ responsibilities to patients are the same regardless which modality of care is used. Patients should have confidence the standard of care they receive, whether
delivered in-person or through telehealth will be the same. Patients should expect competent, confidential care and to receive accurate, timely, and complete information so that they may make informed decisions about their care.

Health care practitioners and stakeholders also have a responsibility to manage risks related to fraud and abuse in the delivery of health care services. There is no known evidence suggesting a higher risk of abuse or fraud involving telehealth over any other modality of care delivery. A practitioner who potentially bills inappropriately for services may be audited regardless of modality of care.

PATIENT-PRACTITIONER RELATIONSHIPS & CONTINUITY OF CARE

Patient-practitioner relationships are key to improved health care. All states recognize the ability for a patient-practitioner relationship to be established via telehealth, with varying laws. The Florida Boards of Medicine and Osteopathic Medicine regulations support the ability for physicians to establish a patient-practitioner relationship through telehealth. This is significant for patients living in isolated communities or with mobility issues who face challenges in establishing and maintaining a relationship with a health care practitioner through in-person visits. The use of telehealth expands the ability for patients and practitioners to establish and facilitate regular visits and follow-up care. Telehealth, in some instances, can assist practitioners in discovering new insights about patients by allowing them to observe and interact with patients in the home setting.

The use of telehealth, however, does not diminish issues related to coordination of care among multiple practitioners. Ideally, when a patient receives care, information is integrated into coordinated Electronic Health Records (EHRs) or similar systems and made available to other practitioners providing treatments or services to the patient. There is some concern among practitioners and payers regarding the potential for care fragmentation or service duplication when patients seek or receive care outside of established provider networks and medical home. Similar to visits that occur in non-network urgent care centers, non-network direct to patient telehealth services could result in episodic care without the information ever being shared with the patient’s primary care provider or health plan - creating health care information silos. There are, however, federal and state initiatives to assist in sharing of patient health information, such as the Florida Health Information Exchange and Medicaid Electronic Health Record Incentive Programs.
RECOMMENDATION(S):

The Council recommends the Florida legislature recognize the ability for practitioners and patients to establish a relationship through telehealth in addition to encourage efforts for ensuring patient care coordination among treating practitioners.

The Council offers the following language for inclusion in Florida statutes:

A health care practitioner-patient relationship may be established through telehealth.

PATIENT CONSENT

Prior to providing health care services, practitioners are required to ensure patients (or legal proxies) are aware of the specific benefits, risks, and alternative courses of action they may take for their care; and must receive and document patient consent. This is typically achieved through an informed consent, which also relates to practitioner liability and legal exposure. In the case of telehealth, it may be particularly beneficial for patients to know the potential risks, and to understand that a condition or treatment may require a practitioner to defer to in-person services. Section 766.103, Florida Statutes, governs the provision of medical consent for treatment and is applicable regardless of the care delivery modality.

RECOMMENDATION(S):

The Council recommends maintaining current consent laws in Florida. The Council notes that additional consent requirements will add unnecessary barriers for both practitioners and patients attempting to utilize telehealth services.

TELEHEALTH & PRESCRIBING

Many medical conditions and procedures require prescription medications as a component of the treatment plan. Both federal and state law governs appropriate prescribing, in particular the prescribing of controlled substances. The Ryan Haight Online Pharmacy Consumer Protection Act (Ryan Haight Act) is a federal law that provides guidelines for the prescribing of controlled substances through the internet. This federal regulation prohibits the prescribing of a controlled substance based solely on answering a questionnaire. The Ryan Haight Act affirmatively recognizes telehealth as a viable means of creating a practitioner-patient relationship, when specified standards are met, for the purpose of prescribing controlled substances.
In Florida, medical doctors (allopathic and osteopathic), dentists, podiatrists, and some advanced registered nurses and physician assistants can prescribe controlled substances. Section 456.42, Florida Statutes, provides requirements for prescribing of controlled substances. The Florida Medical Boards’ rules on telehealth, additionally prohibit the prescribing of controlled substances without an in-person visit – with the limited exceptions of treating of psychiatric disorders in an outpatient setting, treating patients in a licensed health care facility, and treating patients in an emergency medical situation. These rules also specify requirements needed to ensure a complete record for any prescriptions. Scope of practice laws provide additional limitations for prescribing controlled substances when delivering care.

RECOMMENDATION(S)

The Council recommends the Florida legislature recognize the establishment of practitioner-patient relationships through telehealth as appropriate for treating patients, including the prescribing of medications, with limited exceptions for prescribing of controlled substances.

The Council offers the following language for inclusion in Florida statutes:

Health care practitioners, authorized by law, may prescribe medications via telehealth to treat a patient as is deemed appropriate to meet the standard of care established by his or her respective health care regulatory board or council. The prescribing of controlled substances through telehealth should be limited to the treatment of psychiatric disorders and emergency medical services. This should not prohibit an authorized, health care practitioner from ordering

ALLIED HEALTH PRACTITIONERS USE TELEHEALTH TO EXPAND REACH

Allied health practitioners in Florida including physical therapists, audiologists, and speech-language pathologists are discovering the benefits of using telehealth to provide services to their patients. Physical therapists are using telehealth to help in the rehabilitation of veterans. Tele-rehabilitation has been shown to provide more rehabilitation sessions to veterans in rural communities resulting in significant patient function improvement, and unanimous satisfaction by participants.* Audiologists use telehealth for assessment, education, cochlear implant and hearing aid programming, rehabilitation, and neurosurgical monitoring. Speech-Language Pathologists attribute successes in working with children at schools to the flexibility telehealth provides. They also note the significant role telehealth plays in the rehabilitation of stroke patients both at home and in long-term care facilities. Allied health practitioners tout telehealth for improving access, reducing travel fatigue in frail patients, and assisting with care coordination.**


a controlled substance for an inpatient at a facility licensed under chapter 395, F.S. or a patient
of a hospice licensed under chapter 400, F.S.

TECHNOLOGY

Telehealth is an increasingly accessible tool for both practitioners and patients due to
innovation in the current health care technology market. Health care practitioners have noted
some remaining technological barriers to effective telehealth implementations. Primary
examples include limited access to technology and internet connectivity in isolated
communities, equipment costs, and challenges related to interoperability with other health
care systems.

TECHNOLOGY AND PATIENT ACCESS

Many health services can be provided virtually through less expensive mobile devices such as
smartphones. A vast majority of the United States population now has a cellphone, including
92% of adults with an income of less than $30,000 a year. The Florida Public Service
Commission operates and administers the federal LIFELINE program in Florida, which provides
free or discounted mobile phones (including smartphones) to individuals who are eligible and
enrolled in certain social services programs. Several of Florida’s Medicaid Managed Care
plans promote LIFELINE services to their members in order to support health care management
through access to internet-based services. Approximately ten percent of American adults are
“smartphone-only” internet users – meaning they own a smartphone and do not have
traditional broadband service at home.

Florida has been very successful in implementing broadband connections throughout the state
and is considered one of the top ten “most connected states” by Broadband Now, a national
organization that compiles data from the Federal Communications Commission (FCC), the U.S.
Census Bureau, broadband providers, resellers, IP-verified customers and other sources.
Currently, over 97% of Floridians have access to wireline services and 100% have access to
mobile broadband services. A small segment of the population in Florida, about 600,000
individuals, have access to the internet through mobile broadband only. Mobile broadband
allows individuals to access the internet from their mobile devices. Telephone and data service
providers, however, typically set limits on the amount of data a user can consume. These limits
can inhibit some individuals from using their devices to receive health services via telehealth
due to the additional costs imposed by telephone and data service providers for exceeding data
limits.
## TECHNOLOGY AND HEALTH CARE FACILITIES/PRACTITIONERS

Florida health care practitioners and facilities specifically identified the cost of equipment needed to treat patients using telehealth as a barrier. The growing telehealth and technology markets indicate ongoing reductions in cost. Additionally, research and stakeholder input suggests that telehealth technology is available at varying price points. The Council is supportive of reimbursement parity for telehealth services as a strategy to address return on investment (ROI) for initial costs. Federal grant funding programs are available to support the implementation of telehealth programs. Information about the availability of funding and resources to assist practitioners is available through the federally funded Regional Telehealth Resource Centers. The Southeastern Telehealth Resource Center provides resources and guidance to practitioners in Florida for implementing and expanding telehealth services.

