## Agenda
### September 19, 2017
9:00am – 4:00pm

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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)
Tab 1 – Report with Attachments

- Draft Telehealth Advisory Council Report
- Attachment 1 – Florida Telehealth Unitization and Accessibility Report
- Attachment 2 – Telehealth Stakeholder Providing Testimony to the Council
- Attachment 3 – Chart of Healthcare Professions with National Licensure Compacts
Draft Telehealth Advisory Council
Report of Recommendations

Executive Summary
To be completed after main body has been drafted

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 provider 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 professionals, 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; and as informed by formal presentations from approximately 30 individual providers, 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 professionals 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. The Florida Department of Health has projected a need for 3,060 additional primary care physicians in the state by 2025.

The existing and emerging deficiencies in the physician and health care workforce is a driver of innovation as the industry explores new strategies to extend the reach of existing healthcare professionals. 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 healthcare 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 healthcare practitioners 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. While these technologies offer promising solutions, the adoption and expansion of telehealth also presents specific challenges to facilities, professionals, payers, and others. This report is intended to address the specific challenges that were identified in the Florida Report on Telehealth Utilization and Accessibility 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 distant 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. There are as many definitions of telehealth or telemedicine as there are use cases and applications.

The American Telemedicine Association uses the terms telemedicine and telehealth interchangeably. Others use 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. Healthcare 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”. These definitions for telemedicine do include the broader language associated with the term “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 modalities
3. Practitioners treating Florida patients must be appropriately licensed in Florida or appropriately supervised by a licensed Florida healthcare practitioner as prescribed by law or rule
4. Healthcare practitioners must treat within the scope of their practice
5. Telehealth can be healthcare practitioner to healthcare practitioner or healthcare practitioner to patient
6. There must be no limitations on geographic or site locations

The Council offers the following language as a clear definition of telehealth 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 healthcare practitioner, within the scope of their practice, who is located at a site other than the site where a recipient (patient or licensed healthcare practitioner) is located.*
Health Insurance and Telehealth

A large proportion of Florida healthcare stakeholders identify issues surrounding coverage and reimbursement as primary policy concerns influencing the delivery and growth of telehealth services. Healthcare 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). Confirming these reports from healthcare practitioners, a majority of Florida’s licensed health insurers indicated in their response to the state’s Telehealth Utilization and Accessibility survey they offer only limited coverage, if any, for telehealth services. Among Florida insurers that do cover telehealth, coverage is typically limited to specific circumstances and methodologies or require special coding.

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 parity laws to address gaps in coverage for telehealth services. According to a report published in August from the Center for Connected Health Policy, only three of the states with telehealth parity laws explicitly mandate reimbursement parity. Coverage and reimbursement parity laws apply varyingly to private and public payer plans in each state where they exist. 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. The Council recognizes telehealth reimbursement parity as a requirement of health plans to pay healthcare 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 greater 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.

The national paradigm shift among private and public payers toward quality and performance-based payment models serves as another 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 thoughtful integration of telehealth modalities into healthcare practitioner workflows can strongly support practitioners in meeting these goals.

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

A number of healthcare 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 healthcare 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 healthcare 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 the following:

1. Florida’s legislature require Florida-licensed health insurance plans (excluding Medicare) 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 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.

**Telehealth Insurance Reimbursement**

Telehealth reimbursement parity is recognized by the Council as a requirement of health plans to pay healthcare 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 healthcare practitioners, healthcare 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. A majority of practitioners, for example, contend that 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 payment 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 payment parity stifles individual providers’ 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 healthcare 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-State 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 thoughtful 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):
The Council recommends that the Florida legislature require Florida licensed health insurance plans (excluding Medicare plans) to offer reimbursement for covered health care services provided via telehealth. 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.

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 healthcare practitioner 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 that the State of Florida support modifications to Medicare telehealth laws that would expand coverage to include remote patient monitoring as well as store and forward modalities; expand of the types of healthcare 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 healthcare practitioners. Similar to Medicare, Medicaid coverage in Florida is currently 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, 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{xvi}

Recommendation(s):
The Council members and multiple stakeholders have praised 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. The Council recommends the Agency
consider modifications to the Medicaid telehealth fee-for-service rule to include coverage of
store and forward and remote patient monitoring modalities in addition to live video
conferencing. The Council also recommends the Agency work with the Medicaid Managed Care
plans to promote the expansion of telehealth utilization statewide.

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.
The NAIC has developed a Model Network Adequacy Act for use by states in developing
laws around this issue. The Act includes provisions allowing healthcare practitioners who offer
services via telehealth to be included in the plan network for purposes of network adequacy.\textsuperscript{xvii}
Colorado was the first state to allow insurers to count available telehealth services in meeting
network adequacy requirements for certain specialties.\textsuperscript{xviii}

Recommendations(s):
The Council supports the NAIC provisions related to telehealth as a means to ensure network
adequacy among health plans and HMOs.

Health Practitioner Licensure and Telehealth
The ability for technology to bring health care to the patient irrespective of location expands
the market reach of healthcare practitioners in Florida. Health care professionals residing in
Florida are able to treat patients in other states, even globally where authorized. This expansion
of health care access conversely allows Florida patients to receive care from licensed healthcare
practitioners anywhere in the world. Assurances for patient protections and provider
accountability are imperative in these arrangements. In order to ensure adequate protections
and enforcement, Florida’s providers, stakeholders, and payers provided strong testimony to
the Council encouraging a requirement that all health care professionals providing care to
Florida residents using telehealth be licensed in Florida, regardless of where the provider is
physically located.

Interstate Licensure

To ensure patient protection and healthcare 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 healthcare 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 2016\textsuperscript{ix}. 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. Provider participation in a compact is voluntary, and the 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) \textit{Interstate Medical
Licensure Compact} creates an expedited process for eligible physicians to apply for licensure in
compact states.\textsuperscript{xx} The \textit{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.\textsuperscript{xxi} 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 highest possible standard of care for Florida patients while allowing
health professionals to expand their patient reach, the Council recommends the following:

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

2. Participate in health care practitioner licensure compacts that ensure 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 professionals 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 professionals regarding their ability to employ telehealth within their practices. The Department recognizes telehealth as a modality for providing health services as opposed to a separate service, meaning the state’s established standards of care developed by each regulatory health care board are applicable whether care is provided in person or using telehealth.

A number of stakeholders, primarily ancillary health care professionals (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 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 healthcare regulatory board has direct authority for establishing appropriate standards based on knowledge and insight for their respective practitioners.

To ensure clarity for Florida licensed healthcare 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 continue to educate and raise awareness among licensees about their ability to utilize telehealth modalities as a means treat patients when appropriate.

2. The Florida legislature provide health care regulatory boards and councils specific statutory authority to develop standards of care rules for telehealth, if the boards deem it necessary and appropriate.

Patient/Consumer Protection

Health care practitioners’ responsibilities to patients are the same no matter which modality of care is used; and likewise patients should have confidence in the standard of care they receive, whether delivered in-person or through telehealth. 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 healthcare services. There is no known evidence suggesting a higher risk of abuse or fraud involving telehealth over any other mechanism of care. A provider who bills for a disproportionate amount or frequency of services would warrant an audit of
their treatment and billing practices, whether providing healthcare services via telehealth or a more traditional modality of care.

**Patient-Provider Relationships & Continuity of Care**

While there is a significant and growing body of evidence supporting the use of telehealth to expand and improve the provision of health care services, the use of telehealth does not automatically diminish issues related to patient care, including coordination of care among multiple providers. Ideally, when a patient receives care, information from the episode is integrated into coordinated Electronic Health Records (EHRs) or similar systems and made available to inform other treatments and services. There is some concern among providers and payers, under increasing financial risk for patient care outcomes, regarding the high potential for care fragmentation or service duplication that can result when patients seek or receive care outside of established provider networks. 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 - thus creating health care information silos. Although the Council recognizes the ability for healthcare providers and patients to establish a relationship through telehealth, they also note the importance of ensuring that patient care is coordinated among treating providers.

**Recommendation(s):**
The Council supports initiation of healthcare practitioner-patient relationships through telehealth technology; and discourages the adoption of policies that would require patients to see a practitioner in-person before receiving care through telehealth.

**Patient Consent**

Prior to providing healthcare 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 providers’ 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 provider 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 mechanism.

**Recommendation(s):**
The Council recommends maintenance of the current consent laws in Florida. The Council notes that additional consent requirements may add unnecessary barriers for both providers 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](https://www.fllegislature.gov/legislative/2019 sesión-2/documents/title766-2019.pdf)
Protection Act (Ryan Haight Act) is a federal law that provides guidelines for the prescribing of controlled substances through the internet. The Ryan Haight Act affirmatively recognizes telehealth as a viable means of creating a treating relationship 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 opioids without an in-person visit – with the limited exceptions of treating of psychiatric disorders, 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. Although other health practitioners who prescribe do not have specific standard of care provisions, the Ryan Haight Act and scope of practice laws do provide boundaries for prescribing controlled substances when delivering care.

Recommendation(s)

The Council supports the establishment of provider-patient relationships through telehealth and recommends rejecting any provision that would require an in-person examination prior to treating and prescribing medication via telehealth. Limited exceptions should be made for controlled substances as currently outlined in the Boards of Medicine and Osteopathic Medicine rules.

Technology

The technology used to provide telehealth services is well established; it has existed for more than 40 years. Rapidly evolving technological innovation in the current market is making telehealth an increasingly accessible tool for both providers and patients. Healthcare practitioners have noted, however, some overarching technological barriers to effective telehealth implementations. Primary examples include limited access to technology and system networks (internet connectivity) in isolated communities, equipment costs, and challenges related to interoperability with other health care technologies and documentation systems. Noting continually increasing technological capability and decreasing costs, the Council has noted technology as a diminishing barrier in implementing telehealth programs.

Technology and Patient Access

Recognizing that some populations may have lower access to computers in a way that would enable them to be used for telehealth, Council members noted that many health services can be provided virtually through less expensive mobile devices such as smartphones. A vast majority of the United States population now have a cellphone of some kind, 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. xxvi 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. xxvii This growing independence from in-home broadband services, however, does not diminish the need for a strong broadband network in order for telehealth services to expand. 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. xxviii 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 Healthcare Facilities/Practitioners
Florida health care providers specifically identified the cost of equipment needed to treat patients using telehealth as a barrier. xxix The growing telehealth market and innovative technological landscape, however, indicate ongoing price point reductions. Additionally, research and stakeholder input suggests that telehealth technology is available at varying price points. xxx The Council is supportive of payment parity for telehealth services as a strategy to address initial technical cost concerns among providers, offering a clearer path toward Return On Investment (ROI). There are also federal grant funding programs available to support implementation of telehealth programs. Information about the availability of funding and resources to assist providers is available through the nation’s federally funded Regional Telehealth Resource Centers. The Southeastern Telehealth Resource Center provides resources and guidance to providers in Florida for implementing and expanding telehealth services at varying price points. xxxi

Health care facilities and practitioners also identify interoperability gaps between health technology vendors as a challenge at the national and state level. Florida health care facilities have indicated through survey responses that a lack of interoperability between providers is a barrier to development and implementation of telehealth programs. 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. In addition to the challenges related to interoperability between health care provider data systems, there is also a lack of interoperability between telehealth technology and electronic health record (EHR) platforms. Insufficient interoperability among information systems has the potential to increase communication gaps and hinder the continuity of patient care. 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 (ie. health care professionals) who securely share clinical information over the Internet across the United States, using a standardized approach. Exchanges leverage a common set of technical and data standards, legal agreements, and governance. Participants are able to securely share health information with each other, without additional customization and separate legal agreements. Carequality is advancing EHR interoperability by brokering agreements among health IT vendors to implement a framework for point-to-point health information exchange. In Florida, the Agency for Health Care Administration (Agency) provides governance for the statewide Heath Information Exchange (HIE) program, which promotes interoperability and offers services that allow sharing of patient information between healthcare providers when needed.

Recommendation(s):

The Council notes that technology-related barriers for providers will continue to decrease as technological advances and market forces drive cost reductions. Significant barriers remain, however, related to interoperability of health care information systems. Specific challenges to interoperability include varying administrative policies among states and providers, such as privacy laws – leading to misalignment, confusion, misinterpretation and sometimes over-restrictive interpretations of those laws.

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 and healthcare 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.

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


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


Florida House Bill 1061. 2016.


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


Florida Report on Telehealth Utilization and Accessibility

December 2016
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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>Practitioner Type</th>
<th># of Completed Surveys/Renewals</th>
<th># Eligible to Renew</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant Pharmacist</td>
<td>1,470</td>
<td>3,027</td>
<td>49%</td>
</tr>
<tr>
<td>Optician</td>
<td>1,061</td>
<td>3,893</td>
<td>46%</td>
</tr>
<tr>
<td>Registered Pharmacy Technician</td>
<td>14,727</td>
<td>42,577</td>
<td>35%</td>
</tr>
</tbody>
</table>

(Figure 2. DOH Licensees with a Renewal Date between July 1 & Dec 31, 2016)
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.
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.\(^6\) 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.\(^7\) 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.

<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\textsuperscript{11}, 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.\textsuperscript{12}

\textit{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).

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**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</td>
<td>18%</td>
</tr>
<tr>
<td>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/</td>
<td>7%</td>
</tr>
<tr>
<td>Medication Compliance</td>
<td></td>
</tr>
<tr>
<td>Emergency Trauma Care</td>
<td>1%</td>
</tr>
</tbody>
</table>
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 2030.19 As of July 2015, Florida’s seniors made up 19.4% of Florida’s population.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 2025.21 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 2018.22 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).

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).

Figure 12. Sources of Funding for Telehealth Equipment Among Facilities Offering Telehealth Services

Figure 13. Sources of Funding for Telehealth Equipment Among Health Care Professionals Offering Telehealth Services
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: 3.1
- Lack of funding: 2.7
- Unable to determine return on investment: 2.7
- Inability to electronically exchange patient medical records/information: 2.4
- 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: 3.7
- Lack of funding: 3.5
- Unable to determine return on investment: 3.1
- Inability to secure support from physicians in using the technology: 3.0
- Inability to develop partnerships with presenting sites: 3.0
- Inability to develop partnerships with originating sites: 2.9
- Inability to electronically exchange patient medical records/information: 2.9
- Lack of community/patient acceptance of telehealth services: 2.8
- Limitation related to on-line prescribing: 2.5
- Restrictions related to health practitioner licensure: 2.4
- Concerns related to privacy and security: 2.4
- Inability to obtain practitioner credentialing/privileging at partnering facilities: 2.4
- Inability to connect at needed internet bandwidth speeds: 2.2
- Inability to get Medical Malpractice and Professional Liability Insurance: 2.2
- Lack of facility executive support: 2.1
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.\textsuperscript{31} 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.\textsuperscript{32}
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.\(^{33}\)

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.\(^{34}\)

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.\(^{35}\)

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.\(^{36}\)
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**

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<thead>
<tr>
<th>Coverage Type</th>
<th>Percent Reimbursed</th>
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<tr>
<td>Medicare Advantage Plans</td>
<td>61%</td>
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<td>Small Group Plans</td>
<td>43%</td>
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<td>Large Group Plans</td>
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<td>35%</td>
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<tr>
<td>Not on the ACA Exchange</td>
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<td>Medicaid Managed Care (IN FLORIDA)</td>
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**Figure 20. Percentage of Health Plans Reporting Required Conditions for Reimbursement**

- Specific coding requirements: 75%
- Limitations on eligible technologies: 58%
- Limitations on eligible health conditions or services: 42%
- Patient or provider setting requirements/conditions: 42%
- Distance or geographic designations: 33%
- Any other condition which may impact reimbursement for telehealth services that are not applied to claims for in-person health services: 8%
- Prior authorization requirements: 8%
- Frequency or volume of covered encounters: 8%
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

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).

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

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<th>Challenge</th>
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<td>Inability to get Medical Malpractice and Professional Liability Insurance</td>
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<td>Lack of facility executive support</td>
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Legend:
- 5
- 4
- 3
- 2
- 1

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?
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.43

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.44 Allscripts (EHR vendor) began working with the University of South Florida Health (USF Health) on a telehealth - EHR integration project in 2012.45USF Health partnered with The Villages Health system to provide telehealth services to the United States’ largest over-55 community.46

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.47

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.


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 TRECS Institute Presentation. July 2016.


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<tr>
<td>Rena</td>
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<td>Lisa</td>
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**Verbal Testimony**
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Tab 2 – Materials Related to Health Insurance and Telehealth

- NAIC Health Benefit Plan Network Access and Adequacy Model Act
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Foreword

State health policy leaders are faced with the challenge of addressing the diverse health care needs of the populations they serve. As they look for ways to expand patient access to care, especially in rural areas, they turn to the potential of telehealth or telemedicine, the use of technology to deliver health care to patients in a setting different from that of the provider. There would seem to be great potential here—advancements in technology have made these services more reliable and affordable. There is greater access to high-speed broadband and wireless communication as well as more interest in value-based payments for care. While a substantial body of evidence for telehealth exists, its use is not widespread.

State leaders have been looking at ways to expand and clarify telehealth reimbursement policies, especially as they relate to private payers. Since 2010, there has been nearly triple the number of states that have enacted legislation related to telehealth care. These laws range in scope and features. Many contain limiting factors, such as the language used in the law; whether there is payment parity between the service provided via telehealth or in person; the type of telehealth modality used; location of service; and type of provider who can offer the service.

To get a better understanding of these laws and to assess their impact on telehealth utilization, the Center for Connected Health Policy assessed the response by selected commercial payers to telehealth private payer laws. The report was written by Center for Connected Health Policy staff—Mei Wa Kwong, JD, policy advisor and project director; Christine Y. Calouro, MA, program associate; and Laura M. Nasseri, MA, program associate.

The report, which was commissioned by the Reforming States Group (RSG), grew out of the group’s interest in the topic. Supported by the Milbank Memorial Fund since 1992, the RSG is a bipartisan group of state executive and legislative leaders who meet annually to share information, develop professional networks, and commission joint projects.

Telehealth continues to offer great potential to improve the convenience and effectiveness of care. It is our hope that this report will provide evidence and experience to help leaders and decision makers develop policies that promote the appropriate utilization of telehealth modalities and expand access to care for the populations they serve.

Trina A. Gonzalez
Program Officer
Milbank Memorial Fund
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Oklahoma State Department of Health

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Executive Director
Center for Connected Health Policy

Laura Kelly
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Kansas Senate
Introduction

Health systems across the country face increasing pressure to expand access to care, while improving the efficiency and quality of that care in the face of limited resources. Consequently, state policymakers have shown a growing interest and receptivity to the use of telehealth technologies to help meet these demands. Telehealth is defined as the use of electronic technology to provide diagnostic and treatment services, enhanced communication and care coordination, patient monitoring, and education from a distance. This virtual communication can be between two health care providers, or between the health consumer and the provider. Transmittal and response can be in the more widely utilized and known “real time” live video; asynchronous or “store-and-forward” communication, which uses a secure email platform and is not in real-time; or through remote patient monitoring (RPM).

Telehealth care modalities have been in use for decades and have been shown to be as effective in many situations as in-person care, yet they are not as widely used as they might be. While telehealth may not be appropriate for all health care interactions since some situations require physical interaction between patient and provider, a substantial body of literature and evidence demonstrates the benefits of telehealth.

Studies have found that telehealth has been used effectively in a multitude of specialties such as mental health, dermatology, and treatment of chronic diseases. In 2012, Wootton published a literature review of remote control trials for management of five chronic conditions: asthma, chronic obstructive pulmonary disease, diabetes, heart failure, and hypertension. The review included over 1,300 studies. After a thorough analysis, he found a total of 141 remote control trials in which 148 telemedicine interventions had been tested with nearly 37,000 patients. He determined that 108 of the trials were favorable toward the telemedicine intervention, and 38 trials showed no statistical difference between the telemedicine intervention and traditional care. This meta-analysis showed that in 99% of the studies, telemedicine interventions were as good as or better than traditional approaches to care.

The US Department of Veterans Affairs (VA) and the correctional system have been long-time users of technology to provide care without a provider physically present with the patient. A VA report in 2013 showed home telehealth services reduced bed days of care by 59% and hospital admissions by 35%, while clinical video telehealth services reduced bed days of care for mental health patients by 38%. In terms of cost savings, home telehealth (where the patient is home and receives services from a provider in another location) reduced health care costs by roughly $2,000 per person per year, while clinical video telehealth saved roughly $34.45 per consult and store-and-forward telehealth saved roughly $38.81 per consult in travel costs for the patient.

But it is not just government organizations such as the VA and corrections facilities that are benefiting from telehealth. For example, the use of RPM to reduce hospital readmissions, as well as address chronic conditions, as the Wootton study also noted, have led to better results than traditional in-person approaches. The use of store-and-forward for dermatological assessments has been effective and is accepted by both providers and patients.
In recent years, several other factors have played a role in improving the policy and practice environment that make telehealth a more attractive option in health care delivery. These factors include:

- advances in technology that make these services more reliable and less expensive;
- greater access to high-speed broadband and wireless communication;
- increased health coverage for millions of Americans through passage of the Affordable Care Act (ACA), although the availability and distribution of primary and specialty care providers remains skewed; and
- the movement toward value-based payments for care.