A bipartisan focus group conducted by Health Affairs and the national Bipartisan Policy Center identified the lack of interoperability between electronic health record systems and medical devices as a barrier to telehealth expansion. Florida health care facilities also indicated through survey responses that a lack of interoperability between practitioners is a barrier to development and implementation of telehealth programs. The challenges related to interoperability between health care practitioners’ data systems, include a lack of interoperability between telehealth technology and electronic health record (EHR) platforms. Technology vendors and health care organizations are working to improve systems’ interoperability through implementations that support data exchange, such as the national eHealthExchange and Carequality. The eHealthExchange is a growing network of exchange partners, health information organizations and federal Agencies such as the Veteran’s Administration and Social Security Administration Disability Determination, who securely share clinical information using a standardized approach. Carequality is advancing EHR interoperability by brokering agreements among health information technology vendors to implement a framework for point-to-point health information exchange. In Florida, the Agency provides governance for the statewide Health Information Exchange (HIE) program, which promotes interoperability and offers services that allow sharing of patient information between health care practitioners when needed.

### RECOMMENDATION(S):

The Council notes that technology-related barriers for practitioners will continue to decrease as technological advances and market forces drive cost reductions. Barriers remain related to interoperability of health care information systems. The Council recommends:
1. The Agency identify existing resources for health information exchange; existing and potential solutions to expanding interoperability and pathways to potential solutions.

2. The Agency continue promotion of existing programs and services available to increase access to technology, access to broadband networks, and improved interoperability.

3. Medical schools and health care associations provide information and educational opportunities related to the utilization to telehealth to treat patients.

CONCLUSION

The Council heard testimony from almost 100 individuals representing a full spectrum of stakeholders and reviewed hundreds of articles, studies, and reports. The information obtained from stakeholders and documentation supports the benefits of expanding the use of telehealth for treating patients both in rural and urban communities. The information provided also supports the need for policy modifications to remove barriers for expanding telehealth use. The Council’s recommendations found in this report are viable solutions to overcoming identified barriers for telehealth expansion and access.
GLOSSARY OF TERMS

Asynchronous Modality (store-and-forward): Transmission of recorded health history (for example, pre-recorded videos and digital images such as x-rays and photos) through a secure electronic communications system to a practitioner who uses the information to evaluate the case or render a service outside of a real-time or live interaction.

Controlled Substances: A drug or chemical whose manufacture, possession, or use is government regulated.

Coverage Parity: A requirement of health plans to include benefits for services provided via telehealth, when possible and appropriate, to the same extent the plan covers the same services provided in-person but is silent on payment.

Reimbursement Parity: A requirement of health plans to pay healthcare facilities and practitioners for covered services at an equivalent rate whether the service is provided using telehealth or in-person.

Remote Patient Monitoring: Personal health and medical data collection from an individual in one location via electronic communication technologies, which is transmitted to a provider in a different location for use in care and related support.

Scope of Practice: The range of responsibility, extent, and limits of the medical interventions that a health care practitioner may perform.

Standard of Care: The degree of prudence and competence in performing medical tasks accepted as reasonable, and reflective of a skilled and diligent health care practitioner.

Synchronous Modality (live video): same-time collaboration; events and interactions take place in real time.
ENDNOTES


iii Ibid


xiv Ibid

xv State Telehealth Laws and Medicaid Program Policies. Center for Connected Health Policies. April 2017


xviii Lacktman, N. Telehealth Coverage vs. Payment Parity. Aug. 11. 2015


xxiv Florida House Bill 1061. 2016.


xxvii Board of Medicine Rule 64B8-9.0141 Standards for Telemedicine, Florida Administrative Code and Board of Osteopathic Medicine Rule 64B15-14.0081, Florida Administrative Code


xxix Board of Medicine Rule 64B8-9.0141 Standards for Telemedicine, Florida Administrative Code and Board of Osteopathic Medicine Rule 64B15-14.0081, Florida Administrative Code

xxx Florida Health Information Network. [www.fhin.net](http://www.fhin.net)


xxxii Board of Medicine Rule 64B8-9.0141 Standards for Telemedicine, Florida Administrative Code and Board of Osteopathic Medicine Rule 64B15-14.0081, Florida Administrative Code


# Table of Contents

- Executive Summary ................................................................................................................................. 3
- Introduction .................................................................................................................................................. 5
- Florida Telehealth Surveys .......................................................................................................................... 6
  - Survey Methodology – Florida Licensed Health Care Facilities ............................................................. 6
  - Office of Insurance Regulation Survey Methodology ............................................................................. 7
  - Department of Health Survey Methodology ............................................................................................ 8
- Background ..................................................................................................................................................... 10
- Health Care Services Offered via Telehealth .............................................................................................. 12
  - Telehealth Service Examples .................................................................................................................. 15
    - Study on Veterans Affairs Use of Tele-rehabilitation ............................................................................ 15
    - Study on Impact of Virtual Physician Use in Skilled Nursing Facility ................................................ 15
    - Mayo Clinic Tele-Stroke Network Program ....................................................................................... 15
    - United Kingdom Department of Health’s Whole System Demonstrator Program ............................ 15
- The Extent of Telehealth Use by Health Care Practitioner and Facility .................................................... 16
- Costs and Cost Savings .................................................................................................................................. 18
  - Studies Related to Telehealth Costs and Savings ................................................................................... 22
    - United States is the Department of Veteran Affairs ............................................................................. 23
    - United States Department of Justice ................................................................................................... 23
    - Study on Impact of Virtual Physician Use in Skilled Nursing Facility ................................................ 23
    - Mayo Clinic Telestroke Network Program .......................................................................................... 23
- Coverage and Reimbursement for Telehealth Services ................................................................................ 24
  - Private and Commercial Insurance Coverage and Reimbursement ....................................................... 25
  - Medicare and Medicaid Coverage and Reimbursement ......................................................................... 26
- Barriers to Telehealth ................................................................................................................................. 28
  - Financial .................................................................................................................................................... 28
  - Interoperability ......................................................................................................................................... 30
  - Regulation and Liability .......................................................................................................................... 30
  - Knowledge ............................................................................................................................................... 30
- References ..................................................................................................................................................... 31
Executive Summary

Chapter 2016-240, Laws of Florida, was passed during the state’s regular 2016 Legislative Session, and was signed by Governor Rick Scott becoming effective on July 1, 2016. The law directs the state’s Agency for Health Care Administration (AHCA), the Department of Health (DOH), and the Office of Insurance Regulation (OIR) to collaboratively survey the Florida licensed health care facilities, professionals, and payers of health care services in an effort to determine and document:

- The types of health care services provided via telehealth in the state
- The extent to which telehealth is used by health care practitioners and health care facilities nationally and in the state
- The estimated costs and cost savings to health care entities, health care practitioners, and the state associated with using telehealth to provide health care services
- Which health care insurers, health maintenance organizations, and managed care organizations cover health care services provided to patients in Florida via telehealth, whether the coverage is restricted or limited, and how such coverage compares to that insurer’s coverage for services provided in person

The law directs AHCA to compile the survey and research findings and submit a report of such findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives on or before December 31, 2016. This report is submitted by the Agency to meet the requirements of Chapter 2016-240; and represents the collaborative efforts across AHCA, DOH, and OIR.

The new telehealth law also creates a Telehealth Advisory Council for the purpose of making recommendations to the Governor and the Legislature. The law designates the Secretary of AHCA as the Council’s Chair, and designates the State Surgeon General (or designee) as a member. The Agency’s Secretary and the Surgeon General appointed 13 Council members representing specific stakeholder groups. The Council is charged to review the survey and research findings included in this report, and to employ that information to inform recommendations to increase the use and accessibility of services provided via telehealth, including the identification of any barriers to implementing or accessing services provided via telehealth. A report of the Council’s recommendations must be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives on or before October 31, 2017.
Highlighted findings contained within this initial report include:

- Utilization of telehealth is expanding in Florida and nationally, both in terms of the variety of applications and use cases as well as patient volume and demand.
- Nearly half (44.8%) of Florida hospitals responding to AHCA’s telehealth survey indicated that telehealth services are available through their facilities.
- The most frequent use cases of telehealth reported by licensed health care facilities in Florida include: neurology (including stroke care), home health/patient monitoring, primary care, behavioral health, and radiology.
- Nearly half (44%) of home health agencies responding to the Agency’s survey indicated using telehealth to assist with remote patient monitoring.
- Benefits reported from health care facilities and professionals offering telehealth services include improved convenience for both patients and providers, improved efficiencies, and improved patient care outcomes.
- Financial barriers are the most frequently reported obstacles among health care facilities and providers during both implementation and ongoing operations of telehealth programs.
- Due to multiple and often conflicting definitions of telehealth at every level (Federal, State, and among private payers and policymakers), there is significant uncertainty across stakeholder groups regarding types of services and activities that may qualify as telehealth for the purposes of coverage and reimbursement.
- Despite great technological advances over time in the field of Health Information Technology, including Electronic Health Records (EHR) systems and Health Information Exchange (HIE) networks, there remain significant challenges with interoperability between providers across the state and nationally, making it difficult for health care professionals to obtain adequate medical history and clinical information at the time they are treating a patient. These gaps in interoperability were cited by survey respondents as a common barrier to the development and implementation of telehealth programs.
- Research and survey findings indicate that few providers have achieved a financial Return on Investment (ROI) attributable to the implementation of telehealth services; although some examples do exist.
- Many providers reported a lack of detailed knowledge about telehealth services, and indicated interest in gaining access to evidence-based best practices, educational resources, or training opportunities associated with telehealth.