This perfect storm of factors has led to an increased interest by state and federal policymakers to consider incorporating telehealth into the growing demands on health systems and payers. Even with the expected rollback of the ACA, states will still find themselves in the challenging position of addressing the growing health needs of their populations, potentially with less federal assistance.

Bipartisan efforts to reform Medicare telehealth-related policies have repeatedly stalled in Congress, yet states have been quite active in expanding telehealth reimbursement policies, particularly as they relate to private payers. In the last few years, one of the most common forms of telehealth-related legislation is private payer laws that require payers to treat telehealth-delivered care the same way as in-person care. Since 2010, 23 states and the District of Columbia have passed some form of a private payer law, yet prior to 2010, only eight states had laws (among the first laws passed were those in California and Oklahoma in 1997). Across states, the laws range in scope and features, adding complexity to a telehealth policy environment in which no two states are alike.

Although private payer telehealth laws are gaining momentum, there has not been a comprehensive analysis of these laws and the impact they have on expanding the use of and payment for telehealth-delivered services.

To further understand and assess the impact of telehealth private payer laws on utilization, the Center for Connected Health Policy (CCHP) conducted a five-month study (September 2016 to January 2017) that sought to accomplish the following:

- Assess and describe the response by selected commercial payers to telehealth private payer laws.
- Describe the effects of telehealth private payer laws on utilization.
- Assess any influence these laws had on state Medicaid telehealth policies.
- Provide suggestions to improve private payer laws and their impact.

In addition to addressing these issues, this report flags potential issues policymakers may wish to address to expand greater utilization of telehealth modalities. While private payer laws vary in using the term “telemedicine” or “telehealth,” this report will use the term “telehealth” as representative of both terms. Additionally, while many people, including those in the media, may call these laws “telehealth private payer parity laws,” this paper will use the term “telehealth private payer laws.”
Private Payer Laws Analysis

As of September 2016, 31 states and the District of Columbia have passed telehealth private payer laws.\(^7\) (For a list of states, see Appendix B, Table 1.) While these laws share some common features, no two state laws are exactly alike. Additionally, implementation of these laws varies from state to state. Some telehealth private payer laws may contain factors that limit the scope of telehealth reimbursement or use in delivering services, similar to what is seen in Medicare policy—and this may have been the intent of policymakers when crafting the language. Investigating the specific reasons behind the decision to include these factors was beyond the scope of the project. However, it is possible to analyze the comprehensiveness of the enacted telehealth private payer laws by examining the law in each state and its impact on the commercial plans. (Additionally, some of the enacted laws are possibly second or third attempts to get legislation passed. A summary of the failed telehealth private payer laws over the last few years can be found in Appendix A.)

Critically important in this study was the analysis of the actual language and structure of each telehealth private payer law. We found that how the law was written can determine the expansiveness of reimbursement and can predict telehealth utilization. Opinions vary among health care systems, providers, and commercial insurers about what is considered “progressive” telehealth private payer law language. That said, there are specific factors contained in some telehealth private payer laws that recognize telehealth-delivered care to be on a par with services provided in person and attempt to treat them comparably. However, the appearance of these characteristics may come with limitations or caveats that separate and slow the utilization of telehealth. One example is limiting the definition of telehealth to only one modality, when there are three modalities available: live video, store-and-forward, and remote patient monitoring.

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<td>- Did the legislation contain a mandate?</td>
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<td>- Did the legislation require parity in payment?</td>
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<tr>
<td>Modalities</td>
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<tr>
<td>- Did the legislation allow for live video reimbursement?</td>
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<tr>
<td>- Did the legislation allow for store-and-forward reimbursement?</td>
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<td>- Did the legislation allow for remote patient monitoring reimbursement?</td>
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<tr>
<td>Location</td>
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<td>- Did the legislation refrain from placing a geographic limitation?</td>
</tr>
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<td>- Did the legislation refrain from limiting originating sites?</td>
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<td>Providers</td>
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<td>- Did the legislation refrain from limiting providers?</td>
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<td>- Did the legislation refrain from limiting specialties?</td>
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<tr>
<td>- Did the legislation refrain from requiring a telehealth-specific informed consent?</td>
</tr>
<tr>
<td>- Did the legislation refrain from requiring a health care provider to be present at the originating site?</td>
</tr>
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<td>Other</td>
</tr>
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<td>- Did the legislation exclude a requirement that makes a mandate “subject to terms and conditions”?</td>
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<td>- Did the private payer law include Medicaid?</td>
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To understand these differences among states with telehealth private payer laws, CCHP analyzed the existing laws. This examination provided an initial baseline for each state on its telehealth private payer reimbursement policy according to key characteristics. However, while this examination provided a baseline perspective, nuances of written language and the absence of language were seen to affect how the policy was applied. It should also be pointed out that the absence of any one factor did not necessarily have a negative or restrictive impact. For example, if a telehealth private payer law only defines telehealth as the use of live video, a private payer may still choose to include other modalities in its covered benefits. In CCHP’s examination of the telehealth laws among the states, there do not appear to be any statutory limitations on providing payment for a health service via any of the modalities, although there may be other regulatory factors that govern the provision of services via those modalities (such as having a valid medical license, how to establish patient-provider relationship, etc.).

To conduct this assessment, CCHP used the following key criteria to determine the relative impact of these laws on telehealth use and reimbursement:

1. Inclusion/exclusion of language—Is the presence or lack of certain language or phrases a help or hindrance to the utilization of telehealth?
2. Parity in payment—Does the law require that a payment amount for telehealth-delivered services be equal to that which is given for in-person services?
3. Modality—Are there any limitations on what type of telehealth modality can be used?
4. Location—Are there any limitations on where a telehealth service can take place?
5. Providers and specialties—Are there any limitations on the types of provider who may provide services via telehealth and/or the types of specialty it can be used for?

Fourteen questions were developed to address these factors. (See page 6.) The questions were structured so that an answer of “yes” was considered a positive result in favor of progressive telehealth policy and a limitation was not seen as being in place. Each factor was rated with a score of “1” if the response to the question was a “yes,” and a score of “0” if it was a “no.” A detailed explanation of the methodology employed and specific scoring for each state with a telehealth private payer law can be found in Appendix B.

Baseline Results of Analysis

The results of the analysis yielded both common and different features among the state laws. It was difficult to single out any one factor that had the greatest impact on the utilization of telehealth because many of these factors were interconnected and one could affect others.

Inclusion/Exclusion of Language

Overall, the vast majority of state telehealth private payer laws contained some limiting factors. Only Minnesota scored a perfect score of 100% (based on the scoring system described above). Arizona and Montana received the lowest scores of 57.1%. However, the numbers represent only part of the story. While a state law may have received a “0” score for a factor, the presence or absence of a factor did not necessarily mean that telehealth
in that state was stifled. For example, while it might seem unnecessary to assess whether there was an explicit mandate to reimburse for telehealth, if that mandate was not there, a health plan would not be legally required to reimburse for telehealth. From another perspective, if the mandate was there, could there be other sections in the law that would undermine this mandate in some way? These questions, which need to be answered to fully assess the potential impact of the law, are explored below.

Many telehealth private payer laws include the phrase “subject to the terms and conditions of the policy of the payer” or similar limiting language. Fourteen states, or 41.1%, use this type of phrase in their private payer law, although the phrase itself is not clearly defined, allowing for various interpretations. Do the terms and conditions of the policy refer to the general common language and conditions found in any health plan? Or, is the intent of the language to allow payers the flexibility to determine the terms and conditions of their telehealth policies? In other words, does the vagueness of this phrase provide payers with the ability to develop telehealth policies that are limited because these restrictions are part of the “terms and conditions”?

Figure 1.

State Private Payer Laws vs. State Payment Parity Laws

Source: The Center for Connected Health Policy’s State Telehealth Laws and Reimbursement Policies: A Comprehensive Scan of the 50 States and the District of Columbia (September 2016).

Parity in Payment

A misconception among many telehealth proponents is that a state’s telehealth private payer law is an assurance that the payment for telehealth-delivered care will be the same
as it would be if delivered in person. In fact, our research indicates that only three state telehealth private payer laws have an explicit mandate for payment parity. Therefore, in 28 states and the District of Columbia, commercial health plans are only required to cover a telehealth-delivered service if the service is covered if delivered in person, but are not legally required to reimburse at the same rate as is paid for in-person delivered services. This gives private payers the flexibility to set lower or higher rates of reimbursement for telehealth-delivered services.

**Modality**

In all the states with a telehealth private payer law, live video is the modality most often referred to in the definition of telehealth. Store-and-forward and RPM appeared less frequently (See Figure 1.). (Only 71.9% of the state laws included store-and-forward and 56.3% included RPM.) If these modalities are not explicitly described in a state’s definition of telehealth, the private payer can use its discretion as to whether and how much to pay for the service, if at all. As noted earlier in the paper, these other modalities, particularly RPM, have great potential to improve health outcomes for patients and bring down costs, but the exclusion of these modalities in the law allows private payers to exclude services delivered via these modalities from their reimbursement policies.

**Figure 2.**

**Modalities Included in State Private Payer Laws’ Definition of Telehealth**

(N = 32)

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<td>Store-and-Forward</td>
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<tr>
<td>Remote Patient Monitoring</td>
<td>18</td>
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*Source: Data from the Center for Connected Health Policy analysis of private payer laws.*

**Location**

Restrictions that limit where a telehealth service can be provided (the patient’s location), either geographically or by site, appear less often in private payer laws in comparison to the restrictive policies of Medicare. Medicare limits the location of where a patient may
receive a service via telehealth to specifically defined “rural” health professional shortage areas or to nonmetropolitan statistical areas. This limitation has been cited as a significant barrier to the use of telehealth since only certain parts of the country qualify. The fact that most state telehealth reimbursement laws lack these limitations indicates that states tend to view telehealth-delivered care as benefiting more than just the rural underserved population. (Only Arizona contains a geographic limitation, and it will be eliminated in January 2018.) Just four out of the 31 states and the District of Columbia have some type of site limitation. Not having any site restrictions allows private payers to pay for services that take place in less traditional health care locations such as the workplace or home and advances one of the important strengths of telehealth-delivered care, which is providing care anywhere the health consumer is located. However, most laws also do not prohibit restrictions on sites, which would allow providers to still limit where a patient may receive telehealth-delivered services.

Figure 3.

Factors of Private Payer Laws
(out of 31 states and the District of Columbia)

- Include all three modalities
- Include phrase: “Subject to the terms and conditions”
- No geographic or site limits
- No limit on providers or specialties

Source: Data from the Center for Connected Health Policy’s analysis of private payer laws.

Providers and Specialties

Most telehealth private payer laws refrained from requiring that the law be applied to a specific list of providers or specialties. This language in the law theoretically enables health care providers other than physicians to be reimbursed within private payer policies. Audiologists, speech pathologists, physical therapists, and others could presumably be eligible for reimbursement, depending on the parameters of the plan. However, language that requires that all services and providers be reimbursed may not necessarily be present in the actual
law. A law may simply omit any mention of providers or specialties, leaving the payer with the ability to impose certain limitations, such as reimbursement for only a narrow set of services such as physicians’ office consultations.

Other Factors

Other factors that were examined in CCHP’s analysis of telehealth private payer laws were selected based on the potential negative effect they could have on provider behavior. These factors could be seen by providers as additional burdens they would not have to face if providing services in person and could discourage them from using telehealth, because resources to meet these requirements might outweigh the benefits of utilizing the technology. One such requirement is to have a separate informed consent (which in some states can be written and/or oral) specifically for telehealth. There is debate in the field regarding the impact of the additional informed consent. Some believe that requiring an additional informed consent gives the impression that telehealth is more “dangerous” than in-person care and may prejudice patients and deter them from agreeing to the use of the technology. Others view it as an opportunity to provide education and information to patients. And some believe that requiring a form of consent deters providers from using telehealth because it is yet another administrative burden. Though the impact and effects of an additional informed consent are debatable, it was flagged in this analysis due to its potential influence on providers.

Also included in this analysis was whether there was any language specifically related to reimbursement in the Medicaid program. The results were mixed. Nearly one-third of the states did have some Medicaid provision within their telehealth private payer law. This is important because in some states Medicaid may be the largest payer. Not including Medicaid could have the unintended consequence of depriving many beneficiaries of access to services that could be delivered via telehealth. Additionally, as will be discussed in a later section, private payers may adopt telehealth payment policies that mirror either Medicare or Medicaid telehealth policies. How a Medicaid program shapes its telehealth reimbursement policies can have a significant impact on the payment policies of private plans operating in their state.

Key Takeaways from Private Payer Law Analysis (See Figure 3.)

- Inclusion or exclusion of certain language may create barriers to the utilization of telehealth by allowing payers to limit the types or uses of services that are reimbursed.
- Very few telehealth private payer laws mandate parity in payment amount.
- Store-and-forward and RPM are less likely to be included in a telehealth private payer law.
- Unlike Medicare, telehealth private payer laws tend not to include explicit exclusions on types of services, providers, and limitations on locations, both geographic and site.
Private Payer Interviews

To gain a deeper understanding of the impact of the private payer parity laws among the states, CCHP conducted interviews with selected commercial health plan executives. The representatives of the plans included medical officers, vice presidents, counsel, and designated telehealth policy representatives. The interviews were conducted to determine how the telehealth private payer laws affected these plans, how they developed the plans to be in compliance with the law, and how some of the factors identified in the previous section on the payment policies of health plans influenced the plans.

Standardized interviews were conducted with willing commercial payers in six selected states. Questions were developed to address the five previously identified factors that impact utilization of telehealth. These questions were designed to assess how plans dealt with each of the factors that have an impact on telehealth utilization, especially if a law’s vague or omitted language gave private payer plans latitude in developing their telehealth policies. CCHP also asked about the availability of data to determine the extent to which there had been greater receptivity for telehealth among the commercial plans given the existence of a telehealth private payer law.

The criteria used for the selection of these states were (1) a telehealth private payer law had been in place for at least three years, and (2) if any major amendments were made to that law, those amendments must have been in place for at least three years. A goal in the selection process was also to include states that varied in both geography and population. The states selected were California, Mississippi, Montana, Oklahoma, Texas, and Virginia. None of these states had payment parity as part of their private payer laws. All states with an explicit requirement for payment parity failed to meet the three-year enactment requirement. (See Table 1.)

Over a period of four months, a variety of commercial health plans in all six of the selected states were contacted. Initial outreach was made through multiple channels to representatives in the health plans, including media relations and specific staff associated in some way with a plan’s telehealth program. CCHP agreed to not identify the participants in these interviews to obtain the most open responses to the questions possible.

It should be noted that some plans declined to participate, but at least two plans in each state were interviewed either via phone or email. Some interviewees were large national plans that have a presence in multiple sample states, while others were limited to one state. Several interviewees provided copies of their telehealth reimbursement policies. Given that some health plans declined to participate, it is possible that the interview sample may have been more biased toward those willing to incorporate telehealth as a reimbursable benefit. To try to counteract this possibility, CCHP conducted online research of telehealth policies of those health plans that declined to be interviewed, as a means of gathering information that responded to the assessment questions. A list of questions used can be found in Appendix C.
Table 1. Selected Sample Private Payer Law Features

<table>
<thead>
<tr>
<th>State</th>
<th>Parity in Payment</th>
<th>Live Video Included</th>
<th>Store-and-Forward Included</th>
<th>Remote Patient Monitoring Included</th>
<th>No Geographic Limit</th>
<th>No Site Limit</th>
<th>No Limit on Provider</th>
<th>No Limit on Specialty</th>
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Interview Findings

As noted, some private payer laws may appear to require all services delivered via telehealth to be reimbursed as they would if they were provided in person. However, further examination reveals that there may be some flexibility in the interpretation. The specific language included in these laws and other regulations or statutes may impact whether all services are reimbursed the same way that in-person services are or if there are limitations/restrictions imposed by insurance carriers. All payers interviewed had some limitation on their telehealth reimbursement policies in some form or another.

Modality Limitations

While all six sample states’ telehealth private payer laws allowed for all three modalities within telehealth to be reimbursed, the majority of selected plans only reimbursed for live video. Some plans provided limited reimbursement for store-and-forward, but only for specific specialties such as dermatology or ophthalmology. RPM was not being reimbursed by any of the selected payers, although several interviewees noted that, in the near future, it might be either a pilot project or an option in a specific type of plan, such as an employer plan.

Provider and Specialty Limitations

Most of the interviewees said they limited the types of services reimbursed if the service was provided via telehealth. One interviewee said it was the policy of the organization to not reimburse for telehealth-delivered services unless an established patient-provider relationship existed. Another interviewee mentioned that the health plan’s policies mirrored the Medicaid policies in the state. None of the six states in the sample had specific language in the private payer law regarding what services could or could not be reimbursed if the service was provided via telehealth.

Most plans did not limit the type of provider who could provide services, although they did require the provider to be a member of its network, with one exception discussed below. Some plan manuals required additional actions by the provider that included such things as requiring them to share medical records with a primary care provider or obtaining informed consent (factors which may be required by a state licensing board or law).
Parity in Payment

When interviewees were asked if the reimbursement amount was the same regardless of whether the service took place in person or via telehealth, almost all answered yes. One interviewee said its telehealth reimbursement was slightly less than in-person service because they calculated a lower overhead cost for the telehealth service. Another interviewee was uncertain but believed that the reimbursement amount for telehealth services was the same or slightly less than what was paid in person. It should be noted that none of the six sample states had a mandate on parity of payment in their laws, although nearly all the interviewees were paying the same or near the same amounts per service regardless of delivery method.

Location Limitations

In some cases, the health plans imposed other limitations such as defining the specific sites where the telehealth interaction could take place (doctor's office, clinic, etc.), but none of the interviewees had geographic restrictions such as the ones Medicare places on telehealth (it should be noted that in the interviews only commercial plans were discussed and not Medicare Advantage plans).

Third-Party Providers and Network Providers

Several interviewees noted that their organizations had several options for enrollees to utilize telehealth. One option was using a network provider that offered services via telehealth. Reimbursement to that provider operated much the same as if the service had been provided in person. In addition, several interviewees noted that they contracted directly with a third-party provider that provides online services to their enrollees, usually for less complex, more common cases such as colds or sore throats. These third-party providers were contracted by the health plan and paid according to the terms of the negotiated contract. Interestingly, several of the interviewees said their own network providers could join these third-party provider services and still be network providers, although they would receive the contracted rate for services rendered through the third-party provider. In some cases, a health plan may also have its own asynchronous online system that allows enrollees to communicate with their network providers.

CCHP obtained a copy of a telehealth provider manual for a multistate payer that declined to be interviewed for this report. The manual describes the state’s telehealth network program, where the plan has created specific specialty locations that connect with presentation sites (where the patient would be located), thus allowing enrollees to seek telehealth-provided services using their own network providers, not those of a third-party provider. Even though CCHP was unable to interview this payer, the telehealth policy is worth noting because it is a different approach by a payer providing telehealth services.

Utilization and Provider and Consumer Reactions

All the interviewees declined to provide exact figures on telehealth utilization. One interviewee noted that tracking data would be difficult because the organization did not require providers to use the telehealth modifiers of GT (live video) or GQ (asynchronous), which
is typically used when billing for telehealth delivered services, and could not distinguish between an interaction that took place via telehealth or in person. However, the interviewee believed utilization was low. Other interviewees echoed this. When asked for their thoughts about why utilization was low, several reasons were given:

- Patients were reluctant to initially start using telehealth, though once they did, many responded positively. However, there was still a preference by many enrollees to see a provider in person.
- In-network providers were reluctant to utilize the technology for reasons that ranged from lack of training, skepticism that telehealth would provide quality services, or concerns that they could see a loss of business (this was particularly true in at least one case where a plan also engaged a third-party provider).
- Lack of education/awareness that these services were available or understanding exactly what these services could do for enrollees.

When talking about low utilization, several of the interviewees expressed their continued belief in the benefits of telehealth and the hope that there would be greater uptake in its use. However, when asked if they considered expanding their current telehealth policies, several interviewees voiced caution. They noted concerns about efficacy in certain interactions. Most preferred a slower, more thorough approach to expansion that could include their own pilot projects before considering larger changes. While we did not sense any reluctance on the part of the interviewees to move forward with telehealth, it was evident that the interviewees only wanted to reimburse for services for which they felt telehealth could be appropriately used, such as routine office visits.

**Key Takeaways from Private Payer Interviews**

- Most interviewees limited telehealth reimbursement to services provided via live video.
- Most interviewees limited the types of services they will reimburse if provided via telehealth.
- Policies from other sectors such as licensing boards affected the payers’ policies on telehealth.
- Most of the interviewed payers were paying the same amount for telehealth services that they would if the service was delivered in person.
- At least initially, both patients and providers were reluctant to utilize telehealth.
- Telehealth was greatly underutilized.
- Both patients and providers had a lack of understanding/awareness that the plan would pay for telehealth-delivered services.
- While supportive of telehealth, the interviewees noted that they would need to be convinced that expanding payment for services and/or use of other modalities to deliver care was beneficial.
Medicaid Policies

To assess whether there was any correlation between changes in telehealth private payer laws and those in a Medicaid program, CCHP interviewed Medicaid representatives or examined Medicaid policies for the six sample states where private payer interviews were conducted. Half of the sample states, California, Mississippi, and Oklahoma, included a Medicaid policy factor within the private payer law they adopted.

Representatives of each of the state Medicaid programs were interviewed, and the telehealth policies of the respective states described in their Medicaid provider manual were researched and identified. The list of questions asked can be found in Appendix C.

Most of the states interviewed had a Medicaid telehealth policy in place before the telehealth private payer law was enacted, and, in the majority of states, the law’s passage had little or no impact on their policies, unless there was a specific provision that applied, such as in California. When California updated its telehealth laws in 2012, it included private payer provisions along with specific reforms of telehealth coverage policies directed at the Medicaid program.

Medicaid telehealth policies tended to have similarities with private payer policies, with private payers sometimes replicating Medicaid policy. Live video was the most common modality reimbursed in Medicaid programs, as it was for private payers. Medicaid programs tended to be more explicit about defining telehealth or telemedicine as “live” or “real-time” or “interactive.” In Texas, however, another term was used to describe one of the other modalities, such as “telemonitoring” for RPM. California was one of the few (and the only state in the sample selection) that reimbursed for store-and-forward, but only in specific specialties: dermatology, ophthalmology, and dentistry. Additionally, as with many private payers, these Medicaid programs reimburse at the same rate for telehealth as they would for in-person delivered services.

The Medicaid programs in this interview sample did not limit the geographic location of where a patient may receive services. Several interviewees, including those from Montana and Oklahoma, stated that geographic hurdles impeded access to providers—and such hurdles were one reason to institute a telehealth policy. However, half of the sample states (Mississippi, Texas, and Virginia), in fact, had specific site location limits on where a patient may receive services, typically limiting services to some type of licensed health facility.

Half of the sample states’ Medicaid programs described specific lists of eligible providers and services available for telehealth reimbursement, whereas the other half included fewer details on who and what could be reimbursed for telehealth delivered services. Representatives from Montana noted that one of the main reasons the state sought to reimburse for telehealth in its Medicaid program was the severe shortage of providers in the state’s rural/frontier areas. This urgent need may be the reason for Montana’s less detailed and possibly broader telehealth policies when compared with those of other states.
While some states reported that reaction to telehealth-delivered care from providers and enrollees had been positive, they cited some challenges providers face when initiating and maintaining these services. These challenges included the cost of equipment to start a telehealth program and, most significantly, confusion over how to bill—despite the length of time most of these programs have been in place.

In the interviews, it was noted that telehealth policies from other sectors have an impact on the utilization of telehealth by providers. State licensing boards such as the medical board may impose certain requirements on their licensees as to how telehealth is used in their practices. These factors may create enough of a burden to discourage a provider from utilizing the technology. The impact of the licensing board policies echoes some findings in the private payer interviews.

Oklahoma Medicaid noted that it conducts, on average, 10,000 telehealth visits annually. The Texas Medicaid program is legally required to provide a report to the legislature every two years. The most recent report (December 2016) notes that utilization of telehealth has grown steadily over the years, with the number of providers increasing as well. Behavioral health remains a much in-demand service. Although representatives from Virginia did not have figures, they estimated that telehealth is being underutilized in Medicaid. Other interviewees did not provide utilization data or information.

Key Takeaways from Medicaid Interviews

• Private payer laws have little impact on Medicaid telehealth policies unless they are explicitly written into the law.
• Some Medicaid programs have defined lists of services and providers for which they will reimburse, while others have broader policies.
• Providers face challenges in implementing telehealth programs, such as cost of equipment and understanding how to bill.
• Other sectors’ policies, such as licensing boards’ requirements, affect the spread of telehealth.
• Most Medicaid programs pay the same for telehealth-delivered services as they do for in-person services.

Discussion

Based on the findings of this study, several issues have emerged regarding the underutilization of telehealth-delivered care in states, despite attempts to encourage its use with the passage of private payer reimbursement laws.
Examples of Potentially Problematic Private Payer Law Language

All sample states listed below lack language in their telehealth private payer laws that would require payment parity for telehealth-delivered services.

**Language that provides health plans latitude to limit reimbursement to certain services:**

**California – Health & Safety Code Section 1374.13(c)**

No health care service plan shall require that in-person contact occur between a health care provider and a patient before payment is made for the covered services appropriately provided through telehealth, *subject to the terms and conditions of the contract entered into between the enrollee or subscriber and the health care service plan, and between the health care service plan and its participating providers or provider groups.*

**Virginia – Code of Virginia Section 38.2-3418.16(C)**

An insurer, corporation, or health maintenance organization shall not exclude a service for coverage *solely* because the service is provided through telemedicine services and is not provided through face-to-face consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.

**Language that explicitly limits the services that are required to be reimbursed:**

**Arizona – Arizona Code Section 20-841.09(A) & (E)(1)**

All contracts issued, delivered or renewed on or after January 1, 2015 must provide coverage for health care services that are provided through telemedicine if the health care service would be covered were it provided through in-person consultation between the subscriber and a health care provider and provided to a subscriber receiving the service in a rural region of this state.

“Health care services” means services provided for the following conditions or in the following settings:

(a) Trauma  
(b) Burn  
(c) Cardiology  
(d) Infectious diseases  
(e) Mental health disorders  
(f) Neurological diseases including strokes  
(g) Dermatology

**Language that limits where reimbursable telehealth services may take place:**

**Tennessee – Code Title 56. Insurance Section 56-7-1002(a)(4)**

“Qualified site” means the office of a healthcare services provider, a hospital licensed under title 68, a facility recognized as a rural health clinic under federal Medicare regulations, a federally qualified health center, any facility licensed under title 33, or any other location deemed acceptable by the health insurance entity.
Location Limitations
Limits on where patients may receive services appeared to have minimal restrictions either in statute or private payer policies. Geographic limitations were practically nonexistent, and private payers were more willing to allow nontraditional sites such as the home and workplace to act as originating sites for telehealth services (although Medicaid programs tended to stay with health care facilities as eligible sites).

However, other factors provided room for some private payers to create limitations within their telehealth policies, either intentionally or not.

Inclusion/Exclusion of Language
Private payer laws, generally aimed at encouraging uptake in the use of telehealth, may not have been crafted to provide the expanded opportunities for telehealth that policymakers intended. The absence of specific language or inclusion of ambiguous language can create situations that impede the greater utilization of telehealth. For example, just over 41% of the states with private payer laws have a variation of the phrase “subject to the terms and conditions of the policy of the payer” embedded within that law. Yet, the definition or intent of that phrase is unclear and open to interpretation. For providers such as large medical systems, this ambiguity can create a billing nightmare when multiple payers have different terms and conditions for telehealth care.

Virginia provides an example of a “loophole” in the private payer law. The law states, “An insurer, corporation, or health maintenance organization shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through face-to-face consultation or contact....”10 If a payer finds a reason not to cover a telehealth service that is not based on the use of telehealth, it would be well within the law.

Parity in Payment
In 28 states and the District of Columbia, private payers were not legally required to reimburse telehealth services at the same rate as in-person services. It did not appear, however, that many private payers were reimbursing less for telehealth-delivered services than for in-person services. However, a recent action by a payer in New York may be the start of a new trend. The passage of the telehealth parity law in New York did not include payment parity language. After the law went into effect, Excellus Blue Cross Blue Shield notified providers in its network that reimbursement for telehealth-delivered services would be 50% less than what was paid for in-person services.11 Excellus was well within the law to establish that policy. While this appears to be an isolated case, it demonstrates that the lack of a clear payment parity mandate in a telehealth law gives health plans the discretion to set its own reimbursement/payment amounts for telehealth care at lower rates than for comparable in-person care, in effect creating a disincentive for providers to utilize telehealth modalities. Minnesota is one of the states with explicit payment parity language and can serve as a model for other states considering amending or passing a telehealth payment parity law.
Modality

As noted earlier, there is evidence that modalities other than live video offer effective care with favorable patient outcomes and cost savings. Yet, while all private payer laws cover live video, 71.9% and 56.3% include reimbursement for store-and-forward and RPM, respectively. Although there appears to be no restriction on private payers reimbursing for these modalities even if the law does not require them to, many payers, both public and private, are hesitant to do so, preferring to only reimburse for live video and not for the other two modalities. The lack of acceptance of these other modalities ensures that only part of telehealth’s potential is realized.

Services and Providers

Few private payer laws impose any limitations on the type of provider or service that can be reimbursed. However, the laws in these states may lack language specifically addressing providers or services, leaving it to the discretion of a private payer to set policies that define reimbursement. In the interviews conducted with private payers, almost all said they did not have limits on the type of provider who may utilize telehealth and be reimbursed. However, the interviewees placed limitations on the type of services reimbursed when the services were provided via telehealth. For example, while a payer may reimburse for a variety of health care providers, the payer may only reimburse for a limited set of services, such as an office consultation, and not for other services a practitioner may provide via telehealth.

Many reasons were given for these limitations, including the need to have an established provider-patient relationship, belief that certain services could not be adequately provided via telehealth, and billing issues using the current procedural terminology (CPT) codes. To receive payment, a provider submits a claim noting the CPT code that correlates to the service provided. But CPT codes were not designed with telehealth in mind. Some codes require in-person contact between provider and patient. Telehealth providers have struggled with these concerns for some time. The discrepancy between facets of telehealth and CPT codes has led to the American Medical Association’s recent work on telehealth-specific CPT codes that will presumably address such issues.

As an alternative, some payers ask telehealth providers to bill a general office consultation code, a practice that both Medicare and some Medicaid programs also employ. However, doing this might discourage providers from using telehealth since the amount of reimbursement for a general office consultation may be lower than what the provider is entitled to when billing with the proper CPT code. CPT codes represent an obstacle to using telehealth for every service.
Other Factors that Could Influence Use of Telehealth

Beyond reimbursement policies, other factors play a role in influencing the utilization of telehealth-delivered care. Interviewees from the public and private sectors noted that both provider and patient hesitancy or lack of knowledge of telehealth deter its use. Provider and consumer education are not factors of any existing private payer law. Policymakers may wish to consider how both providers and health care consumers can learn about the benefits of telehealth modalities and any changes in the law. This type of consumer education could take the form of requiring health plans to provide adequate information to providers and enrollees, or the state could consider taking a more active educational role. Additionally, specialized training, especially in Medicaid programs, could be offered to providers so they may better understand how to properly bill for telehealth-delivered services.

Other requirements in law or by licensing boards can place additional burdens on providers utilizing telehealth, which could find their way into private payer policies, as noted earlier in some of the private payer interviews. The actions of state licensing boards can have an impact on the success of a telehealth reimbursement policy. If licensing board policies are too burdensome for licensees, they will hesitate to provide services via telehealth. This reduces the number of telehealth providers and the utilization of telehealth. While it is understandable that regulatory boards wish to ensure the health and safety of patients, these policies should provide licensees with the flexibility to utilize the technology when they deem it appropriate and safe.

Contracting with a third-party provider has become increasingly common among private payers, so much so that many might favor using only a contracted third-party entity to provide services via telehealth under a commercial plan and not involve their established network providers. While none of the interviewees indicated this type of favoritism, CCHP has learned that in two states, not among the six sample states, there is concern that this type of third-party provider contracting is edging out network providers. As interviewees indicated, many third-party contractors only see less complex clinical cases. If in-network telehealth providers are not allowed to utilize and be reimbursed for telehealth care, payers will limit the extent of services and conditions that can be treated via technology and possibly create disparate levels of care. There may also be a lack of integration of information to a primary care provider with the use of the third-party contractors, which impacts the continuity of care for patients.
Conclusion

Telehealth-delivered health care continues to have great promise, but policy obstacles inhibit the full potential of these technologies to achieve the Triple Aim of better health outcomes, improved patient and provider experiences, and increased efficient use of resources to lower costs. It is clear from this study that there is a broad misconception that, because telehealth private payer laws are in place in many states around the country, telehealth is achieving its promise of providing the same patient benefit and payment as in-person care. The reality is that many private payer laws have been weakened by their lack of clarity and often contain clauses that may negate much of the intent of the legislation. More careful crafting of the language for these laws and a more comprehensive implementation plan will assist in greater utilization of telehealth to deliver health services. Also, further analysis should be considered in the future to assess the impact of specific payment parity laws in Delaware, Hawaii, and Minnesota after they have been in place for at least three years.

Considerations for Policymakers

- Consider using explicit language in private payer laws that details the exact intent of policymakers, such as ensuring all modalities are to be reimbursed by private payers.
- Ensure that payment parity language is included in the laws if it is the intent of policymakers to have telehealth reimbursed at the same rate as in-person services.
- Consider inclusion of some type of education component for both providers and consumers.
- Consider a robust, comprehensive telehealth policy within the state Medicaid program.
- Work with state licensing boards to create telehealth policies that allow licensees the flexibility to utilize technologies in delivering care but still take into consideration the safety of the patient.
Appendix A

Failed Past Legislation

Over the last few years, states have introduced a multitude of telehealth legislation. Collectively, most of this legislation failed to pass, although approximately 30% to 40% of bills did pass. Many of these bills involve private payer reimbursement and/or reimbursement in a state Medicaid program. By examining these bills, especially if bills on the same subject passed in subsequent years, a picture begins to emerge about the elements that, if not present, affect the eventual passage or failure of the legislation. Additionally, an examination of this kind also provides a history of a state’s attempts at passing private payer and/or Medicaid reimbursement.

Methodology

To translate the failed bills into quantifiable data, two researchers conducted a content analysis. Fourteen factors were examined for private payer bills and 11 factors were looked at for Medicaid bills. The factors were based on the most common features found in telehealth reimbursement language. These factors were also cited as barriers by telehealth advocates if they were missing or restrictive because the opportunities to use and receive reimbursement for telehealth would be limited.

Some legislation included both a private payer and Medicaid reimbursement provision. These bills were evaluated through both the private payer and Medicaid filter noted above.

Each factor was rated with a score of “1” if it appeared in the bill and a score of “0” if it was absent. For example, if a private payer bill allowed for reimbursement for three modalities of telehealth (live video, store-and-forward, remote patient monitoring), the bill was scored as a three—one point for each type of reimbursement. If the bill did not cover reimbursement of any of the three modalities, the researcher scored it as a “0” for each modality.

For private payer bills, a perfect score of “14” (or 100%) was possible or “11” (or 100%) for Medicaid bills. Only failed legislation in the years 2013, 2014, and 2015 were
examined (the 2016 legislative session had not been completed for all states at the time this research took place). Using LexisNexis, the researchers searched for and selected all private payer or Medicaid reimbursement bills introduced in all 50 states and the District of Columbia in the selected years that did not pass. Some states introduced the same bills simultaneously in both houses. If one bill eventually was passed, the other bill was not included in this analysis.

Once the bills were retrieved either through LexisNexis or through the state’s legislative website, two researchers independently scored the bills. Their findings were then compared and, if a difference rate of over 5% was found, the researchers discussed reasons to determine what led to the differences (different interpretation of language, misreading, etc.) and revisited their scoring. Once the differences were below 5%, the lead researcher on the project scored each bill and compared the scores with what the two researchers found. If the difference rate between the lead and the two researcher findings was over 5%, all three researchers met to determine the reasons for the differences. In this study, the scoring on any items between the two parties did not exceed 5%. In cases where the researchers differed on what score to give a feature, the lead researcher made the final determination. Each bill was then given a percentage score, based upon the presence of the positive qualities found in each bill.

Analysis

Twenty-nine states introduced legislation that was related to private payer and/or Medicaid reimbursement for telehealth over the 2013 to 2015 legislative periods. If legislation failed in a previous year, many of the states introduced another private payer bill the following year. Interestingly, not all states that had a bill the following year modified it to contain less expansive features. Several states simply reintroduced the same bill that had failed or had bills that were more expansive than the previous year. Of the 29 states that had failed private payer and/or Medicaid legislation in 2013 to 2015, seven states eventually passed private payer laws. Of those states that passed laws after having failed legislation, those successful bills were generally narrower than the legislation that failed previously.
Appendix A. Table 1. States that Passed Private Payer Laws after Previous Legislation Failed

<table>
<thead>
<tr>
<th>STATE</th>
<th>FAILED LEGISLATION SCORE YEAR 1</th>
<th>FAILED LEGISLATION SCORE YEAR 2</th>
<th>PRIVATE PAYER LAW IN STATUTE SCORE</th>
</tr>
</thead>
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<tr>
<td>Connecticut</td>
<td>85.7%</td>
<td>78.6%</td>
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<tr>
<td>Indiana</td>
<td>—</td>
<td>78.6%</td>
<td>71.4%</td>
</tr>
<tr>
<td>Illinois</td>
<td>78.6%</td>
<td>64.3%</td>
<td>57.1%</td>
</tr>
<tr>
<td>Minnesota</td>
<td>92.9%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>New York</td>
<td>81.8%</td>
<td>81.8%</td>
<td>92.9%</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>85.7%</td>
<td>85.7%</td>
<td>85.7%</td>
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<tr>
<td>Rhode Island</td>
<td>85.7%</td>
<td>78.6%</td>
<td>71.4%</td>
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</tbody>
</table>

Minnesota, New York, and Oklahoma had equivalent or more expansive legislation that eventually passed, but the other states passed scaled-down bills. This indicates that limiting the ambitions of private payer reimbursement may have assisted in eventual passage. Another factor that may have affected the success of legislation was the representative makeup of the state legislatures, but a detailed analysis of this is beyond the scope of this study.

It should be noted that each factor examined was weighted equally. Different parties may weigh certain factors more heavily than others. Therefore, a bill that scored 71.4% may, in some parties’ view, be better than a bill that scored 85.7%. For example, one state may view reimbursable live video, store-and-forward, and remote patient monitoring as more important factors than not having an expansive list of providers who are eligible for reimbursement.

Overall, the most common factors found in nearly all bills were:

- A mandate to cover services if they are provided via telehealth;
- Including live video in that coverage of service; and
- Exclusion of a provider with the patient during a telehealth interaction.

The most common factors missing from the legislation were:

- A specific mandate to pay an equal amount for services regardless of whether they were delivered via telehealth or in person;
- Inclusion of store-and-forward and/or remote patient monitoring for reimbursement; and
- Imposing a geographic restriction.

These factors indicate that while policymakers may be comfortable with requiring reimbursement for live video, they are not as open to including store-and-forward and RPM modalities. Additionally, unlike Medicare, which imposes a geographic restriction on telehealth services, state policymakers are less inclined to require that limitation when developing policy that applies to private payers.
Ten of the 29 states with failed legislation included a Medicaid factor in those bills. Most private payer laws ignore Medicaid, though some states will introduce solo Medicaid legislation. There were a variety of reasons for the lack of Medicaid inclusion, including that a state Medicaid program may already be reimbursing for telehealth. For example, 48 states and the District of Columbia currently reimburse for some live video services.\textsuperscript{13} Another likely factor is cost concerns in Medicaid.

However, one significant omission must be addressed in private payer laws—a mandate to pay the same amount for services regardless of how they are delivered, via telehealth or in person. The majority of state private payer laws lacked this specific language. In general, it has not proven to be an issue because private plans appear to be reimbursing the same for services regardless of how they are delivered. However, in 2016 in New York, a private payer issued a notice to its providers indicating that it will pay 50\% of what would be paid for in-person service if the service was delivered via telehealth. New York’s private payer law lacks a specific requirement to pay the same amount. This may be the start of a trend in states that do not require a private payer to reimburse for the same amount.

Additionally, another feature noted in the scoring is the inclusion in some private payer laws the phrase “subject to the terms and conditions of the contract.” This phrase, depending on whether there is clear direction in the legislative language, can act as a loophole for private payers to impose limitations on telehealth. Does the phrase refer to contracts between the payer and enrollee? If so, then the terms and conditions will most likely be the common ones seen, such as co-pay language or requirements about seeing an in-network provider. Or does the language refer to contracts between the payer and provider? In this case, the payer may put limitations on how and when telehealth is used.
Appendix B

Detailed Methodology in Calculating Baseline for Current Telehealth Private Payer Laws

The Center for Connected Health Policy selected a set of key factors to examine the impact of when and how telehealth is reimbursed under private payer laws. These factors were identified as those that impact the utilization of telehealth based upon the effect they had under Medicare policy for limiting telehealth expansion. Additional features were selected either because they were common policies in state telehealth reimbursement laws or by their very nature imposed restrictions or mandated policy to encourage use of telehealth. Five distinct factors were looked at:

1. Inclusion/exclusion of language—Is the presence or lack of certain language or phrases a help or hindrance to the utilization of telehealth?
2. Parity in payment—Does the law require that a payment amount for telehealth-delivered services be equal to that which is given for in-person services?
3. Modality—Are there any limitations on what type of telehealth modality to be used?
4. Location—Are there any limitations on where a telehealth service can take place?
5. Providers and specialties—Are there any limitations on the types of providers who may provide services via telehealth and/or the types of specialty it can be used for?

A list of 14 questions (See page 23.) was developed to address the five factors above. The questions were structured so if the answer was “yes,” it was considered a positive result in favor of progressive telehealth policy since no limitation appeared to be in place. Each factor was rated with a score of “1” if the response to the question was a “yes” and a score of “0” if it was a “no.” For example, if a private payer law allowed for reimbursement for three modalities of telehealth (live video, store-and-forward, remote patient monitoring), the bill was given a score of three—one point for each type of modality. If the bill did not provide reimbursement for any of the three modalities, the researcher scored it as a “0” for each modality. The higher the score, presumably he higher the probability that the law would create a more favorable environment for telehealth.