This report details these and other findings from survey responses and highlights from a literature review of national telehealth research studies.
Introduction

The United States, including Florida, is experiencing a shortage of health care professionals to serve a growing and aging population. Data referenced in the Florida House of Representatives legislative staff analysis for House Bill 7087 (2016) noted that there were 615 federally designated Health Professional Shortage Areas (HPSAs) within the state for primary care, dental care, and mental health therapists as of June 19, 2014. The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) Bureau of Health Workforce data indicates that the number of HPSAs in Florida has grown to 623 by December of 2016. Multiple national proposals and recommendations have been developed in recent years to address these shortages, including:

- Creation of new scholarships and residency programs to train more providers
- Expanding the scope of practice for certain health care professionals
- More efficient utilization of the existing workforce through the expanded use of telehealth

Chapter 2016-240, Laws of Florida was enacted by the legislature in 2016 creating a Florida telehealth Advisory Council (Council) charged with reviewing research and survey findings and developing recommendations to support expansion or increased access to health services provided through telehealth in the state. The law requires the Florida Agency for Health Care Administration (AHCA), the Florida Department of Health (DOH), and Florida Office of Insurance Regulation (OIR) to respectively survey licensed health care facilities, licensed health care practitioners, and licensed health care insurers and Health Maintenance Organizations (HMOs), to assess the current Telehealth landscape across the state and to inform the Council’s work.

This report presents findings from the surveys as well as research findings compiled from multiple resources representing both Florida and national perspectives. The focus of the surveys and report, as guided by Chapter 2016-240, Laws of Florida, include:

- National and state utilization of telehealth
- Types of healthcare services provided via telehealth
- Costs and cost savings associated with using telehealth to provide health care services
- The extent of insurance coverage for providing health care services via telehealth and how such coverage compares to coverage for in-person services
- Barriers to using or accessing services through telehealth
Survey findings will also be provided to the Telehealth Advisory Council (Council). The Council is, in turn, required to submit a report of recommendations for increasing the use and accessibility of telehealth to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 31, 2017.

Florida Telehealth Surveys

Survey Methodology – Florida Licensed Health Care Facilities

Florida’s Agency for Health Care Administration licenses more than 48,000 health care facilities and businesses in Florida.

Agency staff first identified the facility types most likely to be utilizing telehealth services; then executed a series of direct emails to the facility contact email addresses maintained by the Agency within its facility licensure database for the selected facility types. A personalized email was sent to the executive contact of each facility premise and included brief background information on the authorization and purpose for the survey, instructions on how to complete the survey, the facility’s specific AHCA-issued license number and AHCA file number for reference, and information on how to contact Agency staff with questions about the survey. The email then provided a hyperlink to the Agency’s electronic health facility survey. The survey link was also published to the Agency’s website, on its dedicated Telehealth Advisory Council webpage. The Agency used a variety of approaches to raise awareness of the survey including a press release and electronic provider alerts to subscribed interested parties to notify stakeholders and encourage participation in the survey. The facility survey was launched in August, 2016 and surveys were collected through September 30th. Agency staff monitored response rates by facility type, and sent follow-up emails during the month of September to those facility types with relatively low response rates.

Sixteen facilities types, totaling approximately 11,900 individual facilities, were identified as the most probable users of telehealth. The overall response rate from those facilities was 49%. (Figure 1)
Office of Insurance Regulation Survey Methodology

The Florida Office of Insurance Regulation is responsible for the regulation, compliance, and enforcement of statutes related to the business of insurance in the state. The Office worked closely with the Agency to develop a survey for the state’s licensed health insurance plans and Health Maintenance Organizations (HMOs) that aligned closely with the questions and focus of the health care facility and licensed health care practitioner surveys. The Office leveraged its existing health information systems to create the payer survey in a secure environment.

The Office conducted a direct email distribution of the survey notification to its constituents, including active follow-up with nonresponsive payers periodically throughout the data collection period. The health plan surveys were disseminated in September, and data was collected through the month of October. The Office collected all survey responses and provided a complete dataset of the responses to the Agency for analysis.

Fifty-Four (54) Health Plans offering at least one of six lines of business were surveyed. 100% of the plans surveyed responded.
Department of Health Survey Methodology

The Department of Health licenses health care practitioners in Florida and is required by Chapter 2016-240, Laws of Florida, to survey practitioners as a condition of licensure renewal. Most health care licensees are required to renew their licenses biennially in order to maintain the right to practice; however, some professions require annual renewal of the license. Due to the condensed time period from the effective date of the law (July 1, 2016) to the required submission date for survey findings to the Governor and the legislature (December 31, 2017), there was a limited number of health care professionals scheduled to renew their licenses during the available data collection period.

DOH added the telehealth practitioner survey to their electronic license renewal application effective July 1, 2016. In an effort to gain as much feedback from the state’s licensed health care professionals as possible for this report, a volunteer survey was also offered by AHCA to practitioners. The voluntary electronic survey was posted on the Agency’s dedicated telehealth web page. The Department of Health encouraged provider participation through mutual posting of the survey on both its FLHealthSource.gov homepage as well as their dedicated website for clinical laboratories. Despite these efforts, the voluntary survey received relatively limited response. Information provided in this report includes information from practitioners that completed the Department of Health survey for renewal between July 1, 2016 and December 1, 2016. To date the DOH licensure survey has generated a total of 26,579 responses.

Additional information from DOH licensed practitioners will be provided to the Council as it becomes available for consideration in their final recommendations.

Nine types of practitioners renewed or began renewing their DOH license between July 1 and December 1, 2016. (Figure 2) These licensees include nursing home administrators, athletic trainers, a segment of registered nurses, consultant pharmacists, and a segment of medical doctors. (Figure 3)

<table>
<thead>
<tr>
<th>Figure 2. DOH Licensees with a Renewal Date between July 1 &amp; Dec 31, 2016</th>
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<tbody>
<tr>
<td><strong>Type of Practitioner</strong></td>
</tr>
<tr>
<td>-------------------------</td>
</tr>
<tr>
<td><strong>Consultant Pharmacist</strong></td>
</tr>
<tr>
<td><strong>Optician</strong></td>
</tr>
<tr>
<td><strong>Registered Pharmacy Technician</strong></td>
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</tbody>
</table>
The state’s federally certified Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and the Florida Department of Health’s 67 County Health Departments (CHDs) are also entities which may provide telehealth services. A separate version of the Agency’s electronic health professional survey was created, and a link to the survey was distributed to these entities along with a request for voluntary completion. The Florida Association of Community Health Centers (FACHC) assisted the Agency in distributing the voluntary survey to its’ member FQHCs. The voluntary survey was also published on the Agency’s dedicated telehealth website. Data collection from these provider types is on-going; and any information obtained from these entities will be provided to the Council for consideration in their final recommendations to the Governor and Legislature.