The bills were retrieved either through LexisNexis or through the state’s legislative website with two researchers independently scoring the bills. Their findings were then compared, and if a difference rate of over 5% was found, the researchers discussed reasons to determine what led to the differences (different interpretation of language, misreading, etc.) and resolved their differences until their difference rate was below 5%. The lead project researcher independently scored each bill and compared the score with those of the two researchers. If the difference rate between the lead and the two researchers’ findings was over 5%, all three researchers met to determine the reasons for the differences. In this study, the scoring on any item between the two parties did not exceed 5%. In cases where the researchers differed on what score to give a feature, the lead researcher made the final determination. Each bill was then given a percentage score based upon the presence of the positive qualities found in each bill. See Table 1 for how each law scored.
### Appendix B. Table 1. Scoring of Telehealth State Private Payer Laws

<table>
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<tr>
<th>State</th>
<th>Mandate to Cover Tele-health</th>
<th>Parity in Payment</th>
<th>Live Video Included</th>
<th>Store-and-Forward Included</th>
<th>Remote Patient Monitoring Included</th>
<th>No Geographic Limit</th>
<th>No Site Limit</th>
<th>No Limit on Type of Provider</th>
<th>Additional Informed Consent Not Required</th>
<th>Presenter with Patient Not Required</th>
<th>Subject to the Terms and Conditions</th>
<th>Medicaid Included</th>
<th>Score</th>
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</tbody>
</table>
Appendix C

Questions Asked in Private Payer Interviews

- Besides live video, does your organization reimburse for any other modalities, i.e., store-and-forward or remote patient monitoring?
- Does your plan reimburse for eConsult (physician-to-physician secure email consults)?
- Does your plan reimburse the same services through telehealth as you would through in-person? Or do you have a specific list of telehealth codes you will reimburse for?
- Does your plan have any restrictions on location? Can the patient be located in their home?
- Does your plan reimburse at the same rate for telehealth services, as you would for in-person services?
- In the year that the private payer law went into effect, did your plan’s telehealth reimbursement policy change at all?
- Does your plan have any data on telehealth utilization that you can share? For example, do you know how many telehealth interactions occur each year under your plan?
- Has there been a noticeable impact on cost, quality, or outcomes?
Appendix D

Questions Asked in Medicaid Interviews

• Why did your state Medicaid decide to reimburse for telehealth?
• What were some of the factors that led your state to shape the current telehealth policies in Medicaid?
• What has been the response to telehealth from Medicaid providers? Enrollees?
• What pros/cons has the state Medicaid program seen in adopting telehealth policies?
• What barriers do you see to greater usage of telehealth to deliver services?
• Is your state Medicaid program considering expanding your telehealth policies?
• Did passage of the state private payer law impact the Medicaid policies in any way?
• Do you have any usage data that you will be able to share?
Notes


7. Not all laws have gone into effect.


10. Code of Virginia, Sec. 38.2-3418.16(C).

12. The Medicaid questions list contains three fewer questions because these elements were not typically found in Medicaid legislation, though they were in private payer legislation. These questions were: (1) Did the legislation require parity in payment? (2) Did the legislation refrain from requiring a health care provider to be present at the originating site? and (3) Did the legislation exclude a requirement that makes a mandate “subject to terms and conditions”?

About the Center for Connected Health Policy

The Center for Connected Health Policy (CCHP) is a nonpartisan public interest organization working to maximize telehealth’s ability to improve health outcomes, care delivery, and cost effectiveness. CCHP was established in 2008 with funding from the California Health Care Foundation (CHCF), and is a program of the Public Health Institute, an independent, nonprofit organization dedicated to promoting health, well-being, and improving the quality of life for people throughout California, across the nation, and around the world. CCHP is a resource for California and other state and national health care decision makers providing technical support that can lead to a more receptive policy environment for provision of telehealth services. CCHP conducts objective policy analysis and research, makes nonpartisan policy recommendations, and manages innovative telehealth demonstration projects.

In 2012, CCHP became the federally designated National Telehealth Policy Resource Center (NTPRC) providing technical assistance to 12 Regional Telehealth Resource Centers nationwide, and serves as a national resource on telehealth policy issues. The NTPRC-Policy project is made possible by a grant from the Office of the Advancement of Telehealth, Health Resources and Services Administration, Department of Health and Human Services.

www.cchpca.org/
About the Milbank Memorial Fund

The Milbank Memorial Fund is an endowed operating foundation that works to improve the health of populations by connecting leaders and decision makers with the best available evidence and experience. Founded in 1905, the Fund engages in nonpartisan analysis, collaboration, and communication on significant issues in health policy. It does this work by publishing high-quality, evidence-based reports, books, and *The Milbank Quarterly*, a peer-reviewed journal of population health and health policy; convening state health policy decision makers on issues they identify as important to population health; and building communities of health policymakers to enhance their effectiveness.

*The Milbank Memorial Fund is an endowed operating foundation that engages in nonpartisan analysis, study, research, and communication on significant issues in health policy. In the Fund’s own publications, in reports, films, or books it publishes with other organizations, and in articles it commissions for publication by other organizations, the Fund endeavors to maintain the highest standards for accuracy and fairness. Statements by individual authors, however, do not necessarily reflect opinions or factual determinations of the Fund.*

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Milbank Memorial Fund
645 Madison Avenue
New York, NY  10022
HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY
MODEL ACT

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Section 8. Disclosure and Notice Requirements
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Section 14. Regulations
Section 15. Penalties
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Section 17. Effective Date

Section 1. Title

This Act shall be known and may be cited as the Health Benefit Plan Network Access and Adequacy Act.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act in regulation form. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as regulations.

Section 2. Purpose

The purpose and intent of this Act are to:

A. Establish standards for the creation and maintenance of networks by health carriers; and

B. Assure the adequacy, accessibility, transparency and quality of health care services offered under a network plan by:

(1) Establishing requirements for written agreements between health carriers offering network plans and participating providers regarding the standards, terms and provisions under which the participating provider will provide covered services to covered persons; and
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(2) Requiring health carriers to maintain and follow access plans that consist of policies and procedures for assuring the ongoing sufficiency of provider networks consistent with Section 5 of this Act, including any requirements in Section 5E of this Act related to its availability to the public.

Drafting Note: In states that regulate prepaid health services, this Act may be modified for application to contractual arrangements between prepaid limited health service organizations that provide a single or limited number of health care services and the providers that deliver services to covered persons.

Section 3. Definitions

For purposes of this Act:

A. “Authorized representative” means:

(1) A person to whom a covered person has given express written consent to represent the covered person;

(2) A person authorized by law to provide substituted consent for a covered person; or

(3) The covered person’s treating health care professional only when the covered person is unable to provide consent or a family member of the covered person.

B. “Balance billing” means the practice of a provider billing for the difference between the provider’s charge and the health carrier’s allowed amount.

C. “Commissioner” means the insurance commissioner of this state.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term “commissioner” appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

D. “Covered benefit” or “benefit” means those health care services to which a covered person is entitled under the terms of a health benefit plan.

E. “Covered person” means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

F. “Emergency medical condition” means a physical, mental or behavioral health condition that manifests itself by acute symptoms of sufficient severity, including severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to reasonably expect, in the absence of immediate medical attention, to result in:

(1) Placing the individual’s physical, mental or behavioral health or, with respect to a pregnant woman, the woman’s or her [fetus’] [unborn child’s] health in serious jeopardy;

(2) Serious impairment to a bodily function;

(3) Serious impairment of any bodily organ or part; or
(4) With respect to a pregnant woman who is having contractions:

(a) That there is inadequate time to effect a safe transfer to another hospital before delivery; or

(b) That transfer to another hospital may pose a threat to the health or safety of the woman or [fetus] [unborn child].

G. “Emergency services” means, with respect to an emergency condition, as defined in Subsection F:

(1) A medical or mental health screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and

(2) Any further medical or mental health examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

Drafting Note: States should be aware that the definition of “emergency services” above is derived from the federal definition for the term. Some states have developed a broader definition of “emergency services.” For those states with a broader definition of the term, each state will have to determine which definition is appropriate for their state. States should be aware that if they use this definition of “emergency services,” it could mean that emergency transportation is excluded from the special out-of-network cost-sharing protections applied to emergency services.

H. “Essential community provider” or “ECP” means a provider that:

(1) Serves predominantly low-income, medically underserved individuals, including a health care provider defined in Section 340B(a)(4) of the Public Health Service Act (PHSA); or

(2) Is described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act, as set forth by section 221 of Pub.L.111-8.

Drafting Note: States should be aware that a qualified health plan (QHP) must have a certain number or percentage of essential community providers (ECPs) in a provider network, or if applicable, must meet the alternate standard, in order to be offered on a health insurance exchange under the federal Affordable Care Act (ACA) and implementing regulations.

I. “Facility” means an institution providing [physical, mental or behavioral] health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, urgent care centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

Drafting Note: States that regulate Medicaid managed care plans may wish to broaden this definition.

J. “Health benefit plan” means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of [physical, mental or behavioral] health care services.

K. “Health care professional” means a physician or other health care practitioner licensed, accredited or certified to perform specified [physical, mental or behavioral] health care services consistent with their scope of practice under state law.
Drafting Note: States may wish to specify the licensed health professionals to whom this definition may apply (e.g., physicians, psychologists, nurse practitioners, etc.). This definition applies to individual health professionals, not corporate "persons."

L. “Health care provider” or “provider” means a health care professional, a pharmacy or a facility.

Drafting Note: A pharmacy is an entity where prescription drugs are prepared, compounded, preserved or dispensed. Many types of pharmacies provide a broad range of access for prescription drug benefits in the health care services delivered to a covered person. Any determination of network sufficiency should consider the broad range of pharmacy access points available to covered persons and that certain provisions of this Act may not apply to pharmacy. States should take note of the federal rules implementing the federal Affordable Care Act (ACA) that go into effect Jan 1, 2017, which will require carriers providing essential health benefits (EHBS) in the individual and small group markets to provide a range of pharmacy options, including access through mail order pharmacies and retail pharmacies (see Title 45 CFR – Subpart B – Essential Health Benefits Section 156.122(e)).

M. “Health care services” means services for the diagnosis, prevention, treatment, cure or relief of a physical, mental or behavioral health condition, illness, injury or disease, including mental health and substance use disorders.

N. “Health carrier” or “carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a health insurance company, a health maintenance organization, a hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

Drafting Note: Section 2791(b)(2) of the PIHSA defines the term “health insurance issuer” instead of “health carrier.” The definition of “health carrier” above is consistent with the definition of “health insurance issuer” in Section 2791(b)(2) of the PIHSA.

O. “Intermediary” means a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network.

P. “Limited scope dental plan” means a plan that provides coverage substantially all of which is for treatment of the mouth, including any organ or structure within the mouth, which is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of a group benefit plan.

Drafting Note: In some cases, dental benefits are embedded in or are integral to a health benefit plan, but are separately administered from the medical benefit of the health benefit plan. State insurance regulators should review this definition of “limited scope dental plan” to determine if exceptions from certain specified provisions of this Act should be given to the plan in such situations.

Q. “Limited scope vision plan” means a plan that provides coverage substantially all of which is for treatment of the eye that is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of a group benefit plan.

Drafting Note: In some cases, vision benefits are embedded in or are integral to a health benefit plan, but are separately administered from the medical benefit of the health benefit plan. State insurance regulators should review this definition of “limited scope vision plan” to determine if exceptions from certain specified provisions of this Act should be given to the plan in such situations.
R. "Network" means the group or groups of participating providers providing services under a network plan.

S. "Network plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier.

Drafting Note: The definition of "network plan" is intentionally broad in order to apply to health benefit plans using any type of requirement or incentive for covered persons to choose certain providers over others, such as HMOs, EPOs, PPO, ACOs and other innovative delivery system models.

T. "Participating provider" means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.

U. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.

V. "Primary care" means health care services for a range of common physical, mental or behavioral health conditions provided by a physician or non-physician primary care professional.

Drafting Note: Many states may have an existing definition of "primary care" in their state laws or regulations. Those states that have such a definition should carefully review that definition in comparison with the definition above and decide if the term "primary care" needs to be defined for purposes of this Act using the definition above for "primary care" or the state's existing definition of "primary care."

W. "Primary care professional" means a participating health care professional designated by the health carrier to supervise, coordinate or provide initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

X. (1) "Specialist" means a physician or non-physician health care professional who:

(a) Focuses on a specific area of physical, mental or behavioral health or a group of patients; and

(b) Has successfully completed required training and is recognized by the state in which he or she practices to provide specialty care.

(2) "Specialist" includes a subspecialist who has additional training and recognition above and beyond his or her specialty training.

Y. "Specialty care" means advanced medically necessary care and treatment of specific physical, mental or behavioral health conditions or those health conditions which may manifest in particular ages or subpopulations, that are provided by a specialist, preferably in coordination with a primary care professional or other health care professional.
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Drafting Note: Some states may have an existing definition of "specialty care" in their state laws or regulations. Those states that have such a definition should carefully review that definition in comparison with the definition above and decide if the term "specialty care" needs to be defined for purposes of this Act using the definition above for "specialty care" or the state's existing definition of "specialty care."

Z. "Telemedicine" or "Telehealth" means health care services provided through telecommunications technology by a health care professional who is at a location other than where the covered person is located.

Drafting Note: States should review the definition of "telemedicine" or "telehealth" for consistency with any state laws or regulations related to telemedicine or telehealth.

AA. "Tiered network" means a network that identifies and groups some or all types of providers and facilities into specific groups to which different provider reimbursement, covered person cost-sharing or provider access requirements, or any combination thereof, apply for the same services.

Drafting Note: Health carriers may use different terms other than the term "tier" to refer to the type of network described in the definition above. State insurance regulators should be aware of this for purposes of the definition above and any changes a state may want to make to the definition above as a result, such as using another term or terms in place of or in addition to the term "tier."

BB. "To stabilize" means with respect to an emergency medical condition, as defined in Subsection F, to provide such medical treatment of the condition as may be necessary to assure, within a reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual to or from a facility, or, with respect to an emergency birth with no complications resulting in a continued emergency, to deliver the child and the placenta.

Drafting Note: States should be aware that if they decide not to include the definition of "emergency services" using the language provided in Subsection G, it may not be necessary to include this definition.

CC. "Transfer" means, for purposes of Subsection BB, the movement, including the discharge, of an individual outside a hospital's facilities at the direction of any person employed by, or affiliated or associated, directly or indirectly, with the hospital, but does not include the movement of an individual who:

(1) Has been declared dead; or
(2) Leaves the facility without the permission of any such person.

Section 4. Applicability and Scope

A. Except as provided in Subsection B, this Act applies to all health carriers that offer network plans.

B. The following provisions of this Act shall not apply to health carriers that offer network plans that consist solely of limited scope dental plans or limited scope vision plans:

(1) Section 5A(2) of this Act;
(2) Section 5F(7)(e), (8)(b) and (11) of this Act;

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(3) Section 6L(2)(a)(i)(I) and (III) and (c)(iii)(III) of this Act;

(4) Section 8 of this Act;

(5) Section 9B(2) and (3) of this Act; and

(6) Section 9C(1)(a) and (b), (2) and (3) of this Act.

Drafting Note: In addition to Subsection B, states will need to consider what other types of health benefit plans subject to the insurance laws and regulations of this state that use networks should be subject to the requirements of this Act.

Drafting Note: States may consider accreditation by a nationally recognized private accrediting entity with established and maintained standards that, at a minimum, are substantially similar to or exceed the standards required under this Act, as evidence of meeting some or all of this Act's requirements. However, accreditation should not be used as a substitute for state regulatory oversight nor should accreditation be considered a delegation of state regulatory authority in determining network adequacy. States should consider accreditation as an additional regulatory tool in determining compliance with the standards required under this Act. Under such an approach, the accrediting entity should make available to the state and the public its current standards to demonstrate that the entity's standards meet or exceed the state's requirements. The private accrediting entity or health carrier should provide the state with documentation that the health carrier and its networks have been accredited by the entity and make the underlying accreditation files available to the state upon request.

Section 5. Network Adequacy

A. (1) A health carrier providing a network plan shall maintain a network that is sufficient in numbers and appropriate types of providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults, will be accessible without unreasonable travel or delay.

(2) Covered persons shall have access to emergency services twenty-four (24) hours per day, seven (7) days per week.

Drafting Note: Particular attention should be given to network sufficiency, marketing and disclosure in certain health carrier network plan designs, such as tiered, multi-tiered, layered or multi-level network plans, which include different access to benefits and cost-sharing based on a covered person's choice of provider. State insurance regulators should carefully review filings to ensure that the network plan design is not potentially discriminatory for children and adults with serious, chronic or complex health conditions and that carriers will disclose information in a clear and conspicuous manner so that the covered person can understand the use of the tiered, multi-tiered, layered or multi-level network plan to access the benefits offered within the health benefit plan.

B. The commissioner shall determine sufficiency in accordance with the requirements of this section, and may establish sufficiency by reference to any reasonable criteria, which may include but shall not be limited to:

(1) Provider-covered person ratios by specialty;

(2) Primary care professional-covered person ratios;

(3) Geographic accessibility of providers;

(4) Geographic variation and population dispersion;

(5) Waiting times for an appointment with participating providers;

(6) Hours of operation;
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(7) The ability of the network to meet the needs of covered persons, which may include low-income persons, children and adults with serious, chronic or complex health conditions or physical or mental disabilities or persons with limited English proficiency;

(8) Other health care service delivery system options, such as telemedicine or telehealth, mobile clinics, centers of excellence and other ways of delivering care; and

(9) The volume of technological and specialty care services available to serve the needs of covered persons requiring technologically advanced or specialty care services.

Drafting Note: When determining criteria for evaluating network sufficiency provided in Subsection B, state insurance regulators also may want to consider a number of additional factors, such as the extent to which participating providers are accepting new patients, the degree to which participating physicians are authorized to admit patients to participating hospitals and hospital-based providers are participating providers, and the regionalization of specialty care, which may require some children and adults to cross state lines for care. State insurance regulators also may conduct or review available periodic surveys of covered persons and providers to help inform their monitoring of network adequacy and may choose to make the results publicly available.

Drafting Note: State insurance regulators should consider establishing network sufficiency and accessibility standards that are specific to limited scope dental and/or vision plans. Certain network sufficiency and accessibility requirements for comprehensive health benefit plans may not be appropriate for these type benefit plans. For example, hours of operation for dental offices are traditionally standard business hours and are not utilized to illustrate network sufficiency, nor is telehealth widely utilized in the dental and vision industry.

Drafting Note: Some states have developed specific quantitative standards to ensure adequate access that carriers must, at a minimum, satisfy in order to be considered to have a sufficient network. Such standards have included requirements for carriers to have a minimum number of providers within a specified area (such as a rural or urban area, metropolitan or non-metropolitan area), limits on travel distance to providers, limits on travel time to providers and limits on waiting times to obtain an appointment with a primary care provider. These standards could be incorporated into a law. However, in many cases, these standards are more likely to be included in regulations.

C. (1) A health carrier shall have a process to assure that a covered person obtains a covered benefit at an in-network level of benefits, including an in-network level of cost-sharing, from a non-participating provider, or shall make other arrangements acceptable to the commissioner when:

(a) The health carrier has a sufficient network, but does not have a type of participating provider available to provide the covered benefit to the covered person or it does not have a participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay; or

(b) The health carrier has an insufficient number or type of participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay.

(2) The health carrier shall specify and inform covered persons of the process a covered person may use to request access to obtain a covered benefit from a non-participating provider as provided in Paragraph (1) when:

(a) The covered person is diagnosed with a condition or disease that requires specialized health care services or medical services; and
Drafting Note: For purposes of this paragraph, "specialized health care services or medical services" include the delivery of covered benefits in a manner that is physically accessible and provides communication and accommodations needed by covered persons with disabilities.

(b) The health carrier:

(i) Does not have a participating provider of the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease; or

(ii) Cannot provide reasonable access to a participating provider with the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable travel or delay.

(3) The health carrier shall treat the health care services the covered person receives from a non-participating provider pursuant to Paragraph (2) as if the services were provided by a participating provider, including counting the covered person’s cost-sharing for such services toward the maximum out-of-pocket limit applicable to services obtained from participating providers under the health benefit plan.

(4) The process described under Paragraphs (1) and (2) shall ensure that requests to obtain a covered benefit from a non-participating provider are addressed in a timely fashion appropriate to the covered person’s condition.

Drafting Note: In order to determine what may be considered “in a timely fashion,” state insurance regulators may want to review the timeframes and notification requirements provided in its utilization review law or regulation.

(5) The health carrier shall have a system in place that documents all requests to obtain a covered benefit from a non-participating provider under this subsection and shall provide this information to the commissioner upon request.

(6) The process established in this subsection is not intended to be used by health carriers as a substitute for establishing and maintaining a sufficient provider network in accordance with the provisions of this Act nor is it intended to be used by covered persons to circumvent the use of covered benefits available through a health carrier’s network delivery system options.

(7) Nothing in this section prevents a covered person from exercising the rights and remedies available under applicable state or federal law relating to internal and external claims grievance and appeals processes.

Drafting Note: It is presumed that the health carrier shall make its process under this subsection available in writing to covered persons and to the commissioner, in a form and manner the commissioner may specify.

D. (1) A health carrier shall establish and maintain adequate arrangements to ensure covered persons have reasonable access to participating providers located near their home or business address. In determining whether the health carrier has complied with this provision, the commissioner shall give due consideration to the relative availability of health care providers with the requisite expertise and training in the service area under consideration.
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(2) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity and legal authority of its participating providers to furnish all contracted covered benefits to covered persons.

Drafting Note: If the commissioner determines that there is a deficiency in access to care for a limited scope dental and/or vision plan, the commissioner may work with the health carrier for approval of in-network reimbursements to covered persons.

E. (1) Beginning [insert effective date], a health carrier shall file with the commissioner [for review] [for approval] prior to or at the time it files a newly offered network, in a manner and form defined by rule of the commissioner, an access plan meeting the requirements of this Act.

Drafting Note: States will establish different requirements for the access plan. Paragraph (1) provides for this by giving states the option to require a health carrier to file the access plan with the commissioner for approval before use. Paragraph (1) also gives states the option to require a health carrier to file the access plan with the commissioner for review, but permit the health carrier to use the access plan while it is subject to review. In states that require a health carrier to file access plans with the commissioner for review, the commissioner may want to consider, for example, whether access to specific types of providers or health care services, geographic areas of the state, and other network issues with a past pattern of adequacy concerns require heightened review. Some states may also specify an agency other than the insurance department as the appropriate agency to receive or approve access plans.

(2) (a) The health carrier may request the commissioner to deem sections of the access plan as [proprietary, competitive or trade secret] information that shall not be made public. The health carrier shall make the access plans, absent [proprietary, competitive or trade secret] information, available online, at its business premises, and to any person upon request.

(b) For the purposes of this subsection, information is [proprietary or competitive or a trade secret] if revealing the information would cause the health carrier’s competitors to obtain valuable business information.

Drafting Note: State insurance regulators should be aware that the intent of Paragraph (2) above is that the access plan be considered public information. Health carriers should not be permitted to request that the entire plan is [proprietary, competitive or trade information] and, as such, no provision of the plan may be made public. State insurance regulators should review their open records laws in determining whether a particular provision, if any, of an access plan is [proprietary, competitive or trade secret] information and should not be made public based on information received from the health carrier supporting its request. For purposes of this paragraph, state insurance regulators also should review their laws or regulations to determine which term ‘proprietary,’ ‘competitive’ or ‘trade secret’ is appropriate to use or if some other term is more appropriate. State insurance regulators should rely on the state law or regulation that defines “trade secret” or “proprietary.”

(3) The health carrier shall prepare an access plan prior to offering a new network plan, and shall notify the commissioner of any material change to any existing network plan within fifteen (15) business days after the change occurs. The carrier shall include in the notice to the commissioner a reasonable timeframe within which it will submit to the commissioner for approval or file with the commissioner, as appropriate, an update to an existing access plan.
Drafting Note: State insurance regulators may want to consider defining “material change” for purposes of Paragraph (3) above. For example, a “material change” may be a certain percentage change, as determined by a state, in the health carrier’s network of providers or type of providers available in the network to provide health care services or specialty health care services to covered persons or it may be any change that renders the health carrier’s network non-compliant with one or more network adequacy standards. Types of changes that could be considered material could include: 1) a significant reduction in the number of primary or specialty care physicians available in a network; 2) a reduction in a specific type of provider such that a specific covered service is no longer available; 3) a change to the tiered, multi-tiered, layered or multi-level network plan structure; or 4) a change in inclusion of a major health system that causes the network to be significantly different from what the covered person initially purchased.

Drafting Note: State insurance regulators should be aware that requirements in this section for the access plan may be duplicative of other requirements in other sections of this Act. To the extent there is such duplication, the intent is that the health carrier be required to file or submit, as appropriate, the information one time.

F. The access plan shall describe or contain at least the following:

(1) The health carrier’s network, including how the use of telemedicine or telehealth or other technology may be used to meet network access standards, if applicable;

(2) The health carrier’s procedures for making and authorizing referrals within and outside its network, if applicable;

(3) The health carrier’s process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in network plans;

(4) The factors used by the health carrier to build its provider network, including a description of the network and the criteria used to select [and/or tier] providers;

(5) The health carrier’s efforts to address the needs of covered persons, including, but not limited to children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic or complex medical conditions. This includes the carrier’s efforts, when appropriate, to include various types of ECPs in its network;

(6) The health carrier’s methods for assessing the health care needs of covered persons and their satisfaction with services;

(7) The health carrier’s method of informing covered persons of the plan’s covered services and features, including but not limited to:

(a) The plan’s grievance and appeals procedures;

(b) Its process for choosing and changing providers;

(c) Its process for updating its provider directories for each of its network plans;

(d) A statement of health care services offered, including those services offered through the preventive care benefit, if applicable; and
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(e) Its procedures for covering and approving emergency, urgent and specialty care, if applicable;

Drafting Note: State insurance regulators should ensure that limited scope dental plans have provisions in their access plans or form filings, as appropriate, consistent with current practice to address situations where covered persons need urgent dental care.

Drafting Note: Some states may have an existing definition of “urgent care” in their state laws or regulations. Those states that have an existing definition of “urgent care” may want to consider including that definition in this Act.

(8) The health carrier’s system for ensuring the coordination and continuity of care:

(a) For covered persons referred to specialty physicians; and

(b) For covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(9) The health carrier’s process for enabling covered persons to change primary care professionals, if applicable;

(10) The health carrier’s proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier’s insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier’s insolvency or other cessation of operations, and transitioned to other providers in a timely manner;

(11) The health carrier’s process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at their participating hospitals; and

Drafting Note: If a limited scope dental and/or vision plan uses hospitals and/or other type of facility in its provider network, then the limited scope dental and/or vision plan shall comply with the Act’s requirements pertaining to hospitals and/or other type of facility.

(12) Any other information required by the commissioner to determine compliance with the provisions of this Act.

Drafting Note: State insurance regulators may want to consider requiring that an access plan include information on the health carrier’s efforts to ensure that its participating providers meet available and appropriate quality of care standards and health outcomes for network plans that the health carrier has designed to include providers that have high quality of care and health outcomes.

Drafting Note: States should be aware that for dental network plans, some state insurance regulators may not require the preparation and submission of a so-called “access plan” for purposes of determining the sufficiency of a dental provider network. These states may require other documentation to be included in the form filings to accomplish this purpose in order to review and determine the sufficiency of a dental and/or vision provider network. State insurance regulators, however, should be aware that dental carriers seeking certification to offer limited scope dental plans on a health insurance exchange or exchange use the term “access plan.”
Section 6. Requirements for Health Carriers and Participating Providers

A health carrier offering a network plan shall satisfy all the requirements contained in this section.

A. A health carrier shall establish a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health care services for which the provider will be responsible, including any limitations or conditions on services.

B. Every contract between a health carrier and a participating provider shall set forth a hold harmless provision specifying protection for covered persons. This requirement shall be met by including a provision substantially similar to the following:

"Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider (except for a health care professional who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy."

C. Every contract between a health carrier and a participating provider shall set forth that in the event of a health carrier or intermediary insolvency or other cessation of operations, the provider's obligation to deliver covered services to covered persons without balance billing will continue until the earlier of:

1. The termination of the covered person's coverage under the network plan, including any extension of coverage provided under the contract terms or applicable state or federal law for covered persons who are in an active course of treatment or totally disabled; or

Drafting Note: The reference to termination of coverage in Paragraph (1) above is meant to encompass all the ways a covered person's coverage can be terminated. The grounds, conditions and effective date of termination are dictated by other provisions of law, which are outside the scope of this Act, such as nonpayment of premium or the performance of an act or practice that constitutes fraud or an intentional misrepresentation of material fact in connection with the coverage. State insurance regulators should keep this in mind in implementing Paragraph (1).

2. The date the contract between the carrier and the provider, including any required extension for covered persons in an active course of treatment, would have terminated if the carrier or intermediary had remained in operation.
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D. The contract provisions that satisfy the requirements of Subsections B and C shall be construed in favor of the covered person, shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier, and shall supersede any oral or written contrary agreement between a provider and a covered person or the representative of a covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered services provisions required by Subsections B and C of this section.

Drafting Note: Subsection D above provides that the obligation to hold the patient harmless for services rendered in the provider's capacity as a participating provider survives the termination of the provider contract. The hold harmless obligation does not apply to services rendered after the termination of the provider contract, except to the extent that the network relationship is extended to provide continuity of care under Subsection I.

E. In no event shall a participating provider collect or attempt to collect from a covered person any money owed to the provider by the health carrier.

F. (1) Health carrier selection standards for selecting and tiering, as applicable, of participating providers shall be developed for providers and each health care professional specialty.

(2) (a) The standards shall be used in determining the selection [and tiering] of participating providers by the health carrier and its intermediaries with which it contracts.

(b) The standards shall meet the requirements of [insert reference to state provisions equivalent to the Health Care Professional Credentialing Verification Model Act].

(3) (a) Selection [and tiering] criteria shall not be established in a manner:

(i) That would allow a health carrier to discriminate against high-risk populations by excluding [and tiering] providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health care services utilization; or

(ii) That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health care services utilization.

(b) (i) In addition to Subparagraph (a) of this paragraph, a health carrier's selection criteria may not discriminate with respect to participation under the health benefit plan against any provider who is acting within the scope of the provider's license or certification under applicable state law or regulations.

(ii) The provisions of Subparagraph (b)(i) of this paragraph may not be construed to require a health carrier to contract with any provider willing to abide by the terms and conditions for participation established by the carrier.
Drafting Note: States should be aware that the provisions of Subparagraph (b) above are based in large part on the provisions of Section 2706(a) of the Public Health Service Act (PHSA). The Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (collectively, the Departments), the federal agencies charged with implementing the ACA, issued on May 26, 2015, sub-regulatory guidance in the form of frequently asked questions (FAQs), which provides an enforcement safe harbor for health insurance issuers subject to Section 2706(a) of the PHSA. Specifically, in the Affordable Care Act Implementation FAQs Part XXVII, Q4 and Q5 issued May 26, 2015, the Departments restated their current enforcement approach to Section 2706(a) of the PHSA which is to not take any enforcement action against a health insurance issuer offering group or individual coverage, with respect to implementing the requirements of Section 2706(a) of the PHSA as long as the issuer is using a good faith, reasonable interpretation of the statutory provision.

(4) Paragraph (3) shall not be construed to prohibit a carrier from declining to select a provider who fails to meet the other legitimate selection criteria of the carrier in compliance with this Act.

(5) The provisions of this Act do not require a health carrier, its intermediaries or the provider networks with which they contract, to employ specific providers acting within the scope of their license or certification under applicable state law that may meet their selection criteria, or to contract with or retain more providers acting within the scope of their license or certification under applicable state law than are necessary to maintain a sufficient provider network, as required under Section 5 of this Act.

Drafting Note: This subsection is intended to prevent health carriers from avoiding risk by excluding either of two types of providers: (1) those providers who are geographically located in areas that contain potentially high-risk populations; or (2) those providers who actually treat or specialize in treating high-risk populations, regardless of where the provider is located. Exclusion based on geographic location may discourage individuals from enrolling in the plan because they would be required to travel outside their neighborhood to obtain services. Exclusion based on the provider’s specialty or on the type of patient contained in the provider’s practice may discourage a person unwilling to change providers in the course of treatment from enrolling in the plan. For example, if a carrier were permitted to exclude physicians whose practices included many patients infected with HIV, the carrier could avoid enrolling these persons in its plan, since those persons would probably not want to change physicians in the course of treatment. This subsection does not prevent health carriers from requiring all providers that participate in the carrier’s network to meet all the carrier’s requirements for participation.

G. A health carrier shall make its standards for selecting and tiering, as applicable, participating providers available for review [and approval] by the commissioner. A description in plain language of the standards the health carrier uses for selecting and tiering, as applicable, shall be available to the public.

Drafting Note: State insurance regulators should review how a health carrier markets or represents its network plans to consumers particularly for those network plans that carriers market or represent to consumers as using quality at least one method of assessing whether to include providers in the network. In addition, for such network plans, state insurance regulators also should review a health carrier’s provider selection standards to ensure that quality is actually being used to assess whether to include providers in the network.

Drafting Note: The disclosure of a health carrier’s selection standards to providers and consumers is an important issue to be considered by states and could be addressed in this Act or in another law.

H. A health carrier shall notify participating providers of the providers’ responsibilities with respect to the health carrier’s applicable administrative policies and programs, including but not limited to payment terms; utilization review; quality assessment and improvement programs; credentialing; grievances and appeals procedures; data reporting requirements; reporting requirements for timely notice of changes in practice, such as discontinuance of accepting new patients; confidentiality requirements; and any applicable federal or state programs.

I. A health carrier shall not offer an inducement to a provider that would encourage or otherwise incent the provider to deliver less than medically necessary services to a covered person.
J. A health carrier shall not prohibit a participating provider from discussing any specific or all treatment options with covered persons irrespective of the health carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance or appeals processes established by the carrier or a person contracting with the carrier or in accordance with any rights or remedies available under applicable state or federal law.

Drafting Note: States should be aware that the term "participating provider" is meant to include a health care professional acting within the scope of their authority who may not be in the typical physician office setting or hospital setting, and may include licensed, accredited or certified staff, such as patient care coordinators, operating under the supervision of a participating provider.

K. Every contract between a health carrier and a participating provider shall require the provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with the applicable state and federal laws related to the confidentiality of medical and health records and the covered person’s right to see, obtain copies of or amend their medical and health records.

L. (1) (a) A health carrier and participating provider shall provide at least sixty (60) days written notice to each other before the provider is removed or leaves the network without cause.

Drafting Note: In addition to when a provider is removed or leaves the network without cause, with respect to tiered network plans, states may want to consider the implications that consumers may face, including continuity of care and financial implications, when a participating provider is reassigned in the middle of a policy or contract year to another tier with higher cost-sharing requirements.

(b) The health carrier shall make a good faith effort to provide written notice of a provider’s removal or leaving the network within thirty (30) days of receipt or issuance of a notice provided in accordance with Subparagraph (a) of this paragraph to all covered persons who are patients seen on a regular basis by the provider being removed or leaving the network, irrespective of whether it is for cause or without cause.

(c) When the provider being removed or leaving the network is a primary care professional, all covered persons who are patients of that primary care professional shall also be notified. When the provider either gives or receives the notice in accordance with Subparagraph (a) of this paragraph, the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier.

(2) (a) For purposes of this paragraph, the following terms have the meanings indicated:

(i) "Active course of treatment" means:

(1) An ongoing course of treatment for a life-threatening condition;

(II) An ongoing course of treatment for a serious acute condition;
(III) The second or third trimester of pregnancy; or

(IV) An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

(ii) “Life-threatening health condition” means a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted.

(iii) “Serious acute condition” means a disease or condition requiring complex on-going care which the covered person is currently receiving, such as chemotherapy, post-operative visits or radiation therapy.

(b) For purposes of Subparagraph (a)(i) of this paragraph, a covered person shall have been treated by the provider being removed or leaving the network on a regular basis to be considered in an “active course of treatment.”

(c) (i) When a covered person’s provider leaves or is removed from the network, a health carrier shall establish reasonable procedures to transition the covered person who is in an active course of treatment to a participating provider in a manner that provides for continuity of care.

(ii) The health carrier shall provide the notice required under Paragraph (1), and shall make available to the covered person a list of available participating providers in the same geographic area who are of the same provider type and information about how the covered person may request continuity of care as provided under this paragraph.

(iii) The procedures shall provide that:

(I) Any request for continuity of care shall be made to the health carrier by the covered person or the covered person’s authorized representative;

(II) Requests for continuity of care shall be reviewed by the health carrier’s Medical Director after consultation with the treating provider for patients who meet the criteria listed in Paragraph (2) and are under the care of a provider who has not been removed or leaving the network for cause. Any decisions made with respect to a request for continuity of care shall be subject to the health benefit plan’s internal and external grievance and appeal processes in accordance with applicable state or federal law or regulations;
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(III) The continuity of care period for covered persons who are in their second or third trimester of pregnancy shall extend through the postpartum period; and

(IV) The continuity of care period for covered persons who are undergoing an active course of treatment shall extend to the earlier of:

a. The termination of the course of treatment by the covered person or the treating provider;

b. [Ninety (90) days] unless the Medical Director determines that a longer period is necessary;

c. The date that care is successfully transitioned to a participating provider;

d. Benefit limitations under the plan are met or exceeded; or

e. Care is not medically necessary.

Drafting Note: The current accreditation standard for the length of the continuity of care period is 90 days. When determining the length of time for the continuity of care period, states should consider the number of providers, especially specialty providers who are available to treat serious health conditions in their states. States that have relatively few specialists or where consumers face significant wait times for appointments may want to adjust the continuity of care time frame.

(iv) In addition to the provisions of Item (iii)(IV), a continuity of care request may only be granted when:

(I) The provider agrees in writing to accept the same payment from and abide by the same terms and conditions with respect to the health carrier for that patient as provided in the original provider contract; and

(II) The provider agrees in writing not to seek any payment from the covered person for any amount for which the covered person would not have been responsible if the physician or provider were still a participating provider.

Drafting Note: In the event of a termination of a limited scope dental or vision plan participating provider, the commissioner may work with the plan's health carrier for approval of in-network benefits provided to the covered person until the episode of care is concluded.

Drafting Note: States may want to review other state laws and regulations and consider adding special enrollment periods to address potential issues consumers may face, particularly with respect to continuity of care issues, when a consumer's enrollment or non-enrollment in a health benefit plan is the result of a material error, inaccuracy or misrepresentation in a provider directory, including when a provider is listed as a participating provider, but subsequently is found not to have been a participating provider at the time of enrollment or when a participating provider was listed as accepting new patients, but was not accepting new patients at the time of enrollment.
M. The rights and responsibilities under a contract between a health carrier and a participating provider shall not be assigned or delegated by either party without the prior written consent of the other party.

N. A health carrier is responsible for ensuring that a participating provider furnishes covered benefits to all covered persons without regard to the covered person’s enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill or licensing restrictions.

O. A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments or deductibles from covered persons pursuant to the evidence of coverage, or of the providers’ obligations, if any, to notify covered persons of their personal financial obligations for non-covered services.

P. A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.

Q. A health carrier shall establish a mechanism by which participating providers may determine in a timely manner at the time services are provided whether or not an individual is a covered person or is within a grace period for payment of premium during which the carrier may hold a claim for services pending receipt of payment of premium.

Drafting Note: There are situations that may arise when using the mechanism established in accordance with Subsection Q above when a participating provider has verified an individual’s eligibility on the date of service, but later the provider learns that the individual was not actually eligible or has been terminated due to failure to pay premium or due to some other situation that may arise due to enrollment timing issues and other issues under the federal Affordable Care Act (ACA). Providers in this situation are permitted to bill the individual for payment of services provided. States may want to look at establishing possible protections for consumers in such situations when carriers have verified eligibility.

R. A health carrier shall establish procedures for resolution of administrative, payment or other disputes between providers and the health carrier.

S. A contract between a health carrier and a provider shall not contain provisions that conflict with the provisions contained in the network plan or the requirements of this Act.

T. (1) (a) At the time the contract is signed, a health carrier and, if appropriate, an intermediary shall timely notify a participating provider of all provisions and other documents incorporated by reference in the contract.

(b) While the contract is in force, the carrier shall timely notify a participating provider of any changes to those provisions or documents that would result in material changes in the contract.

(c) For purposes of this paragraph, the contract shall define what is to be considered timely notice and what is to be considered a material change.
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Drafting Note: State insurance regulators may want to consider reviewing the sample contract forms filed with the commissioner under Section 11 of this Act in order to determine if the provisions in the contract defining what is to be considered timely notice and what is to be considered a material change reflect fair contracting between the parties to the contract. Retroactive application of a change in the contract or in a document incorporated by reference will not be considered timely notice of the change. If the regulatory authority to review provider contracts lies with some state agency other than the insurance department, a state should consider adding language to this section. Section 11 of this Act or some other section of the Act referencing that agency to ensure appropriate regulatory oversight of provider contracting issues.

(2) A health carrier shall timely inform a provider of the provider's network participation status on any health benefit plan in which the carrier has included the provider as a participating provider.

Section 7. Requirements for Participating Facilities with Non-Participating Facility-Based Providers

A. For purposes of this section, “facility-based provider” means a provider who provides health care services to patients who are in an in-patient or ambulatory facility, including services such as pathology, anesthesiology, emergency room care, radiology or other services provided in an in-patient or ambulatory facility setting. These health care services are typically arranged by the facility by contract or agreement with the facility-based provider as part of the facility’s general business operations, and a covered person or the covered person’s health benefit plan generally does not specifically select or have a choice of providers from which to receive such services within the facility.

Drafting Note: States should carefully review the definition of “facility-based provider” above to make sure it includes any provider who may bill separately from the facility for health care services provided at the in-patient or ambulatory facility.