<table>
<thead>
<tr>
<th>Provider Type</th>
<th># of Completed Surveys/Renewals</th>
<th># Eligible to Renew</th>
<th>Response Rate</th>
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<td>Anesthesiologist Assistants</td>
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<td>300</td>
<td>17%</td>
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<tr>
<td>Diagnostic Radiological Physicist</td>
<td>37</td>
<td>103</td>
<td>36%</td>
</tr>
<tr>
<td>Hearing Aid Specialist</td>
<td>57</td>
<td>1,059</td>
<td>5%</td>
</tr>
<tr>
<td>Licensed Clinical Social Worker</td>
<td>5</td>
<td>10,192</td>
<td>0%</td>
</tr>
<tr>
<td>Licensed Marriage and Family Therapists</td>
<td>1</td>
<td>2,069</td>
<td>0%</td>
</tr>
<tr>
<td>Medical Doctor</td>
<td>10,575</td>
<td>35,058</td>
<td>32%</td>
</tr>
<tr>
<td>Medical Health Physicin</td>
<td>12</td>
<td>38</td>
<td>32%</td>
</tr>
<tr>
<td>Medical Nuclear Radiological Physicists</td>
<td>25</td>
<td>58</td>
<td>43%</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>225</td>
<td>8,960</td>
<td>3%</td>
</tr>
<tr>
<td>Occupational Therapist Assistant</td>
<td>99</td>
<td>5,446</td>
<td>2%</td>
</tr>
<tr>
<td>Optometrist</td>
<td>370</td>
<td>3,408</td>
<td>11%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>44</td>
<td>10,166</td>
<td>0%</td>
</tr>
<tr>
<td>Therapeutic Radiological Physicist</td>
<td>244</td>
<td>401</td>
<td>36%</td>
</tr>
</tbody>
</table>
Background

The term Telemedicine is often used as synonymous with telehealth, although some stakeholders consider telehealth to be a more comprehensive term that encompasses not only direct patient care (diagnosis and treatment), but also educational and administrative processes. There is no universally accepted definition of telehealth. The definition used for the survey is from Segen’s Medical Dictionary, which provides a fairly broad definition:

“Telehealth is a generic term for the remote delivery of health care through the use of electronic information and telecommunications technologies.”

Definitions for telehealth/telemedicine associated with Florida regulations can be found in the Florida Boards of Medicine and Osteopathic Medicine rules 64B8-9.0141, FAC and 64B15-14.0081, FAC respectively.

“Telemedicine” means the practice of medicine by a licensed Florida physician or physician assistant where patient care, treatment, or services are provided through the use of medical information exchanged from one site to another via electronic communications. Telemedicine shall not include the provision of health care services only through an audio only telephone, email messages, text messages, facsimile transmission, U.S. Mail or other parcel service, or any combination thereof.

Additionally, the Agency for Health Care Administration defines telehealth for the purpose of fee-for-service reimbursement under the state’s Medicaid program, in rule 59G-1.057, FAC:

“The practice of health care delivery by a practitioner who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis, or treatment.”

Although telehealth technology in some form has been in use since the 1960s, patient demand for care access has more recently pushed telehealth into the mainstream. National studies show that 74% of consumers use telehealth services; 76% of patients value access to care over the need for human interaction with their health provider; 70% of patients are comfortable talking with their health provider via text, email or video; and 30% of patients are already using computers or mobile devices to check medical or diagnostic information.
A national survey of health care executives published in 2016 reported 63% of health care practitioners use some type of telehealth platform to provide health services. Only 6% percent of surveyed practitioners in Florida indicate they use telehealth to provide health care services (Figure 4).

In 2013, 52% of hospitals in the nation utilized telehealth and another 10% were beginning the process. Of Florida hospitals responding to the AHCA statewide survey, 45% indicate they offer health care through some form of telehealth (Figure 5). A majority of the facilities offering telehealth services in Florida indicate the benefits are patient convenience and better coordination of care (Figure 6). Patient interest combined with health practitioner workforce shortages and advancements in technology make telehealth increasingly vital to the health care delivery system.
Health Care Services Offered via Telehealth

The United States Department of Health and Human Services notes that telehealth is not a type of health care service; it is a means or method used to deliver health care. The standard of care for providing health services should not alter based on the mode of delivery. Telehealth services can enable real-time (synchronous) communication between patients and care providers through video conferencing; facilitate the storage and forwarding (asynchronous) of clinical data to offsite location for evaluation by specialist teams; and support remote monitoring of patient’s chronic conditions via sensors and monitoring equipment. Telehealth technology is evolving into wearable and even implantable devices (mobile health) that detect information such as EKG readings. Under each of the broader categories are various models of use.

### Examples of Hospital-Based Telehealth Platforms

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telesstroke</td>
<td>Remote evaluations, diagnoses and treatment recommendations are transmitted from neurologists to emergency medicine physicians treating stroke patients at other sites</td>
</tr>
<tr>
<td>Teleradiology</td>
<td>Radiology images and associated data are transmitted between locations for the purpose of primary interpretation or consult and clinical review</td>
</tr>
<tr>
<td>Tele-ICU</td>
<td>Networks of audiovisual communication and computer systems are linked with critical care physicians and nurses to ICUs in other, often remote hospitals</td>
</tr>
<tr>
<td>Telemental Health</td>
<td>Mental health and substance abuse services are provided from a distance using videoconferencing and other advanced communication technologies</td>
</tr>
<tr>
<td>Telepathology</td>
<td>The practice of pathology is performed at a remote location by means of video cameras, monitors, and a remote controlled microscope</td>
</tr>
<tr>
<td>Remote Clinical Monitoring</td>
<td>Disease management of patients using continuous or frequent periodic remote clinical monitoring via advanced communication technologies (EKG, glucose testing, etc.)</td>
</tr>
<tr>
<td>Telepharmacy</td>
<td>Pharmaceutical care for patients (or supervision to technicians) is provided at a distance using advanced telecommunications technology</td>
</tr>
<tr>
<td>Cybersurgery</td>
<td>Surgeons use surgical techniques with a telecommunication conduit connected to a robotic instrument to operate on a remote patient</td>
</tr>
</tbody>
</table>
Telehealth is currently used in a broad array of applications. The use of telehealth crosses most health service disciplines including, but not limited to, primary medical care, specialty care, chronic disease management, behavioral counseling, physical therapy, speech therapy, pharmacy, and home health (Figure 7). One of the most prevalent forms of hospital-based telemedicine is radiological services, which use an asynchronous platform which allows radiologists to perform their work in distant locations. Over 5 million patients have had diagnostic radiology tests read by an off-site specialist, according to the American Telehealth Association. In the late 1990s and early 2000s, there were initiatives by some radiology groups to locate physicians in Europe and Australia in order to leverage the benefits of time zone differences with the United States. For example, a physician working during the daytime hours in Australia could cover the night shift in the United States.

Figure 7: Florida Licensed Facilities Reporting Telehealth Utilization, by Facility Type and Service Type.
Despite a vast number of potential applications and use cases; current telehealth industry utilization can be categorized into four major classifications of health care services:\(^\text{13}\):

- **Patient care**, including the sharing of audio, video, and medical data between the patient and health care practitioner; specialist consultation; and diagnostic image review for the purpose of treatment and diagnosis

- **Remote patient monitoring**, including the collection and transmission of patient health data to monitoring stations (i.e. electrocardiogram, glucose levels, blood pressure readings, etc.)

- **Medical education and mentoring** of health care practitioners on special topics or procedures

- **Consumer medical and health information** which can assist in improving life style changes for improved health

Findings from the Agency’s survey of Florida licensed health care facilities demonstrates varied usage of telehealth modalities across provider types, with the most use and variation occurring among hospitals. Teleneurology is one of the most prevalent services offered from facilities who utilize telehealth in Florida (Figure 8).

---

**Figure 8.** Types of Health Care Services Offered by Hospitals Completing the Survey That Currently Use Telehealth

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology</td>
<td>19%</td>
</tr>
<tr>
<td>Extend Care/Post-Discharge/Home Health/Remote Patient Monitoring</td>
<td>18%</td>
</tr>
<tr>
<td>Primary Care</td>
<td>18%</td>
</tr>
<tr>
<td>Psychiatry/Mental Health/Behavioral Health</td>
<td>15%</td>
</tr>
<tr>
<td>Radiology</td>
<td>13%</td>
</tr>
<tr>
<td>Chronic Disease/Cancer</td>
<td>11%</td>
</tr>
<tr>
<td>Pediatric Care/Pediatric Specialty Care</td>
<td>9%</td>
</tr>
<tr>
<td>Intensive Care/Critical Care</td>
<td>8%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>7%</td>
</tr>
<tr>
<td>Tele-pharmaceutical/Tele-prescribing/Medication Compliance</td>
<td>7%</td>
</tr>
<tr>
<td>Emergency Trauma Care</td>
<td>1%</td>
</tr>
</tbody>
</table>

Percent of Respondents
Telehealth Service Examples

Study on Veterans Affairs Use of Tele-rehabilitation
The United States Department of Veterans Affairs (VA) introduced its telehealth program in 1990 and is considered a pioneer in this industry. During calendar year 2012, the VA served more than 485,000 patients and completed approximately 1.4 million telehealth consultations. One study examined the VA’s use of telehealth on a group of 26 veterans living in rural areas who received physical therapy via in-home video or tele-rehabilitation. All of the participants in the tele-rehabilitation study showed significant improvement and reported satisfaction with their experience. In addition to positive results, the use of tele-rehabilitation in this case was associated with minimizing time, expense, and inconvenience of receiving in-person care.