B. Non-emergency out-of-network services.

(1) At the time a participating facility schedules a procedure or seeks prior authorization from a health carrier for the provision of non-emergency services to a covered person, the facility shall provide the covered person with an out-of-network services written disclosure that states the following:

(a) That certain facility-based providers may be called upon to render care to the covered person during the course of treatment;

(b) That those facility-based providers may not have contracts with the covered person’s health carrier and are therefore considered to be out-of-network;

(c) That the service(s) therefore will be provided on an out-of-network basis;

(d) A description of the range of the charges for the out-of-network service(s) for which the covered person may be responsible;

(e) A notification that the covered person may either agree to accept and pay the charges for the out-of-network service(s), contact the covered person’s health carrier for additional assistance or rely on whatever other rights and remedies that may be available under state or federal law; and
(f) A statement indicating that the covered person may obtain a list of facility-based providers from his or her health benefit plan that are participating providers and that the covered person may request those participating facility-based providers.

Drafting Note: The notice required in this subsection could replace the notice in Section 8B of this Act.

(2) At the time of admission in the participating facility where the non-emergency services are to be performed on the covered person, the facility shall provide the covered person with the written disclosure, as outlined in Paragraph (1), and obtain the covered person’s or the covered person’s authorized representative’s signature on the disclosure document acknowledging that the covered person received the disclosure document in advance prior to the time of admission.

C. Out-of-network emergency services.

(1) For out-of-network emergency services, the non-participating facility-based provider shall include a statement on any billing notice sent to the covered person for services provided informing the covered person that he or she is responsible for paying their applicable in-network cost-sharing amount, but has no legal obligation to pay the remaining balance. Such statement also shall inform the covered person of his or her obligation to forward the bill to their health carrier for consideration under the Provider Mediation Process described in Subsection G if the difference in the billed charge and the plan’s allowable amount is more than [$500.00].

Drafting Note: A state that has enacted provisions concerning payment for emergency services provided by a non-participating provider, which permit a non-participating provider to balance bill the covered person, should be aware that the provisions of Paragraph (1) above would not permit a non-participating provider to balance bill the covered person in that situation. As such, if a state decides to adopt the provisions of Paragraph (1) above, the state should review their laws or regulations that may be equivalent to Section 11C of the Utilization Review and Benefit Determination Model Act (#73) and revise them accordingly:

(2) Nothing in this section precludes a covered person from agreeing to accept and pay the charges for the out-of-network service(s) and not using the Provider Mediation Process described in Subsection G.

D. Limitation on balance billing covered persons.

(1) In instances where a non-participating facility-based provider sends a billing notice directly to a covered person for the non-participating facility-based provider’s service(s), the billing notice shall include the Payment Responsibility Notice in Paragraph (2).

(2) The Payment Responsibility Notice shall state the following or substantially similar language:

“Payment Responsibility Notice – The service[s] outlined below was [were] performed by a facility-based provider who is a non-participating provider with your health care plan. At this time, you are responsible for paying your applicable cost-sharing obligation - copayment, coinsurance or deductible amount – just as you would be if the provider is within your plan’s network. With regard to the remaining balance, you have three choices: 1) you may choose to pay the balance of the bill; OR 2) if the difference in the billed charge and the plan’s allowable amount is more than [$500.00], you may
send the bill to your health care plan for processing pursuant to the health carrier’s non-
participating facility-based provider billing process or the provider mediation process required by
[this Section] OR 3) you may rely on other rights and remedies that may be available in your state."

(3) Non-participating facility-based providers may not attempt to collect
payment, excluding appropriate cost-sharing, from covered persons when the
provider has elected to trigger the health carrier’s non-participating facility-
based provider billing process described in Subsection E.

(4) Non-participating facility-based providers who do not provide a covered
person with a Payment Responsibility Notice, as outlined in Paragraph (2),
may not balance bill the covered person.

(5) Nothing in this section precludes a covered person from agreeing to accept
and pay the bill received from the non-participating facility-based provider
and not using the Provider Mediation Process described in Subsection G.

E. Health carrier out-of-network facility-based provider payments.

(1) Health carriers shall develop a program for payment of non-participating
facility-based provider bills submitted pursuant to this section.

(2) Health carriers may elect to pay non-participating facility-based provider
bills as submitted or the health carrier may pay in accordance with the
benchmark established in Subsection F.

(3) Non-participating facility-based providers who object to the payment(s) made
in Paragraph (2) may elect the Provider Mediation Process described in
Subsection G.

(4) This section does not preclude a health carrier and an out-of-network facility-
based provider from agreeing to a separate payment arrangement.

F. Benchmark for non-participating facility-based provider payments. Payments to non-
participating facility-based providers shall be presumed to be reasonable if it is based
on the higher of the health carrier’s contracted rate or [XX] percentage of the
Medicare payment rate for the same or similar services in the same geographic area.

Drafting Note: Subsection F above proposes that states set a benchmark or benchmarks for payments to non-participating
facility-based providers. States can consider a number of options to use as the default reimbursement presumed to be
reasonable, including, as provided in Subsection F, using a percentage of the Medicare payment that a state considers
appropriate to determine the rate for the same or similar services in the same geographic area as provided in Subsection F
and others such as: a) some percentage of a public, independent, database of charges for the same or similar services in the
same geographic area, or b) some percentage of usual, customary and reasonable (UCR) charges in the state. If defined in
state law or regulation. In setting a benchmark or benchmarks, states should carefully consider the impact on the market.
Setting a rate too high or too low may negatively impact the ability of facility-based providers and health carriers to agree on
a contract.

G. Provider Mediation Process.

(1) Health carriers shall establish a provider mediation process for payment of
non-participating facility-based provider bills for providers objecting to the
application of the established payment rate outlined in Subsection F.
The health carrier provider mediation process shall be established in accordance with one of the following recognized mediation standards:

(a) The Uniform Mediation Act;

(b) Mediation.org, a division of the American Arbitration Association;

(c) The Association for Conflict Resolution (ACR);

(d) The American Bar Association Dispute Resolution Section; or

(e) The State of [XX] [state dispute resolution, mediation or arbitration section].

Drafting Note: Some states have included a provider mediation process in an independent dispute resolution process. The intent and effect is similar to this process.

Following completion of the provider mediation process, the cost of mediation shall be split evenly and paid by the health carrier and the non-participating facility-based provider.

A health carrier provider mediation process may not be used when the health carrier and the non-participating facility-based provider agree to a separate payment arrangement or when the covered person agrees to accept and pay the non-participating facility-based provider’s charges for the out-of-network service(s).

A health carrier shall maintain records on all requests for mediation and completed mediations under this subsection during a calendar year and, upon request, submit a report to the commissioner in the format specified by the commissioner.

Drafting Note: In promulgating regulations to implement this section, the commissioner and other appropriate state agencies involved in the rulemaking process should consider a number of provisions related to this subsection, such as the timing of the notice that the mediation process has been triggered, the timeframe to trigger the process and the standard rights and obligations of the parties participating in the mediation process.

H. The rights and remedies provided under this section to covered persons shall be in addition to and may not preempt any other rights and remedies available to covered persons under state or federal law.

I. Enforcement. The [insert appropriate state agency with hospital/provider oversight, consumer protection division, or attorney general] and the [insert insurance department] shall be responsible for enforcement of the requirements of this section.

J. Applicability.

(1) The provisions of this section shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined by [insert the reference to state law that defines long-term care insurance], vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare,

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Medicaid, or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

(2) The requirements of this section do not apply to providers or covered persons using the process established in Section 5C of this Act.

(3) The requirements of this section do not apply to facilities that have made arrangements with facility-based providers they employ or with whom they have contracts which prevent balance bills from being sent to persons covered by the same health benefit plans with which the facility contracts.

Drafting Note: This section is not intended to be used in situations where the covered person affirmatively chooses, prior to the provision of the services, to obtain health care services from a non-participating facility-based provider.

K. Regulations. The commissioner and the [insert appropriate state agency with hospital/provider oversight, consumer protection division, or attorney general as indicated in Subsection I, above] may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this section. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 8. Disclosure and Notice Requirements

A. (1) A health carrier shall develop a written disclosure or notice to be provided to a covered person or the covered person's authorized representative at the time of pre-certification, if applicable, for a covered benefit to be provided at a facility that is in the covered person's health benefit plan network that there is the possibility that the covered person could be treated by a health care professional that is not in the same network.

(2) The disclosure or notice shall indicate that the covered person may be subject to higher cost-sharing, as described in the covered person's plan summary of coverage and benefits documents, including balance billing, if the covered services are performed by a health care professional, who is not in the covered person's plan network even though the covered person is receiving the covered services at a participating facility, and that information on what the covered person's plan will pay for the covered services provided by a non-participating health care professional is available on request from the health carrier. The disclosure or notice also shall inform the covered person or the covered person's authorized representative of options available to access covered services from a participating provider.
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B. For non-emergency services, as a requirement of its provider contract with a health carrier, a facility shall develop a written disclosure or notice to be provided to a covered person of the facility within ten (10) days of an appointment for in-patient or outpatient services at the facility or at the time of a non-emergency admission at the facility that confirms that the facility is a participating provider of the covered person’s network plan and informs the covered person that a health care professional, such as an anesthesiologist, pathologist or radiologist, who may provide services to the covered person while at the facility may not be a participating provider in the same network.

Drafting Note: States should be aware that network adequacy issues could arise due to an insufficient number of participating providers available to provide adequate and reasonable access for covered persons to covered benefits related to facility-based health care professionals who are not in the same network as the facility. States may want to consider developing appropriate laws and regulations to apply notice and disclosure standards to facilities to advise covered persons of the potential for balance billing by non-participating providers performing covered services at those facilities.

Drafting Note: If a limited scope dental and/or vision plan uses hospitals and/or other type of facility in its provider network, then the limited scope dental and/or vision plan shall comply with the Act’s requirements pertaining to hospitals and/or other type of facility.

Section 9. Provider Directories

A. (1) (a) A health carrier shall post electronically a current and accurate provider directory for each of its network plans with the information and search functions, as described in Subsection C.

(b) In making the directory available electronically, the carrier shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

(2) (a) The health carrier shall update each network plan provider directory at least monthly.

Drafting Note: In addition to requiring health carriers to update their provider directories at least monthly, to help improve the accuracy of the directories, states could consider the following: 1) a requirement that health carriers in some manner, such as through an automated verification process, contact providers listed as participating providers who have not submitted claims within the past six months or other time frame a state may feel is appropriate, to determine whether the provider still intends to be in network; and 2) closely monitoring consumer complaints.

Drafting Note: In situations in which a covered person receives covered services from a non-participating provider due to a material misrepresentation in the provider directory indicating that the provider is a participating provider, state insurance regulators should refer the issue to their consumer complaint division for a resolution, such as requiring the health carrier to cover the benefit claim as if the services were obtained from a participating provider.

(b) The health carrier shall periodically audit at least a reasonable sample size of its provider directories for accuracy and retain documentation of such an audit to be made available to the commissioner upon request.

(3) A health carrier shall provide a print copy, or a print copy of the requested directory information, of a current provider directory with the information described in Subsection B upon request of a covered person or a prospective covered person.
(4) For each network plan, a health carrier shall include in plain language in both the electronic and print directory, the following general information:

(a) In plain language, a description of the criteria the carrier has used to build its provider network;

(b) If applicable, in plain language, a description of the criteria the carrier has used to tier providers;

(c) If applicable, in plain language, how the carrier designates the different provider tiers or levels in the network and identifies for each specific provider, hospital or other type of facility in the network which tier each is placed, for example by name, symbols or grouping, in order for a covered person or a prospective covered person to be able to identify the provider tier; and

(d) If applicable, note that authorization or referral may be required to access some providers.

(5) (a) A health carrier shall make it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this state.

(b) The health carrier shall include in both its electronic and print directories a customer service email address and telephone number or electronic link that covered persons or the general public may use to notify the health carrier of inaccurate provider directory information.

(6) For the pieces of information required pursuant to Subsections B, C and D in a provider directory pertaining to a health care professional, a hospital or a facility other than a hospital, the health carrier shall make available through the directory the source of the information and any limitations, if applicable.

(7) A provider directory, whether in electronic or print format, shall accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency.

B. The health carrier shall make available through an electronic provider directory, for each network plan, the information under this subsection in a searchable format:

(1) For health care professionals:

(a) Name;

(b) Gender;

(c) Participating office location(s);

(d) Specialty, if applicable;
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(e) Medical group affiliations, if applicable;
(f) Facility affiliations, if applicable;
(g) Participating facility affiliations, if applicable;
(h) Languages spoken other than English, if applicable; and
(i) Whether accepting new patients.

(2) For hospitals:

(a) Hospital name;
(b) Hospital type (i.e. acute, rehabilitation, children’s, cancer);
(c) Participating hospital location; and
(d) Hospital accreditation status; and

(3) For facilities, other than hospitals, by type:

(a) Facility name;
(b) Facility type;
(c) Types of services performed; and
(d) Participating facility location(s).

C. For the electronic provider directories, for each network plan, a health carrier shall make available the following information in addition to all of the information available under Subsection B:

(1) For health care professionals:

(a) Contact information;
(b) Board certification(s); and
(c) Languages spoken other than English by clinical staff, if applicable.

(2) For hospitals: Telephone number; and

(3) For facilities other than hospitals: Telephone number.

D. (1) The health carrier shall make available in print, upon request, the following provider directory information for the applicable network plan:

(a) For health care professionals:

(i) Name:
Health Benefit Plan Network Access and Adequacy Model Act

(ii) Contact information;

(iii) Participating office location(s);

(iv) Specialty, if applicable;

(v) Languages spoken other than English, if applicable; and

(vi) Whether accepting new patients.

(b) For hospitals:

(i) Hospital name;

(ii) Hospital type (i.e. acute, rehabilitation, children’s, cancer); and

(iii) Participating hospital location and telephone number; and

(c) For facilities, other than hospitals, by type:

(i) Facility name;

(ii) Facility type;

(iii) Types of services performed; and

(iv) Participating facility location(s) and telephone number.

(2) The health carrier shall include a disclosure in the directory that the information in Paragraph (1) included in the directory is accurate as of the date of printing and that covered persons or prospective covered persons should consult the carrier’s electronic provider directory on its website or call [insert appropriate customer service telephone number] to obtain current provider directory information.

Drafting Note: In addition to the information provided in Subsections B, C and D health carriers may include or make available in their provider directories additional information, such as information concerning the structural accessibility, presence of accessible examination and diagnostic equipment and availability of programmatic accessibility.

Drafting Note: States should consider that the information included in electronic and print provider directories for limited scope dental and/or vision plans may have to differ from the information included in provider directories for major medical, comprehensive health benefit plans. For example, information on provider medical group affiliations and board certifications are not typically included in provider directories for limited scope dental and/or vision plans.

Section 10. Intermediaries

A contract between a health carrier and an intermediary shall satisfy all the requirements contained in this section.

A. Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of Section 6 of this Act.
B. A health carrier's statutory responsibility to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary.

C. A health carrier shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons.

D. A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from the health carrier.

E. If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons.

F. If applicable, an intermediary shall maintain the books, records, financial information and documentation of services provided to covered persons at its principal place of business in the state and preserve them for [cite applicable statutory duration] in a manner that facilitates regulatory review.

G. An intermediary shall allow the commissioner access to the intermediary's books, records, financial information and any documentation of services provided to covered persons, as necessary to determine compliance with this Act.

H. A health carrier shall have the right, in the event of the intermediary's insolvency, to require the assignment to the health carrier of the provisions of a provider's contract addressing the provider's obligation to furnish covered services. If a health carrier requires assignment, the health carrier shall remain obligated to pay the provider for furnishing covered services under the same terms and conditions as the intermediary prior to the insolvency.

I. Notwithstanding any other provision of this section, to the extent the health carrier delegates its responsibilities to the intermediary, the carrier shall retain full responsibility for the intermediary's compliance with the requirements of this Act.

Drafting Note: States may want to consider requiring intermediaries to register with the state department of insurance, or other state agency as the state may feel is appropriate, or impose some other type of regulatory scheme on such entities, to ensure the state has the regulatory authority to regulate them and keep track of their activities.

Section 11. Filing Requirements and State Administration

A. At the time a health carrier files its access plan, the health carrier shall file [for approval] with the commissioner sample contract forms proposed for use with its participating providers and intermediaries.

Drafting Note: States may want to review their open records laws to determine whether the sample contract forms filed under Subsection A are considered public information.
Health Benefit Plan Network Access and Adequacy Model Act

B. A health carrier shall submit material changes to a contract that would affect a provision required under this Act or implementing regulations to the commissioner [for approval] at least [cite period of time in the form approval statute] days prior to use.

Drafting Note: Subsections A and B provide an option for states to require health carriers to file with the commissioner for informational purposes any material changes to a contract or to require health carriers to file contracts and material changes for prior approval. A state should choose which option is appropriate for the state.

Drafting Note: States should consider that when health carriers make changes in contracted provider payment rates, coinsurance, copayments or deductibles, or other plan benefit modifications, such changes could materially impact a covered person’s access to covered benefits or timely access to participating providers; and as such, would be considered a material change to a contract subject to the requirement to file with the commissioner for informational purposes or filing for prior approval.

[C. If the commissioner takes no action within sixty (60) days after submission of a contract or a material change to a contract by a health carrier, the contract or change is deemed approved.]

D. The health carrier shall maintain provider and intermediary contracts at its principal place of business in the state, or the health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon twenty (20) days prior written notice from the commissioner.

Section 12. Contracting

A. The execution of a contract by a health carrier shall not relieve the health carrier of its liability to any person with whom it has contracted for the provision of services, nor of its responsibility for compliance with the law or applicable regulations.

B. All contracts shall be in writing and subject to review.

Drafting Note: Each state should add provisions that are consistent with that state’s current regulatory requirements for the approval or disapproval of health carrier contracts, documents or actions. For example, a state may want to add a provision requiring a health carrier to obtain prior approval of contracts, or requiring a health carrier to file a contract before using it, or requiring a health carrier to certify that all its contracts comply with this Act.

C. All contracts shall comply with applicable requirements of the law and applicable regulations.

Section 13. Enforcement

A. If the commissioner determines that a health carrier has not contracted with a sufficient number of participating providers to assure that covered persons have accessible health care services in a geographic area, or that a health carrier’s network access plan does not assure reasonable access to covered benefits, or that a health carrier has entered into a contract that does not comply with this Act, or that a health carrier has not complied with a provision of this Act, the commissioner shall require a modification to the access plan or institute a corrective action plan, as appropriate, that shall be followed by the health carrier, or may use any of the commissioner’s other enforcement powers to obtain the health carrier’s compliance with this Act.
Drafting Note: The reference to requiring the health carrier to modify the access plan instead of instituting a corrective action is to reflect the idea that sometimes the network changes through no fault of the health carrier and in those instances, the commissioner may require the health carrier to modify the access plan to bring the health carrier into compliance with the network adequacy requirements of this Act.

Drafting Note: State insurance regulators may use a variety of tools and/or methods to determine a health carrier's ongoing compliance with the provisions of this Act and whether the health carrier's provider network is sufficient and provides covered persons with reasonable access to covered benefits. Such tools and/or methods include consumer surveys, reviewing and tracking consumer complaints and data collection on the use of out-of-network benefits.

B. The commissioner will not act to arbitrate, mediate or settle disputes regarding a decision not to include a provider in a network plan or in a provider network or regarding any other dispute between a health carrier, its intermediaries or one or more providers arising under or by reason of a provider contract or its termination.

Section 14. Regulations

The commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 15. Penalties

A violation of this Act shall [insert appropriate administrative penalty from state law].

Section 16. Separability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 17. Effective Date

This Act shall be effective [insert date]. [If applicable:] The [insert year of adoption] amendments to this Act shall be effective [insert date].

A. All provider and intermediary contracts in effect on [insert effective date] shall comply with this Act no later than eighteen (18) months after [insert effective date]. The commissioner may extend the eighteen (18) months for an additional period not to exceed six (6) months if the health carrier demonstrates good cause for an extension.

B. A new provider or intermediary contract that is issued or put in force on or after [insert a date that is six (6) months after the effective date of this Act] shall comply with this Act.

C. A provider contract or intermediary contract not described in Subsection A or Subsection B shall comply with this Act no later than eighteen (18) months after [insert effective date].

D. Transition period for compliance with amended Section 5 of this Act.
Health Benefit Plan Network Access and Adequacy Model Act

Option 1.

For states with access plan requirements comparable to the pre-2015 Act: No later than [twelve (12) months] after [insert effective date of amendments], each health carrier offering or renewing network plans in this state shall file revised access plans consistent with Section 5 of this Act, as amended, for all in-force network plans.

Option 2.

For states without access plan requirements comparable to the pre-2015 Act: No later than [twelve (12) months] after [insert effective date of Act or effective date of amendments], each health carrier offering or renewing network plans in this state shall file access plans consistent with Section 5 of this Act for all in-force network plans.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

2015 Fall National Meeting – (amended).
HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY MODEL ACT

These charts are intended to provide the readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings which are related to the NAIC model. Such guidance provides the reader with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has made an interpretation of adoption or related state activity based on the definitions listed below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

This state page does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist the reader in targeting useful information. For further details, the laws cited should be consulted. The NAIC attempts to provide current information; however, due to the timing of our publication production, the information provided may not reflect the most up to date status. Therefore, readers should consult state law for additional adoptions and subsequent bill status.
HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY MODEL ACT

KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a substantially similar manner. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

RELATED STATE ACTIVITY: States that have citations identified in this column have not adopted the most recent version of the NAIC model in a substantially similar manner. Examples of Related State Activity include but are not limited to: An older version of the NAIC model, legislation or regulation derived from other sources such as Bulletins and Administrative Rulings.