Study on Impact of Virtual Physician Use in Skilled Nursing Facility
Cobble Hill Health Center, a 360 bed Skilled Nursing Facility in New York, participated in one-year study that looked at the impact of using “virtual physicians” (video conferencing) outside of regular primary care physician hours. According to the study 60%-70% of nursing facility to hospital transfers, when viewed in retrospect, should not occur. Additionally, these transfers often lead this senior population to increased confusion, fall risk, risk of skin ulcers, and exposure to hospital acquired infections. During the one-year study, 91 patients avoided unnecessary hospitalizations. Of those, 63% were long term care residents and 37% were short term patients.

Mayo Clinic Tele-Stroke Network Program
Real-time applications of telehealth can allow for instantaneous assistance through a live video conferencing “hub and spoke” model. These real-time applications are often used for specialist consultation. One example is for tele-neurology, when a patient is experiencing a stroke and a neurologist is hours away. The Mayo Clinic has implemented a model to assist smaller and underserved hospitals with less extensive neurology services in providing stroke care. The study notes improved patient functional outcomes – with a higher percentage reporting no significant disability, higher overall self-reported health, and improved neurological status within 24 hours and after 90 days.

United Kingdom Department of Health’s Whole System Demonstrator Program
The United Kingdom’s study on remote patient monitoring is the largest known randomized control trial of telehealth. The study involved 6,191 patients, including 3,030 patients who had one of three conditions: diabetes, chronic heart failure (CHF), or Chronic Obstructive Pulmonary Disease (COPD). The patients were remotely monitored by 238 general practitioners. Study
results published in 2012 indicated a 45% reduction in mortality rates and 20% reduction in emergency department admissions among the study population.\textsuperscript{18}

The Extent of Telehealth Use by Health Care Practitioner and Facility

The use of telehealth technologies to provide health care services is growing at a significant rate. Among Florida facilities and practitioners that completed the survey and who indicated they use telehealth, a majority have recently begun providing telehealth services. 55% of practitioners and 19% of facilities indicate they began offering telehealth services for the first time within the last year (Figures 9 & 10). Major factors driving the adoption of telehealth include advancing technologies, an aging population, health practitioner shortage, and greater acceptance of innovative treatment by patients. Although telehealth capabilities have been available for many years, recent advancements in technology and greater accessibility to those technologies are catalysts for growth.
Florida is especially impacted by a senior population that is growing faster than the national rate. Persons aged 65 years and older comprised 12.4% of the United States population in 2000, but are expected to grow to be 19% of the population by 2030.\textsuperscript{19} As of July 2015, Florida’s seniors made up 19.4% of Florida’s population.\textsuperscript{20} Our nation’s senior population is known to have higher rates of chronic disease including congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes, hypertension (high blood pressure), and end stage renal disease than persons under the age of 65. This growing population with complex care needs is largely responsible for rising health care costs nationally and presents an urgent need for innovative care delivery. Furthermore, while the senior population is increasing, the health practitioner population is decreasing. The Association of American Medical Colleges anticipates a shortfall of more than 130,000 physicians nationally by 2025.\textsuperscript{21} Patients are also becoming more proactive in their health care delivery choices - with utilization of telehealth services expected to increase nationally from an estimated 250,000 patients in 2013 to an estimated 3.2 million patients in 2018.\textsuperscript{22} Based on survey responses, a majority of Florida patients using telehealth services offered through licensed facilities are between the ages of 18-64. Close behind, 44% of persons receiving health care via telehealth technology are seniors (Figure 11).

\textbf{Figure 11. Reported Age Categories of Floridians Using Telehealth Services}

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Percent of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-17 years</td>
<td>7%</td>
</tr>
<tr>
<td>18-64 years</td>
<td>49%</td>
</tr>
<tr>
<td>65 years or over</td>
<td>44%</td>
</tr>
</tbody>
</table>

Percent of Respondents
Costs and Cost Savings

There are a number of different and varying costs associated with the development and operation of telehealth services. Costs vary by delivery model and are a product of project establishment and equipment investments, maintenance fees, communications fees, and staffing expenses. Health care providers typically absorb the cost for implementation of telehealth services. Florida facilities and practitioners are not immune to these costs, indicating that equipment and on-going costs needed to provide telehealth services were purchased using general operating funds (Figures 12 & 13).
Operational cost savings derived from employing telehealth services are typically denoted from a Health System perspective rather than an individual provider perspective. The American Hospital Association notes that direct return on investment for health care providers is limited; particularly when there is limited coverage and reimbursement by health plans for the services offered by telehealth. Florida health facilities and practitioners identify costs, reimbursement, and inability to determine a Return on Investment (ROI) as challenges in providing telehealth services (Figures 15, 16, and 17).

From a national perspective, some studies have determined that telehealth can help achieve the Institute for Healthcare Improvement’s (IHI) Triple Aim goals of improving the patient experience of care, improving population health, and lowering health care costs by improving access to appropriate, lower-cost services such as timely primary or specialty care, or through lower-cost settings such as clinics, homes or workplaces. The U.S. Centers for Medicare and Medicaid Services (CMS) view telehealth as a cost-effective alternative to traditional service delivery. Florida health providers corroborate this theory by identifying diagnosis/treatment and emergency care as top uses for telehealth (Figure 14).

In terms of telehealth cost effectiveness related to clinical outcomes, some stakeholders believe additional research is needed. A stakeholder group brought together by the Center for Connected Health Policy found that additional controlled studies need to be done in this area. The studies in this field are each limited to different telehealth modalities, settings, diseases or conditions, or patient groups. This diversity makes it difficult to generalize cost effectiveness as a whole.
Figure 15. Barriers to Implementation Among Facilities Offering Telehealth

On a scale of 1-5, with one (1) being no barrier and five (5) being a major barrier, how would you rate the barriers experienced by this facility during implementation of telehealth services?

- Lack of health insurance reimbursement for telehealth services provided: 2.7
- Lack of funding: 2.7
- Unable to determine return on investment: 2.4
- Inability to electronically exchange patient medical records/information: 2.3
- Inability to secure support from physicians in using the technology: 2.3
- Lack of community/patient acceptance of telehealth services: 2.1
- Concerns related to privacy and security: 2.0
- Inability to develop partnerships with presenting sites: 2.0
- Limitation related to on-line prescribing: 2.0
- Inability to develop partnerships with originating sites: 2.0
- Inability to connect at needed internet bandwidth speeds: 2.0
- Restrictions related to health practitioner licensure: 2.0
- Inability to obtain practitioner credentialing/privileging at partnering facilities: 1.8
- Inability to get Medical Malpractice and Professional Liability Insurance: 1.7
- Lack of facility executive support: 1.6
Figure 16. Barriers to Implementation Among Facilities Attempting to Offer Telehealth Services

On a scale of 1-5, with one (1) being no barrier and five (5) being a major barrier, how would you rate the barriers experienced by this facility when trying to implement telehealth services?

- Lack of health insurance reimbursement for telehealth services provided
- Lack of funding
- Unable to determine return on investment
- Inability to secure support from physicians in using the technology
- Inability to develop partnerships with presenting sites
- Inability to develop partnerships with originating sites
- Inability to electronically exchange patient medical records/information
- Lack of community/patient acceptance of telehealth services
- Limitation related to on-line prescribing
- Restrictions related to health practitioner licensure
- Concerns related to privacy and security
- Inability to obtain practitioner credentialing/privileging at partnering facilities
- Inability to connect at needed internet bandwidth speeds
- Inability to get Medical Malpractice and Professional Liability Insurance
- Lack of facility executive support

Legend
- 5
- 4
- 3
- 2
- 1

Number of Responses
Studies Related to Telehealth Costs and Savings

Some studies related to cost effectiveness in telehealth have found comparable costs or cost savings compared to traditional care delivery. In a legislatively mandated report, Maryland’s Department of Health and Hygiene found that Medicaid expenditures using a live video conferencing model could increase costs to the state by increasing services provided. The report also noted that the costs could potentially be off-set by reductions in emergency department visits and transportation expenses. A separate study by Dale Yamamoto found potential savings of $126 per acute care visit for private payers. This study also estimates Medicare could save approximately $45 per telehealth visit when compared to the average estimated cost of $156 for in-person care.
United States is the Department of Veteran Affairs

One of the largest users of telehealth in the United States is the Department of Veteran Affairs (VA). The VA has reported that home telehealth services reduced bed days associated with inpatient hospital care by 59% and overall hospital admissions by 35% in 2013. Additionally, clinical video telehealth services reduced bed days of care for mental health care patients by 38%. The VA identified cost savings of approximately $2,000 per person per year for home telehealth; $34.45 per consult for clinical video telehealth, and $38.81 in travel costs per consult for store-and-forward telehealth.  

United States Department of Justice

A report from the US Department of Justice in 1999 identified potential for cost savings in the prison system. The initial demonstration included installing a telemedicine network and interoperable health data exchange capabilities. The report demonstrated that telehealth could play an important role in delivering quality health care in correctional systems at a cost savings to most institutions. Based on the data from the study, the cost-benefit analysis concluded a telehealth consultation would cost an average of $71, compared with $173 for an in-person consultation. A follow up report in 2002 provided guidance to correctional institutions on conducting a cost benefit analysis for determining the most appropriate technologies and implementations.  

Study on Impact of Virtual Physician Use in Skilled Nursing Facility

The Cobble Hill study, which used virtual physicians during “off” hours to supplement in-person care, was able to identify a project “net system savings” of over $1.1 million. However, the study noted a projected increase in spending of over 137,000 for the New York Medicaid program. 

Mayo Clinic Telestroke Network Program

A telestroke network program implemented by Mayo Clinic reported a net savings to hospitals for Medicare patients. This savings takes into consideration initial hospitalization recurrent stroke, nursing home and rehabilitation costs. Additionally, Mayo identifies that Medicare expenditures decrease overall when considering inpatient, recurrent stroke and rehabilitation reimbursements. This is determined by the offset expenditures from decreasing recurrent stroke and rehabilitation care.
Coverage and Reimbursement for Telehealth Services

Reimbursement levels and allowances for telehealth services vary from state to state and from entity to entity. Some public and private payers limit reimbursement for health services offered through telehealth technology by the type of telehealth service offered and/or by the locations where care is provided and received. 43% of Florida health insurers indicate that they cover some form of telehealth services (Figure 18). Companies who offer Medicare Advantage plans were shown as having the largest percentage of plans offering reimbursement to health care providers for service provided through telehealth technologies (Figure 19). Coverage typically is limited to certain delivery types and requires special coding (Figure 20). A majority of health insurers indicate very limited coverage. Florida health care provider and practitioner survey responses (Figures 15 & 16) concur with health insurer responses by citing a lack of reimbursement as a barrier to implementation.

**Figure 18. Percentage of Health Plans That Reimburse for Telehealth**

**Figure 19. Percentage of Health Plans That Reimburse for Telehealth by Coverage Type**

**Figure 20. Percentage of Health Plans Reporting Required Conditions for Reimbursement**
Private and Commercial Insurance Coverage and Reimbursement

As of December 2016, 29 states, including the District of Columbia, have active parity laws which require private payer coverage and payment for telehealth services to be equitable with coverage and reimbursements for face-to-face health services. Additional states have passed similar parity laws that will become effective in 2017. Of this latter group, Massachusetts is the only state that has regulations exclusively requiring private insurance companies to reimburse for services provided through telehealth. The definition of telehealth in each of these states varies, and some state definitions may include limitations on the telehealth modalities encompassed in required coverage and payment models. (Figure 21)

Figure 21. States with Specific Telehealth Coverage and Reimbursement Regulations

MEDICAID AND PRIVATE PAYER COVERAGE AND REIMBURSEMENT POLICIES

Note: Not all private payer laws require coverage of telehealth.
Sources: American Telemedicine Association; Center for Connected Health Policy; NCSL
Notable differences in the state regulations include whether telehealth services must be reimbursed at the same rate as in-person services; or whether the state only requires that the same services be covered but allow for variable rates of reimbursement. Florida does not currently have any statutory requirements related to private payer parity for telehealth services. Some private payers in the state have voluntarily opted to provide coverage and reimbursement for telehealth services (Figure 22).

**Figure 22**: Percentage of Health Plans Providing Coverage and Reimbursement for Telehealth

<table>
<thead>
<tr>
<th>Health Plan Type</th>
<th>Percentage of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA Exchange plans</td>
<td>60%</td>
</tr>
<tr>
<td>MEDICAID MANAGED CARE (IN FLORIDA)</td>
<td>67%</td>
</tr>
<tr>
<td>MEDICARE ADVANTAGE PLANS</td>
<td>46%</td>
</tr>
<tr>
<td>ACA non-Exchange plans</td>
<td>60%</td>
</tr>
<tr>
<td>LARGE GROUP PLANS</td>
<td>70%</td>
</tr>
<tr>
<td>SMALL GROUP PLANS</td>
<td>73%</td>
</tr>
<tr>
<td><strong>Legend</strong></td>
<td></td>
</tr>
<tr>
<td>Greater</td>
<td>10%</td>
</tr>
<tr>
<td>Same</td>
<td>20%</td>
</tr>
<tr>
<td>Less Than</td>
<td>30%</td>
</tr>
<tr>
<td>Unknown</td>
<td>46%</td>
</tr>
</tbody>
</table>

**Medicare and Medicaid Coverage and Reimbursement**

Medicare offers coverage for specific telehealth services delivered at designated sites covered under Medicare. The U.S. Centers for Medicare and Medicaid Services (CMS) requires both a distant site and a separate originating site (hub and spoke model) within its definition of allowable telehealth services. Asynchronous (store and forward) activities are only reimbursed by Medicare in federal demonstration projects in Hawaii and Alaska. To qualify for Medicare reimbursement, the originating site must be located in a federally defined rural county, designated rural, or identified as a participant in a federal telemedicine demonstration project as of December 21, 2000. Additionally, the originating site is limited to specific designated locations including a practitioner’s office, a Critical Access Hospital (CAH) or other hospital, a federally certified Rural Health Clinic (RHC); a Federally Qualified Health Center (FQHC), renal dialysis centers associated with a hospital or CAH, skilled nursing facility, or community mental health center.

In addition to the 28 states that require parity coverage for telehealth services, there are currently 18 states that provide Medicaid coverage and reimbursement for telehealth services. At least 17 states have some reimbursement for remote patient monitoring; and nine states reimburse for store and forward services under their Medicaid program. Within each of these reimbursement models, there are variances in the types of services, specialties, providers, and locations that are covered.
The Florida Medicaid fee-for-service rules were updated in June, 2016 to expand telehealth payments to a broader array of practitioners. Similar to Medicare, Medicaid coverage in Florida is limited to live video conferencing, and pays the practitioner that provides the diagnosis only. With the vast majority of Florida Medicaid beneficiaries enrolled in managed care, Florida’s Medicaid Managed Care plans are authorized to cover telehealth services with greater flexibility; however, there is no mandate for coverage. Based on survey responses by Florida health plans, coverage for telehealth is greatest for Medicaid Managed Care and Affordable Care Act Exchange Plans (Figure 22). Florida health care providers indicate very little reimbursement for telehealth services no matter the plan type (Figure 23).
Barriers to Telehealth

Although telehealth adoption and expansion are on the rise, stakeholders consistently acknowledge there are challenges. The primary issues related to telehealth often cited are financial, interoperability, and licensure. Florida providers and practitioners noted financial issues and lack of interoperability as top barriers and challenges for implementing and continuing to offer telehealth services. (Figures 15 & 17) Health plans indicate regulations and liability concerns as barrier to providing coverage and reimbursement. (Figure 24)

Financial

Florida facility and practitioner licensees who responded to the survey indicated the top three barriers to implementing telehealth involve finances: inadequate reimbursement from payers, insufficient funding capital, and the inability to determine return on investment. These were also ongoing challenges for facilities in maintaining their programs. The same top three barriers were identified by organizations that had tried to implement telehealth in the past, but had discontinued their telehealth programs prior to responding to the survey. (Figures 15, 16, 17) Although not the most frequently reported concern from payers, costs were identified among the top three on-going challenges related to reimbursement for telehealth services.
Figure 25. On-Going Challenges for Facilities Offering Telehealth

On a scale of 1-5, with one (1) being no challenge and five (5) being a major challenge, how would you rate the on-going challenges this facility encounters in offering telehealth services?