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

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## HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY MODEL ACT

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<td>• Clarification from Board of Medicine Counsel regarding Telemedicine Rule</td>
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August 24, 2017

Telehealth Advisory Council  
c/o Agency for Health Care Administration  
2727 Mahan Drive, MS #16  
Tallahassee, FL 32308  

Council Members:  

I have been asked to clarify the patient examination provision set forth in the Board of Medicine’s Rule 64B8-9.0141(6), F.A.C., Standards for Telemedicine Practice. The relevant portion of the rule in question reads as follows:  

(6) Physicians and physician assistants shall not provide treatment recommendations, including issuing a prescription, via electronic or other means, unless the following elements have been met:  
(a) A documented patient evaluation, including history and physical examination to establish the diagnosis for which any legend drug is prescribed.  
(b) Discussion between the physician or the physician assistant and the patient regarding treatment options and the risks and benefits of treatment.  
(c) Maintenance of contemporaneous medical records meeting the requirements of Rule 64B8-9.003, F.A.C.  

It is important to note that nothing in the plain language of the rule indicates that any of the required elements set forth in the rule must be done in the physical presence of the patient. A virtual physical examination conducted via telemedicine technology meets the standards set forth in the rule if the patient is treated in a manner that complies with the standard of care.¹  

The only caveat is for the prescribing of controlled substances. Physicians and Physicians Assistants may not prescribe controlled substances via telemedicine, excepted in the limited circumstances noted in the rule. Those exceptions are for the treating of psychiatric disorders, treating patients in a licensed health care facility, and treating patients in an emergency medical situation.  

¹ Rule 64B8-9.0141, F.A.C., does not apply to the prescribing of controlled substances by Nurse Practitioners. The Board of Nursing does not have a comparable telemedicine rule.
August 24, 2017
Telehealth Advisory Council
Page II

It is important to note, however, that the provisions of Rule 64B8-9.0141(6) must be read in conjunction with federal law: more specifically, the Ryan Haight Online Pharmacy Consumer Protection Act (hereinafter the Ryan Haight Act). The Ryan Haight Act provides that no controlled substance may be delivered, distributed, or dispensed by means of telemedicine technologies without a valid prescription. It defines a valid prescription as one that is issued for a legitimate medical purpose in the usual course of professional practice by: 1) a practitioner who has conducted at least one in-person medical evaluation of the patient; or 2) a covering practitioner. An "in-person medical evaluation" means a medical evaluation that is conducted with the patient in the physical presence of the prescribing practitioner, without regard to whether portions of the evaluation are conducted by other health professionals.

The Board’s rule and the Ryan Haight Act, when read together, require that even when treating psychiatric disorders, the prescribing physician or physician assistant must conduct at least one in-person physical evaluation of the patient prior to prescribing the patient controlled substances via telemedicine.

Thank you for this opportunity to answer your question regarding the Board of Medicine’s Telemedicine rule. If you have any further questions regarding this matter or other telehealth issues, please do not hesitate to ask.

Sincerely,

[Signature]

Edward A. Telechea,
Chief Assistant Attorney General
Counsel to the Board of Medicine
64B8-9.0141 Standards for Telemedicine Practice.

(1) "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.

(2) The standard of care, as defined in Section 456.50(1)(e), F.S., shall remain the same regardless of whether a Florida licensed physician or physician assistant provides health care services in person or by telemedicine.

(3) Florida licensed physicians and physician assistants providing health care services by telemedicine are responsible for the quality of the equipment and technology employed and are responsible for their safe use. Telemedicine equipment and technology must be able to provide, at a minimum, the same information to the physician and physician assistant which will enable them to meet or exceed the prevailing standard of care for the practice of medicine.

(4) Controlled substances shall not be prescribed through the use of telemedicine except for the treatment of psychiatric disorders. This provision does not preclude physicians or physician assistants from ordering controlled substances through the use of telemedicine for patients hospitalized in a facility licensed pursuant to Chapter 395, F.S.

(5) Prescribing medications based solely on an electronic medical questionnaire constitutes the failure to practice medicine with that level of care, skill, and treatment which is recognized by reasonably prudent physicians as being acceptable under similar conditions and circumstances, as well as prescribing legend drugs other than in the course of a physician's professional practice.

(6) Physicians and physician assistants shall not provide treatment recommendations, including issuing a prescription, via electronic or other means, unless the following elements have been met:

(a) A documented patient evaluation, including history and physical examination to establish the diagnosis for which any legend drug is prescribed.

(b) Discussion between the physician or the physician assistant and the patient regarding treatment options and the risks and benefits of treatment.

(c) Maintenance of contemporaneous medical records meeting the requirements of Rule 64B8-9.003, F.A.C.

(7) The practice of medicine by telemedicine does not alter any obligation of the physician or the physician assistant regarding patient confidentiality or recordkeeping.

(8) A physician-patient relationship may be established through telemedicine.

(9) Nothing contained in this rule shall prohibit consultations between physicians or the transmission and review of digital images, pathology specimens, test results, or other medical data by physicians or other qualified providers related to the care of Florida patients.

(b) This rule does not apply to emergency medical services provided by emergency physicians, emergency medical technicians (EMTs), paramedics, and emergency dispatchers. Emergency medical services are those activities or services to prevent or treat a sudden critical illness or injury and to provide emergency medical care and prehospital emergency medical transportation to sick, injured, or otherwise incapacitated persons in this state.

(c) The provisions of this rule shall not apply where a physician or physician assistant is treating a patient with an emergency medical condition that requires immediate medical care. An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention will result in serious jeopardy to patient health, serious impairment to bodily functions, or serious dysfunction of a body organ or part.

(d) The provisions of this rule shall not be construed to prohibit patient care in consultation with another physician who has an ongoing relationship with the patient, and who has agreed to supervise the patient's treatment, including the use of any prescribed medications, nor on-call or cross-coverage situations in which the physician has access to patient records.

Rulemaking Authority 458.331(1)(v) FS. Law Implemented 458.331(1)(v), 458.347(4)(g) FS. History–New 3-12-14, Amended 7-22-14, 10-26-14, 3-7-16.
The 2017 Florida Statutes

Title XXXII  Chapter 456  View Entire
REGULATION OF PROFESSIONS HEALTH PROFESSIONS AND
AND OCCUPATIONS OCCUPATIONS: GENERAL PROVISIONS

456.42 Written prescriptions for medicinal drugs.—
(1) A written prescription for a medicinal drug issued by a health care practitioner licensed by law to prescribe such drug must be legibly printed or typed so as to be capable of being understood by the pharmacist filling the prescription; must contain the name of the prescribing practitioner, the name and strength of the drug prescribed, the quantity of the drug prescribed, and the directions for use of the drug; must be dated; and must be signed by the prescribing practitioner on the day when issued. However, a prescription that is electronically generated and transmitted must contain the name of the prescribing practitioner, the name and strength of the drug prescribed, the quantity of the drug prescribed in numerical format, and the directions for use of the drug and must be dated and signed by the prescribing practitioner only on the day issued, which signature may be in an electronic format as defined in s. 668.003(4).

(2) A written prescription for a controlled substance listed in chapter 893 must have the quantity of the drug prescribed in both textual and numerical formats, must be dated in numerical, month/day/year format, or with the abbreviated month written out, or the month written out in whole, and must be either written on a standardized counterfeit-proof prescription pad produced by a vendor approved by the department or electronically prescribed as that term is used in s. 408.0611. As a condition of being an approved vendor, a prescription pad vendor must submit a monthly report to the department that, at a minimum, documents the number of prescription pads sold and identifies the purchasers. The department may, by rule, require the reporting of additional information.

One Hundred Tenth Congress of the United States of America

AT THE SECOND SESSION

Begun and held at the City of Washington on Thursday, the third day of January, two thousand and eight

An Act

To amend the Controlled Substances Act to address online pharmacies.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Ryan Haight Online Pharmacy Consumer Protection Act of 2008".

SEC. 2. REQUIREMENT OF A VALID PRESCRIPTION FOR CONTROLLED SUBSTANCES DISPENSED BY MEANS OF THE INTERNET.

Section 309 of the Controlled Substances Act (21 U.S.C. 829) is amended by adding at the end the following:

"(e) CONTROLLED SUBSTANCES DISPENSED BY MEANS OF THE INTERNET.—

"(1) No controlled substance that is a prescription drug as determined under the Federal Food, Drug, and Cosmetic Act may be delivered, distributed, or dispensed by means of the Internet without a valid prescription.

"(2) As used in this subsection:

"(A) The term 'valid prescription' means a prescription that is issued for a legitimate medical purpose in the usual course of professional practice by—

"(i) a practitioner who has conducted at least 1 in-person medical evaluation of the patient; or

"(ii) a covering practitioner.

"(B)(i) The term 'in-person medical evaluation' means a medical evaluation that is conducted with the patient in the physical presence of the practitioner, without regard to whether portions of the evaluation are conducted by other health professionals.

"(ii) Nothing in clause (i) shall be construed to imply that 1 in-person medical evaluation demonstrates that a prescription has been issued for a legitimate medical purpose within the usual course of professional practice.

"(C) The term 'covering practitioner' means, with respect to a patient, a practitioner who conducts a medical evaluation (other than an in-person medical evaluation) at the request of a practitioner who—

"(i) has conducted at least 1 in-person medical evaluation of the patient or an evaluation of the patient through the practice of telemedicine, within the previous 24 months; and

"(ii) is temporarily unavailable to conduct the evaluation of the patient."
H. R. 6353—2

“(3) Nothing in this subsection shall apply to—

“(A) the delivery, distribution, or dispensing of a controlled substance by a practitioner engaged in the practice of telemedicine; or

“(B) the dispensing or selling of a controlled substance pursuant to practices as determined by the Attorney General by regulation, which shall be consistent with effective controls against diversion.”.

SEC. 3. AMENDMENTS TO THE CONTROLLED SUBSTANCES ACT RELATING TO THE DELIVERY OF CONTROLLED SUBSTANCES BY MEANS OF THE INTERNET.

(a) In General.—Section 102 of the Controlled Substances Act (21 U.S.C. 802) is amended by adding at the end the following:

“(50) The term ‘Internet’ means collectively the myriad of computer and telecommunications facilities, including equipment and operating software, which comprise the interconnected worldwide network of networks that employ the Transmission Control Protocol/Internet Protocol, or any predecessor or successor protocol to such protocol, to communicate information of all kinds by wire or radio.

“(51) The term ‘deliver, distribute, or dispense by means of the Internet’ refers, respectively, to any delivery, distribution, or dispensing of a controlled substance that is caused or facilitated by means of the Internet.

“(52) The term ‘online pharmacy’—

“(A) means a person, entity, or Internet site, whether in the United States or abroad, that knowingly or intentionally delivers, distributes, or dispenses, or offers or attempts to deliver, distribute, or dispense, a controlled substance by means of the Internet; and

“(B) does not include—

“(i) manufacturers or distributors registered under subsection (a), (b), (d), or (e) of section 303 who do not dispense controlled substances to an unregistered individual or entity;

“(ii) nonpharmacy practitioners who are registered under section 303(f) and whose activities are authorized by that registration;

“(iii) any hospital or other medical facility that is operated by an agency of the United States (including the Armed Forces), provided such hospital or other facility is registered under section 303(f);

“(iv) a health care facility owned or operated by an Indian tribe or tribal organization, only to the extent such facility is carrying out a contract or compact under the Indian Self-Determination and Education Assistance Act;

“(v) any agent or employee of any hospital or facility referred to in clause (iii) or (iv), provided such agent or employee is lawfully acting in the usual course of business or employment, and within the scope of the official duties of such agent or employee, with such hospital or facility, and, with respect to agents or employees of health care facilities specified in clause (iv), only to the extent such individuals are furnishing services pursuant to the contracts or compacts described in such clause;

“(vi) mere advertisements that do not attempt to facilitate an actual transaction involving a controlled substance;
(vii) a person, entity, or Internet site that is not in the United States and does not facilitate the delivery, distribution, or dispensing of a controlled substance by means of the Internet to any person in the United States;

(viii) a pharmacy registered under section 303(f) whose dispensing of controlled substances via the Internet consists solely of—

(I) refilling prescriptions for controlled substances in schedule III, IV, or V, as defined in paragraph (55); or

(II) filling new prescriptions for controlled substances in schedule III, IV, or V, as defined in paragraph (56); or

(ix) any other persons for whom the Attorney General and the Secretary have jointly, by regulation, found it to be consistent with effective controls against diversion and otherwise consistent with the public health and safety to exempt from the definition of an 'online pharmacy'.

(53) The term 'homepage' means the opening or main page or screen of the website of an online pharmacy that is viewable on the Internet.

(54) The term 'practice of telemedicine' means, for purposes of this title, the practice of medicine in accordance with applicable Federal and State laws by a practitioner (other than a pharmacist) who is at a location remote from the patient and is communicating with the patient, or health care professional who is treating the patient, using a telecommunications system referred to in section 1834(m) of the Social Security Act, which practice—

(A) is being conducted—

(i) while the patient is being treated by, and physically located in, a hospital or clinic registered under section 303(f); and

(ii) by a practitioner—

(I) acting in the usual course of professional practice;

(II) acting in accordance with applicable State law; and

(III) registered under section 303(f) in the State in which the patient is located, unless the practitioner—

(aa) is exempted from such registration in all States under section 302(d); or

(bb) is—

(AA) an employee or contractor of the Department of Veterans Affairs who is acting in the scope of such employment or contract; and

(BB) registered under section 303(f) in any State or is utilizing the registration of a hospital or clinic operated by the Department of Veterans Affairs registered under section 303(f);

(B) is being conducted while the patient is being treated by, and in the physical presence of, a practitioner—

(i) acting in the usual course of professional practice;

(ii) acting in accordance with applicable State law; and
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"(iii) registered under section 303(f) in the State in which the patient is located, unless the practitioner—
  "(I) is exempted from such registration in all States under section 302(d); or
  "(II) is—
    "(aa) an employee or contractor of the Department of Veterans Affairs who is acting in the scope of such employment or contract; and
    "(bb) registered under section 303(f) in any State or is using the registration of a hospital or clinic operated by the Department of Veterans Affairs registered under section 303(f);
  "(C) is being conducted by a practitioner—
    "(i) who is an employee or contractor of the Indian Health Service, or is working for an Indian tribe or tribal organization under its contract or compact with the Indian Health Service under the Indian Self-Determination and Education Assistance Act;
    "(ii) acting within the scope of the employment, contract, or compact described in clause (i); and
    "(iii) who is designated as an Internet Eligible Controlled Substances Provider by the Secretary under section 311(g)(2);
  "(D)(i) is being conducted during a public health emergency declared by the Secretary under section 319 of the Public Health Service Act; and
    "(ii) involves patients located in such areas, and such controlled substances, as the Secretary, with the concurrence of the Attorney General, designates, provided that such designation shall not be subject to the procedures prescribed by subchapter II of chapter 5 of title 5, United States Code;
  "(E) is being conducted by a practitioner who has obtained from the Attorney General a special registration under section 311(h);
  "(F) is being conducted—
    "(i) in a medical emergency situation—
      "(I) that prevents the patient from being in the physical presence of a practitioner registered under section 303(f) who is an employee or contractor of the Veterans Health Administration acting in the usual course of business and employment and within the scope of the official duties or contract of that employee or contractor;
      "(II) that prevents the patient from being physically present at a hospital or clinic operated by the Department of Veterans Affairs registered under section 303(f);
    "(III) during which the primary care practitioner of the patient or a practitioner otherwise practicing telemedicine within the meaning of this paragraph is unable to provide care or consultation; and
    "(IV) that requires immediate intervention by a health care practitioner using controlled substances to prevent what the practitioner reasonably believes in good faith will be imminent and serious clinical consequences, such as further injury or death; and
    "(ii) by a practitioner that—
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“(I) is an employee or contractor of the Veterans Health Administration acting within the scope of that employment or contract;

“(II) is registered under section 303(f) in any State or is utilizing the registration of a hospital or clinic operated by the Department of Veterans Affairs registered under section 303(f); and

“(III) issues a controlled substance prescription in this emergency context that is limited to a maximum of a 5-day supply which may not be extended or refilled; or

“(G) is being conducted under any other circumstances that the Attorney General and the Secretary have jointly, by regulation, determined to be consistent with effective controls against diversion and otherwise consistent with the public health and safety.

“(55) The term 'refilling prescriptions for controlled substances in schedule III, IV, or V'—

“(A) means the dispensing of a controlled substance in schedule III, IV, or V in accordance with refill instructions issued by a practitioner as part of a valid prescription that meets the requirements of subsections (b) and (c) of section 309, as appropriate; and

“(B) does not include the issuance of a new prescription to an individual for a controlled substance that individual was previously prescribed.

“(56) The term 'filling new prescriptions for controlled substances in schedule III, IV, or V' means filling a prescription for an individual for a controlled substance in schedule III, IV, or V, if—

“(A) the pharmacy dispensing that prescription has previously dispensed to the patient a controlled substance other than by means of the Internet and pursuant to the valid prescription of a practitioner that meets the applicable requirements of subsections (b) and (c) of section 309 (in this paragraph referred to as the 'original prescription');

“(B) the pharmacy contacts the practitioner who issued the original prescription at the request of that individual to determine whether the practitioner will authorize the issuance of a new prescription for that individual for the controlled substance described in subparagraph (A); and

“(C) the practitioner, acting in the usual course of professional practice, determines there is a legitimate medical purpose for the issuance of the new prescription.”.

(b) REGISTRATION REQUIREMENTS.—Section 303(f) of the Controlled Substances Act (21 U.S.C. 823(f)) is amended in the matter preceding paragraph (1)—

(1) in the first sentence, by adding after “schedule II, III, IV, or V” the following: “and shall modify the registrations of pharmacies so registered to authorize them to dispense controlled substances by means of the Internet”; and

(2) in the second sentence, by striking “if he determines that the issuance of such registration” and inserting “or such modification of registration if the Attorney General determines that the issuance of such registration or modification”.

(c) REPORTING REQUIREMENTS.—Section 307(d) of the Controlled Substances Act (21 U.S.C. 827(d)) is amended by—
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(1) striking "(d) Every" and inserting "(d)(1) Every"; and
(2) adding at the end the following:

"(2) Each pharmacy with a modified registration under section
303(f) that authorizes the dispensing of controlled substances by
means of the Internet shall report to the Attorney General the
controlled substances it dispenses, in the amount specified, and
in such time and manner as the Attorney General by regulation
shall require, except that the Attorney General, under this para-
graph, may not require any pharmacy to report any information
other than the total quantity of each controlled substance that
the pharmacy has dispensed each month. For purposes of this
paragraph, no reporting shall be required unless the pharmacy
has met 1 of the following thresholds in the month for which
the reporting is required:

"(A) 100 or more prescriptions dispensed.
"(B) 5,000 or more dosage units of all controlled substances
combined."

(d) ONLINE PRESCRIPTION REQUIREMENTS.—

(1) IN GENERAL.—The Controlled Substances Act is
amended by inserting after section 310 (21 U.S.C. 830) the
following:

"ADDITIONAL REQUIREMENTS RELATING TO ONLINE PHARMACIES AND
TELEMEDICINE

"SEC. 311. (a) IN GENERAL.—An online pharmacy shall display
in a visible and clear manner on its homepage a statement that
it complies with the requirements of this section with respect to
the delivery or sale or offer for sale of controlled substances and
shall at all times display on the homepage of its Internet site
a declaration of compliance in accordance with this section.

"(b) LICENSURE.—Each online pharmacy shall comply with the
requirements of State law concerning the licensure of pharmacies
in each State from which it, and in each State to which it, delivers,
distributes, or dispenses or offers to deliver, distribute, or dispense
controlled substances by means of the Internet, pursuant to
applicable licensure requirements, as determined by each such
State.

"(c) INTERNET PHARMACY SITE DISCLOSURE INFORMATION.—
Each online pharmacy shall post in a visible and clear manner
on the homepage of each Internet site it operates, or on a page
directly linked thereto in which the hyperlink is also visible and
clear on the homepage, the following information for each pharmacy
that delivers, distributes, or dispenses controlled substances pursu-
ant to orders made on, through, or on behalf of, that website:

"(1) The name and address of the pharmacy as it appears
on the pharmacy's Drug Enforcement Administration certificate
of registration.

"(2) The pharmacy's telephone number and email address.

"(3) The name, professional degree, and States of licensure
of the pharmacist-in-charge, and a telephone number at which
the pharmacist-in-charge can be contacted.

"(4) A list of the States in which the pharmacy is licensed
to dispense controlled substances.

"(5) A certification that the pharmacy is registered under
this part to deliver, distribute, or dispense by means of the
Internet controlled substances.
(6) The name, address, telephone number, professional degree, and States of licensure of any practitioner who has a contractual relationship to provide medical evaluations or issue prescriptions for controlled substances, through referrals from the website or at the request of the owner or operator of the website, or any employee or agent thereof.