Legend:
- Black: 5
- Blue: 4
- Light Blue: 3
- Yellow: 2
- Orange: 1

Lack of health insurance reimbursement for telehealth services provided: 3.2
Lack of funding: 2.7
Unable to determine return on investment: 2.6
Inability to electronically exchange patient medical records/information: 2.4
Inability to secure support from physicians in using the technology: 2.2
Lack of community/patient acceptance of telehealth services: 2.0
Concerns related to privacy and security: 2.0
Inability to develop partnerships with providing sites: 1.9
Inability to connect at needed internet bandwidth speeds: 1.9
Inability to develop partnerships with originating sites: 1.9
Limitation related to on-line prescribing: 1.9
Restrictions related to health practitioners licensure: 1.9
Inability to obtain practitioner credentialing/privileging at partnering facilities: 1.8
Inability to get Medical Malpractice and Professional Liability Insurance: 1.7
Lack of facility executive support: 1.6
Interoperability

Florida facility and practitioner licensees offering telehealth point to the lack of interoperability between providers as a significant barrier to implementing telehealth. (Figures 15, 16, and 17).

Survey respondents for Florida facilities point to the lack of interoperability between providers as a significant barrier to implementing telehealth. A bipartisan focus group brought together by Health Affairs and the Bipartisan Policy Center also identified the lack of interoperability between electronic health record systems and medical devices as a barrier to telehealth expansion. They noted that the lack of interoperability is both a technical and human issue. In some instances, the technical capability in place limits sharing of data; however, in some cases technology vendors, individual practitioners, or health facilities express an unwillingness to share information with other health care providers.  

In addition to interoperability between health care provider data systems, there is also a lack of interoperability between telehealth technology and electronic health record (EHR) platforms. Recently, Cerner (EHR vendor) and American Well began a partnership to merge their capabilities. Allscripts (EHR vendor) began working with the University of South Florida Health (USF Health) on a telehealth - EHR integration project in 2012. USF Health partnered with The Villages Health system to provide telehealth services to the United States’ largest over-55 community.

Regulation and Liability

44% of health plans surveyed noted government regulations and liability as barriers for covering telehealth services. The issue of interstate practice and reimbursement is among the legal issues health plans must consider. Licensure of health care practitioner is the responsibility of each state. Practitioners must be licensed in the state where the patient resides. Health plans must ensure they are reimbursing health providers that are appropriately licensed in the jurisdiction where they are treating patients.

Knowledge

All facilities who completed the survey were provided an opportunity to express their opinion on “what would assist [them] in implementing, sustaining, or expanding telehealth services”. The responses varied greatly, however, there was a noted interest in additional information about telehealth in general and specific research data. The types of services and activities that fall under the auspice of telehealth were also an area of interest. Other respondents added the need for resources to assist them in determining using if telehealth would be appropriate for their facility.
References

16 Whitman, John, MBA, NHA; Donny Tuchman, NHA. “Reducing Avoidable SNF to Hospital Admissions and Readmissions by Implement a Virtual Physician Service, Enabled through Technology” The TRECS Institute Presentation. July 2016.
35 Whitman, John, MBA, NHA; Tuchman, Donny NHA. “Reducing Avoidable SNF to Hospital Admissions and Readmissions by Implement a Virtual Physician Service, Enabled through Technology” The TREC Institute Presentation. July 2016.
39 § 42USC Section 1395(m)(m)(4)(C)(i). Print.
41 § 59G-1.057, Florida Administrative Code. Print.
# Telehealth Stakeholders Providing Testimony

## Formal Presentations

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<th>First Name</th>
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**Written Testimony**

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<td>Richard Long, PhD, LMFT</td>
<td>Florida and Georgia licensed MFT, Florida Qualified Supervisor &amp; Florida Qualified Supervisor and an AAMFT Approved Supervisor</td>
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<td>Yes</td>
<td>National Council of State Boards of Nursing (NCSBN)</td>
<td>26 enacted (including Florida) 5 pending legislation</td>
<td>The licensure compact was updated and has 26 participating states including Florida with pending legislation on 5 other states. Does not apply to APRNs.</td>
</tr>
<tr>
<td>Advanced Practice Registered Nurses</td>
<td>Yes</td>
<td>National Council of State Boards of Nursing (NCSBN)</td>
<td>3 enacted 2 pending legislation</td>
<td>This compact will come into effect once 10 states have enacted the legislation.</td>
</tr>
<tr>
<td>Psychologists</td>
<td>Yes</td>
<td>Psychology Inter-jurisdictional Compact (PSYPACT)</td>
<td>3 enacted 6 pending legislation</td>
<td>PSYPACT becomes operational when seven states enact PSYPACT.</td>
</tr>
<tr>
<td>Emergency Medical Services (EMT &amp; Paramedic)</td>
<td>Yes</td>
<td>National Registry of Emergency Medical Technicians</td>
<td>11 enacted 8 pending legislation</td>
<td>“REPLICA” licensure Compact enacted May 8, 2017</td>
</tr>
<tr>
<td>Physical Therapists</td>
<td>Yes</td>
<td>The Federation of State Boards of Physical Therapy</td>
<td>14 enacted 4 pending legislation</td>
<td>Compact enacted April 25, 2017</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>No, but e-transfer</td>
<td>National Association of the Boards of Pharmacy</td>
<td>N/A</td>
<td>The NABP offers an Electronic Licensure Transfer Program for qualifying pharmacists.</td>
</tr>
<tr>
<td>Dentists</td>
<td>No</td>
<td>American Association of Dental Boards</td>
<td>N/A</td>
<td>Investigating the merits of establishing an Interstate Dental Licensure Compact</td>
</tr>
<tr>
<td>Speech-Language Pathologist and Audiologists</td>
<td>No</td>
<td>State Governments – National Center for Interstate Compacts (CSG)</td>
<td>N/A</td>
<td>American Speech-Language-Hearing Association (ASHA), National Council of State Boards (NCSB), and stakeholders—are establishing an Advisory Committee to discuss the development of a compact.</td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>No</td>
<td>The American Occupational Therapy Association, Inc.</td>
<td>N/A</td>
<td>Investigating the merits of establishing professional license portability for the occupational therapy profession possibly through the creation of a licensure compact.</td>
</tr>
<tr>
<td>Respiratory Therapists</td>
<td>No</td>
<td>American Association for Respiratory Care</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Mental Health Counselors/Social Workers</td>
<td>No</td>
<td>Association of Social Work Boards</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
Reference Materials:

- Correspondence from Council Members in response to Additional Materials from October 3 Council meeting
- Correspondence from Senior Assistant Attorney General at the request of Agency staff
Bill Manzie, MBA
Administrative Director of Telehealth Strategy
T: 954-276-1425
E: wmanzie@mhs.net
www.MHS.net/MemorialDOCNow

From: King, Pamela [mailto:Pamela.King@ahca.myflorida.com]
Sent: Wednesday, October 04, 2017 3:18 PM
To: Amanda-Dr. Terkonda <Spivey.Amanda@mayo.edu>; Manzie, William <wmanzie@mhs.net>; Clary, Shannon <Shannon.Clary@ahca.myflorida.com>; Darren Hay <darren@careangel.com>; Dr. Bertha <EBertha@centene.com>; Dr. Burdick <ABurdick@med.miami.edu>; Dr. Landry <kim.landry@lifeguardambulance.com>; Dr. Philip <Celeste.Philip@flhealth.gov>; Dr. Selznick <Selznick531@gmail.com>; Dr. Terkonda <terkonda.sarvam@mayo.edu>; Leslee Gross <LesleeG@baptisthealth.net>; Liz Miller <elizabeth.miller@wellcare.com>; Matthew Stanton <stantom3@ccf.org>; Mike Smith <mike.smith@med.fsu.edu>; Monica Stynchula <monica@reunioncare.com>; Helvey, Nikole <Nikole.Helvey@ahca.myflorida.com>; Sarah-Dr. Philip <Sarah.hofmeister@flhealth.gov>; Senior, Justin <Justin.Senior@ahca.myflorida.com>
Subject: Oct 3 meeting follow up

***********************************************************************
THIS EMAIL ORIGINATED FROM OUTSIDE OF MHS. PLEASE EXERCISE CAUTION WITH ATTACHMENTS, LINKS, OR REQUESTED ACTIONS.
***********************************************************************

Hello Council Members

Great meeting yesterday! I have three items of business for your information and/or action:

1. I am attaching two (2) letters and an email for your perusal. They were sent as testimony to the Council during the meeting yesterday. They will also be posted on the Telehealth website as additional information from the October 3 meeting. I know this isn’t a question, but what I heard loud and clear is that the clinical providers would like to see payment parity. Thank you for sharing the additional letters.

2. If you have not already done so, please take one moment and look at how your name is presented on the report to make sure it is as you and your organization want it to be.

William Manzie, MBA
Memorial Healthcare System

3. Reminder the Oct. 17 meeting is scheduled from 9 – 12 in Tallahassee at the Betty Easley Conference Center – More information is forth coming. Please let me know if you will need to attend virtually.
King, Pamela

From: Steven Selznick <selznick531@gmail.com>
Sent: Wednesday, October 4, 2017 9:50 PM
To: King, Pamela
Cc: Amanda-Dr. Terkonda; Bill Manzie; Clary, Shannon; Darren Hay; Dr. Bertha; Dr. Burdick; Dr. Landry; Dr. Philip; Dr. Terkonda; Leslee Gross; Liz Miller; Matthew Stanton; Mike Smith; Monica Stynchula; Helvey, Nikole; Sarah-Dr. Philip; Senior, Justin
Subject: Re: Oct 3 meeting follow up

Follow Up Flag: Flag for follow up
Flag Status: Completed

See below

Steven Selznick

Sent from my iPhone

On Oct 4, 2017, at 3:17 PM, King, Pamela <Pamela.King@ahca.myflorida.com> wrote:

Hello Council Members

Great meeting yesterday! I have three items of business for your information and/or action:

1. I am attaching two (2) letters and an email for your perusal. They were sent as testimony to the Council during the meeting yesterday. They will also be posted on the Telehealth website as additional information from the October 3 meeting.

I believe in payment parity.
I like Anna’s comments from Impower

2. If you have not already done so, please take one moment and look at how your name is presented on the report to make sure it is as you and your organization want it to be.

Correct

3. Reminder the Oct. 17 meeting is scheduled from 9 – 12 in Tallahassee at the Betty Easley Conference Center – More information is forth coming. Please let me know if you will need to attend virtually.

Virtually

Thanks all! Be Well!

Pam

Pamela King, Health IT Outreach Coordinator
King, Pamela

From: Kim Landry <kim.landry@lifeguardambulance.com>
Sent: Tuesday, October 10, 2017 9:38 AM
To: King, Pamela; Amanda-Dr. Terkonda; Bill Manzie; Clary, Shannon; Darren Hay; Dr. Bertha; Dr. Burdick; Dr. Philip; Dr. Selznicke; Dr. Terkonda; Leslee Gross; Liz Miller; Matthew Stanton; Mike Smith; Monica Stynchula; Helvey, Nikole; Sarah-Dr. Philip; Senior, Justin
Subject: RE: Oct 3 meeting follow up

Follow Up Flag: Follow up
Flag Status: Flagged

Sorry I’m a little late getting these comments to you.

From: King, Pamela [mailto:Pamela.King@ahca.myflorida.com]
Sent: Wednesday, October 4, 2017 2:18 PM
To: Amanda-Dr. Terkonda <Spivey.Amanda@mayo.edu>; Bill Manzie <Wmanzie@mhs.net>; Clary, Shannon <Shannon.Clary@ahca.myflorida.com>; Darren Hay <darren@careangel.com>; Dr. Bertha <EBertha@centene.com>; Dr. Burdick <ABurdick@med.miami.edu>; Kim Landry <kim.landry@lifeguardambulance.com>; Dr. Philip <Celeste.Philip@flhealth.gov>; Dr. Selznicke <Selznicke531@gmail.com>; Dr. Terkonda <terkonda.sarvam@mayo.edu>; Leslee Gross <LesleeG@baptisthealth.net>; Liz Miller <elizabeth.miller@wellcare.com>; Matthew Stanton <stantom3@ccf.org>; Mike Smith <mike.smith@med.fsu.edu>; Monica Stynchula <monica@reunioncare.com>; Helvey, Nikole <Nikole.Helvey@ahca.myflorida.com>; Sarah-Dr. Philip <Sarah.hofmeister@flhealth.gov>; Senior, Justin <Justin.Senior@ahca.myflorida.com>
Subject: Oct 3 meeting follow up

CAUTION: This email originated from outside of the organization. DO NOT click links or open attachments unless you recognize the sender and know the content is safe. NEVER provide your User ID or password.

Hello Council Members

Great meeting yesterday! I have three items of business for your information and/or action:

1. I am attaching two (2) letters and an email for your perusal. They were sent as testimony to the Council during the meeting yesterday. They will also be posted on the Telehealth website as additional information from the October 3 meeting.
   Payment parity is very important to practitioners who will provide care or services via telehealth. It will be difficult to recruit or expect a practitioner to offer services via telehealth if the reimbursement will be less than providing the same service in person. The risk to the practitioner is the same, the skill and thought process involved in the evaluation, acquisition and interpretation of data, treatment, Rx, follow up plans, etc. are all the same (providing the same standard of care). Whether a service is provided in person or via telehealth, the malpractice insurance cost to the practitioner is the same.

2. If you have not already done so, please take one moment and look at how your name is presented on the report to make sure it is as you and your organization want it to be.

Could you also include, (in addition to Leon County EMS), Lifeguard Ambulance Service.

3. Reminder the Oct. 17 meeting is scheduled from 9 – 12 in Tallahassee at the Betty Easley Conference Center – More information is forth coming. Please let me know if you will need to attend virtually.
From: Ed Tellechea <Ed.Tellechea@myfloridalegal.com>
Sent: Thursday, October 5, 2017 10:54 AM
To: King, Pamela
Subject: RE: Telehealth Draft Report

Follow Up Flag: Follow up
Flag Status: Flagged

My thoughts:

Standard of care is a big issue. It's important to make sure that telehealth is not promoted at the expense of the standard of care and patient safety. Many of the telehealth bills contain that very sacrifice. The following is an example. It's from SB 280 and the quoted language has appeared in previous telehealth bills from the last 2 legislative sessions.

(2) PRACTICE STANDARDS.— (a) The standard of care for a telehealth provider providing medical care to a patient is the same as the standard of care generally accepted for a health care professional providing in-person health care services to a patient. A telehealth provider may use telehealth to perform a patient evaluation. If a telehealth provider conducts a patient evaluation sufficient to diagnose and treat the patient, the telehealth provider is not required to research the patient's medical history or conduct a physical examination of the patient before using telehealth to provide services to the patient.

It's starts off fine by defending the standard of care but it is then immediately followed by a huge exception that basically negates its initial defense of the standard of care. If the standard of care requires an examination of the patient's medical history and a physical examination then it should be regardless of whether patient care is provided via telehealth or in person. Such language I believe comes from the mistaken belief that a physical examination cannot be done via telehealth technology. "Physical examination" does not always equate with the "laying of hands" on the patient. It can be done through the use of appropriate technology and through other means.

The legislature and state agencies should resist the urge to interject themselves into the development of the standard of care for telehealth. It should be left alone and allowed to develop naturally and organically like in all other areas of practice.

Licensure is also an important issue. Florida needs to make sure that its citizen's are protected through the licensure process. I agree that if you are treating patients physically located in Florida, Florida must have the necessary jurisdiction over those healthcare providers that are providing the service regardless of where they are located. Such must be done through some type of licensure process. We cannot rely on the jurisdiction where the physician is located to protect Florida's patients. In this day and age of budgetary limitations, I can assure you that each state will prioritize the protection of its residents and will make the protection of out of state patients a very low priority.

Legislation must also address the difficulties of enforcement actions against healthcare providers in other jurisdictions. For example, how will Florida enforcement agencies be able to subpoena medical records and other evidence located in other jurisdictions? There will be a myriad of jurisdiction issue raised. Travel cost will also be an issue. DOH prosecutors prosecuting out of state providers and enforcement actions will be more complicated and expensive. This will be a tough nut to crack.

Overall, I like the report. You folks did a good job. However, the real tough work lays ahead at the legislature.

Edward A. Tellechea
Chief Assistant Attorney General
Administrative Law Bureau
Office of the Attorney General
PL-01, The Capitol