(7) The following statement, unless revised by the Attorney General by regulation: This online pharmacy will only dispense a controlled substance to a person who has a valid prescription issued for a legitimate medical purpose based upon a medical relationship with a prescribing practitioner. This includes at least one prior in-person medical evaluation or medical evaluation via telemedicine in accordance with applicable requirements of section 309.

(d) Notification.—

(1) In General.—Thirty days prior to offering a controlled substance for sale, delivery, distribution, or dispensing, the online pharmacy shall notify the Attorney General, in such form and manner as the Attorney General shall determine, and the State boards of pharmacy in any States in which the online pharmacy offers to sell, deliver, distribute, or dispense controlled substances.

(2) Contents.—The notification required under paragraph (1) shall include—

(A) the information required to be posted on the online pharmacy’s Internet site under subsection (c) and shall notify the Attorney General and the applicable State boards of pharmacy, under penalty of perjury, that the information disclosed on its Internet site under subsection (c) is true and accurate;

(B) the online pharmacy’s Internet site address and a certification that the online pharmacy shall notify the Attorney General of any change in the address at least 30 days in advance; and

(C) the Drug Enforcement Administration registration numbers of any pharmacies and practitioners referred to in subsection (c), as applicable.

(3) Existing Online Pharmacies.—An online pharmacy that is already operational as of the effective date of this section, shall notify the Attorney General and applicable State boards of pharmacy in accordance with this subsection not later than 30 days after such date.

(e) Declaration of Compliance.—On and after the date on which it makes the notification under subsection (d), each online pharmacy shall display on the homepage of its Internet site, in such form as the Attorney General shall by regulation require, a declaration that it has made such notification to the Attorney General.

(f) Reports.—Any statement, declaration, notification, or disclosure required under this section shall be considered a report required to be kept under this part.

(g) Notice and Designations Concerning Indian Tribes.—

(1) In General.—For purposes of sections 102(52) and 512(c)(6)(B), the Secretary shall notify the Attorney General, at such times and in such manner as the Secretary and the Attorney General determine appropriate, of the Indian tribes or tribal organizations with which the Secretary has contracted
or compacted under the Indian Self-Determination and Education Assistance Act for the tribes or tribal organizations to provide pharmacy services.

"(2) DESIGNATIONS.—

"(A) IN GENERAL.—The Secretary may designate a practitioner described in subparagraph (B) as an Internet Eligible Controlled Substances Provider. Such designations shall be made only in cases where the Secretary has found that there is a legitimate need for the practitioner to be so designated because the population served by the practitioner is in a sufficiently remote location that access to medical services is limited.

"(B) PRACTITIONERS.—A practitioner described in this subparagraph is a practitioner who is an employee or contractor of the Indian Health Service, or is working for an Indian tribe or tribal organization under its contract or compact under the Indian Self-Determination and Education Assistance Act with the Indian Health Service.

"(h) SPECIAL REGISTRATION FOR TELEMEDICINE.—

"(1) IN GENERAL.—The Attorney General may issue to a practitioner a special registration to engage in the practice of telemedicine for purposes of section 102(54)(E) if the practitioner, upon application for such special registration—

"(A) demonstrates a legitimate need for the special registration; and

"(B) is registered under section 303(f) in the State in which the patient will be located when receiving the telemedicine treatment, unless the practitioner—

"(i) is exempted from such registration in all States under section 302(d); or

"(ii) is an employee or contractor of the Department of Veterans Affairs who is acting in the scope of such employment or contract and is registered under section 303(f) in any State or is utilizing the registration of a hospital or clinic operated by the Department of Veterans Affairs registered under section 303(f).

"(2) REGULATIONS.—The Attorney General shall, with the concurrence of the Secretary, promulgate regulations specifying the limited circumstances in which a special registration under this subsection may be issued and the procedures for obtaining such a special registration.

"(3) DENIALS.—Proceedings to deny an application for registration under this subsection shall be conducted in accordance with section 304(c).

"(i) REPORTING OF TELEMEDICINE BY VHA DURING MEDICAL EMERGENCY SITUATIONS.—

"(1) IN GENERAL.—Any practitioner issuing a prescription for a controlled substance under the authorization to conduct telemedicine during a medical emergency situation described in section 102(54)(F) shall report to the Secretary of Veterans Affairs the authorization of that emergency prescription, in accordance with such requirements as the Secretary of Veterans Affairs shall, by regulation, establish.

"(2) TO ATTORNEY GENERAL.—Not later than 30 days after the date that a prescription described in subparagraph (A) is issued, the Secretary of Veterans Affairs shall report to
the Attorney General the authorization of that emergency prescription.

(4) CLARIFICATION CONCERNING PRESCRIPTION TRANSFERS.—Any transfer between pharmacies of information relating to a prescription for a controlled substance shall meet the applicable requirements under regulations promulgated by the Attorney General under this Act.

(2) TECHNICAL AND CONFORMING AMENDMENTS.—The table of contents for the Comprehensive Drug Abuse Prevention and Control Act of 1970 (Public Law 91–513; 84 Stat. 1236) is amended by inserting after the item relating to section 310 the following:

“Sec. 311. Additional requirements relating to online pharmacies and telemedicine.”

(e) OFFENSES INVOLVING CONTROLLED SUBSTANCES IN SCHEDULES III, IV, AND V.—Section 401(b) of the Controlled Substances Act (21 U.S.C. 841(b)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (D), by striking “or in the case of any controlled substance in schedule III (other than gamma hydroxybutyric acid), or 30 milligrams of flunitrazepam”; and

(B) by adding at the end the following:

“(E)(i) Except as provided in subparagraphs (C) and (D), in the case of any controlled substance in schedule III, such person shall be sentenced to a term of imprisonment of not more than 10 years and if death or serious bodily injury results from the use of such substance shall be sentenced to a term of imprisonment of not more than 15 years, a fine not to exceed the greater of that authorized in accordance with the provisions of title 18, United States Code, or $500,000 if the defendant is an individual or $2,500,000 if the defendant is other than an individual, or both.

“(ii) If any person commits such a violation after a prior conviction for a felony drug offense has become final, such person shall be sentenced to a term of imprisonment of not more than 20 years and if death or serious bodily injury results from the use of such substance shall be sentenced to a term of imprisonment of not more than 30 years, a fine not to exceed the greater of twice that authorized in accordance with the provisions of title 18, United States Code, or $1,000,000 if the defendant is an individual or $5,000,000 if the defendant is other than an individual, or both.

“(iii) Any sentence imposing a term of imprisonment under this subparagraph shall, in the absence of such a prior conviction, impose a term of supervised release of at least 2 years in addition to such term of imprisonment and shall, if there was such a prior conviction, impose a term of supervised release of at least 4 years in addition to such term of imprisonment.”;

(2) in paragraph (2)—

(A) by striking “3 years” and inserting “5 years”;

(B) by striking “6 years” and inserting “10 years”;

(C) by striking “after one or more prior convictions” and all that follows through “have become final,” and inserting “after a prior conviction for a felony drug offense has become final,”; and

(3) in paragraph (3)—
(A) by striking "2 years" and inserting "4 years";
(B) by striking "after one or more convictions" and all that follows through "have become final," and inserting "after a prior conviction for a felony drug offense has become final;"; and
(C) by adding at the end the following "Any sentence imposing a term of imprisonment under this paragraph may, if there was a prior conviction, impose a term of supervised release of not more than 1 year, in addition to such term of imprisonment."

(f) OFFENSES INVOLVING DISPENSING OF CONTROLLED SUBSTANCES BY MEANS OF THE INTERNET.—Section 401 of the Controlled Substances Act (21 U.S.C. 841) is amended by adding at the end the following:

"(b) OFFENSES INVOLVING DISPENSING OF CONTROLLED SUBSTANCES BY MEANS OF THE INTERNET.—

"(1) IN GENERAL.—It shall be unlawful for any person to knowingly or intentionally—

"(A) deliver, distribute, or dispense a controlled substance by means of the Internet, except as authorized by this title; or

"(B) aid or abet (as such terms are used in section 2 of title 18, United States Code) any activity described in subparagraph (A) that is not authorized by this title.

"(2) EXAMPLES.—Examples of activities that violate paragraph (1) include, but are not limited to, knowingly or intentionally—

"(A) delivering, distributing, or dispensing a controlled substance by means of the Internet by an online pharmacy that is not validly registered with a modification authorizing such activity as required by section 303(f) (unless exempt from such registration);

"(B) writing a prescription for a controlled substance for the purpose of delivery, distribution, or dispensation by means of the Internet in violation of section 309(e);

"(C) serving as an agent, intermediary, or other entity that causes the Internet to be used to bring together a buyer and seller to engage in the dispensing of a controlled substance in a manner not authorized by sections 303(f) or 309(e);

"(D) offering to fill a prescription for a controlled substance based solely on a consumer's completion of an online medical questionnaire; and

"(E) making a material false, fictitious, or fraudulent statement or representation in a notification or declaration under subsection (d) or (e), respectively, of section 311.

"(3) INAPPLICABILITY.—

"(A) This subsection does not apply to—

"(i) the delivery, distribution, or dispensation of controlled substances by nonpractitioners to the extent authorized by their registration under this title;

"(ii) the placement on the Internet of material that merely advocates the use of a controlled substance or includes pricing information without attempting to propose or facilitate an actual transaction involving a controlled substance; or
"(iii) except as provided in subparagraph (B), any activity that is limited to—

"(I) the provision of a telecommunications service, or of an Internet access service or Internet information location tool (as those terms are defined in section 231 of the Communications Act of 1934); or

"(II) the transmission, storage, retrieval, hosting, formatting, or translation (or any combination thereof) of a communication, without selection or alteration of the content of the communication, except that deletion of a particular communication or material made by another person in a manner consistent with section 230(c) of the Communications Act of 1934 shall not constitute such selection or alteration of the content of the communication.

"(B) The exceptions under subclauses (I) and (II) of subparagraph (A)(iii) shall not apply to a person acting in concert with a person who violates paragraph (1).

"(4) KNOWING OR INTENTIONAL VIOLATION.—Any person who knowingly or intentionally violates this subsection shall be sentenced in accordance with subsection (b).

(g) PUBLICATION.—Section 403(c) of the Controlled Substances Act (21 U.S.C. 843(c)) is amended by—

(1) striking "(c)" and inserting "(c)(1)"; and

(2) adding at the end the following:

"(2)(A) It shall be unlawful for any person to knowingly or intentionally use the Internet, or cause the Internet to be used, to advertise the sale of, or to offer to sell, distribute, or dispense, a controlled substance where such sale, distribution, or dispensing is not authorized by this title or by the Controlled Substances Import and Export Act.

"(B) Examples of activities that violate subparagraph (A) include, but are not limited to, knowingly or intentionally causing the placement on the Internet of an advertisement that refers to or directs prospective buyers to Internet sellers of controlled substances who are not registered with a modification under section 303(f).

"(C) Subparagraph (A) does not apply to material that either—

"(i) merely advertises the distribution of controlled substances by nonpractitioners to the extent authorized by their registration under this title; or

"(ii) merely advocates the use of a controlled substance or includes pricing information without attempting to facilitate an actual transaction involving a controlled substance."

(h) INJUNCTIVE RELIEF.—Section 512 of the Controlled Substances Act (21 U.S.C. 882) is amended by adding at the end the following:

"(c) STATE CAUSE OF ACTION PERTAINING TO ONLINE PHARMACIES.—

"(1) IN GENERAL.—In any case in which the State has reason to believe that an interest of the residents of that State has been or is being threatened or adversely affected by the action of a person, entity, or Internet site that violates the provisions of section 303(f), 309(e), or 311, the State may
bring a civil action on behalf of such residents in a district court of the United States with appropriate jurisdiction—

"(A) to enjoin the conduct which violates this section;
"(B) to enforce compliance with this section;
"(C) to obtain damages, restitution, or other compensation, including civil penalties under section 402(b); and
"(D) to obtain such other legal or equitable relief as the court may find appropriate.

"(2) SERVICE; INTERVENTION.—

"(A) Prior to filing a complaint under paragraph (1), the State shall serve a copy of the complaint upon the Attorney General and upon the United States Attorney for the judicial district in which the complaint is to be filed. In any case where such prior service is not feasible, the State shall serve the complaint on the Attorney General and the appropriate United States Attorney on the same day that the State's complaint is filed in Federal district court of the United States. Such proceedings shall be independent of, and not in lieu of, criminal prosecutions or any other proceedings under this title or any other laws of the United States.

"(B) Upon receiving notice respecting a civil action pursuant to this section, the United States shall have the right to intervene in such action and, upon so intervening, to be heard on all matters arising therein, and to file petitions for appeal.

"(C) Service of a State's complaint on the United States as required in this paragraph shall be made in accord with the requirements of rule 4(i)(1) of the Federal Rule of Civil Procedure.

"(3) POWERS CONFERRED BY STATE LAW.—For purposes of bringing any civil action under paragraph (1), nothing in this Act shall prevent an attorney general of a State from exercising the powers conferred on the attorney general of a State by the laws of such State to conduct investigations or to administer oaths or affirmations or to compel the attendance of witnesses of or the production of documentary or other evidence.

"(4) VENUE.—Any civil action brought under paragraph (1) in a district court of the United States may be brought in the district in which the defendant is found, is an inhabitant, or transacts business or wherever venue is proper under section 1391 of title 28, United States Code. Process in such action may be served in any district in which the defendant is an inhabitant or in which the defendant may be found.

"(5) NO PRIVATE RIGHT OF ACTION.—No private right of action is created under this subsection.

"(6) LIMITATION.—No civil action may be brought under paragraph (1) against—

"(A) the United States;

"(B) an Indian Tribe or tribal organization, to the extent such tribe or tribal organization is lawfully carrying out a contract or compact under the Indian Self-Determination and Education Assistance Act; or

"(C) any employee of the United States or such Indian tribe or tribal organization, provided such agent or employee is acting in the usual course of business or
employment, and within the scope of the official duties of such agent or employee therewith."

(i) IMPORT AND EXPORT ACT.—Section 1010(b) of the Controlled Substances Import and Export Act (21 U.S.C. 960(b)) is amended—

(1) in paragraph (4)—

(A) by striking "or any quantity of a controlled substance in schedule III, IV, or V, (except a violation involving flunitrazepam and except a violation involving gamma hydroxybutyric acid)";

(B) by inserting "or" before "less than one kilogram of hashish oil"; and

(C) by striking "imprisoned" and all that follows through the end of the paragraph and inserting "sentenced in accordance with section 401(b)(1)(D)";

(2) by adding at the end the following:

"(5) In the case of a violation of subsection (a) involving a controlled substance in schedule III, such person shall be sentenced in accordance with section 401(b)(1).

(6) In the case of a violation of subsection (a) involving a controlled substance in schedule IV, such person shall be sentenced in accordance with section 401(b)(2).

(7) In the case of a violation of subsection (a) involving a controlled substance in schedule V, such person shall be sentenced in accordance with section 401(b)(3)."; and

(3) in paragraph (3), by striking ", nor shall a person so sentenced be eligible for parole during the term of such a sentence" in the final sentence.

(j) Effective Date.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this Act shall take effect 180 days after the date of enactment of this Act.

(2) DEFINITION OF PRACTICE OF TELEMEDICINE.—

(A) IN GENERAL.—Until the earlier of 3 months after the date on which regulations are promulgated to carry out section 311(h) of the Controlled Substances Act, as amended by this Act, or 15 months after the date of enactment of this Act—

(i) the definition of the term "practice of telemedicine" in subparagraph (B) of this paragraph shall apply for purposes of the Controlled Substances Act; and

(ii) the definition of the term "practice of telemedicine" in section 102(54) of the Controlled Substances Act, as amended by this Act, shall not apply.

(B) TEMPORARY PHASE-IN OF TELEMEDICINE REGULA-

TION.—During the period specified in subparagraph (A), the term "practice of telemedicine" means the practice of medicine in accordance with applicable Federal and State laws by a practitioner (as that term is defined in section 102 of the Controlled Substances Act (21 U.S.C. 802)) (other than a pharmacist) who is at a location remote from the patient and is communicating with the patient, or health care professional who is treating the patient, using a telecommunications system referred to in section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)), if the practitioner is using an interactive telecommunications system that satisfies the requirements of section 410.78(a)(3) of title 42, Code of Federal Regulations.
(C) RULE OF CONSTRUCTION.—Nothing in this subsection may be construed to create a precedent that any specific course of conduct constitutes the "practice of telemedicine" (as that term is defined in section 102(54) of the Controlled Substances Act, as amended by this Act) after the end of the period specified in subparagraph (A).

(k) GUIDELINES AND REGULATIONS.—

(1) IN GENERAL.—The Attorney General may promulgate and enforce any rules, regulations, and procedures which may be necessary and appropriate for the efficient execution of functions under this Act or the amendments made by this Act, and, with the concurrence of the Secretary of Health and Human Services where this Act or the amendments made by this Act so provide, promulgate any interim rules necessary for the implementation of this Act or the amendments made by this Act, prior to its effective date.

(2) SENTENCING GUIDELINES.—The United States Sentencing Commission, in determining whether to amend, or establish new, guidelines or policy statements, to conform the Federal sentencing guidelines and policy statements to this Act and the amendments made by this Act, should not construe any change in the maximum penalty for a violation involving a controlled substance in a particular schedule as being the sole reason to amend, or establish a new, guideline or policy statement.

(l) ANNUAL REPORT.—Not later than 180 days after the date of enactment of this Act, and annually for 2 years after the initial report, the Drug Enforcement Administration, in consultation with the Department of State, shall submit to Congress a report describing—

(1) the foreign supply chains and sources of controlled substances offered for sale without a valid prescription on the Internet;

(2) the efforts and strategy of the Drug Enforcement Administration to decrease the foreign supply chain and sources of controlled substances offered for sale without a valid prescription on the Internet; and

(3) the efforts of the Drug Enforcement Administration to work with domestic and multinational pharmaceutical companies and others to build international cooperation and a commitment to fight on a global scale the problem of distribution of controlled substances over the Internet without a valid prescription.
H. R. 6353—15

SEC. 4. RULE OF CONSTRUCTION.

Nothing in this Act or the amendments made by this Act shall be construed as authorizing, prohibiting, or limiting the use of electronic prescriptions for controlled substances.

Speaker of the House of Representatives.

Vice President of the United States and President of the Senate.
The 2017 Florida Statutes

Title XLV
TORTS

Chapter 766
MEDICAL MALPRACTICE AND RELATED MATTERS

766.103 Florida Medical Consent Law.—
(1) This section shall be known and cited as the “Florida Medical Consent Law.”
(2) In any medical treatment activity not covered by s. 768.13, entitled the “Good Samaritan Act,” this act shall govern.
(3) No recovery shall be allowed in any court in this state against any physician licensed under chapter 458, osteopathic physician licensed under chapter 459, chiropractic physician licensed under chapter 460, podiatric physician licensed under chapter 461, dentist licensed under chapter 466, advanced registered nurse practitioner certified under s. 464.012, or physician assistant licensed under s. 458.347 or s. 459.022 in an action brought for treating, examining, or operating on a patient without his or her informed consent when:
(a) The action of the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced registered nurse practitioner, or physician assistant in obtaining the consent of the patient or another person authorized to give consent for the patient was in accordance with an accepted standard of medical practice among members of the medical profession with similar training and experience in the same or similar medical community as that of the person treating, examining, or operating on the patient for whom the consent is obtained; and
2. A reasonable individual, from the information provided by the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced registered nurse practitioner, or physician assistant, under the circumstances, would have a general understanding of the procedure, the medically acceptable alternative procedures or treatments, and the substantial risks and hazards inherent in the proposed treatment or procedures, which are recognized among other physicians, osteopathic physicians, chiropractic physicians, podiatric physicians, or dentists in the same or similar community who perform similar treatments or procedures; or
(b) The patient would reasonably, under all the surrounding circumstances, have undergone such treatment or procedure had he or she been advised by the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced registered nurse practitioner, or physician assistant in accordance with the provisions of paragraph (a).
(4)(a) A consent which is evidenced in writing and meets the requirements of subsection (3) shall, if validly signed by the patient or another authorized person, raise a rebuttable presumption of a valid consent.
(b) A valid signature is one which is given by a person who under all the surrounding circumstances is mentally and physically competent to give consent.

History.—s. 11, ch. 75-9; s. 21, ch. 83-175; s. 1150, ch. 97-102; s. 62, ch. 97-264; ss. 230, 297, ch. 98-166; s. 2, ch. 2007-176; s. 11, ch. 2016-145.

Note.—Former s. 768.132; s. 768.46.
Tab 4 – Legislation Discussion

- ATA Model State Bill Components
- Minnesota Telehealth Law
- Hawaii Telehealth Law
- Delaware Telehealth Law
- Florida Senate Bill 280 - 2018
ATA MODEL STATE BILL COMPONENTS

Telemedicine for Quality Improvement and Healthcare Modernization Act
A bill to expand patient access to healthcare services, improve quality of care and reduce costs through the use of telemedicine.

PREAMBLE: Telemedicine can efficiently improve access and quality of care for underserved patients by providing consultations and specialty care. Remote monitoring and home telehealth can help the chronically ill stay at home and out of hospitals and emergency rooms, dramatically reducing costs. Today, more and more people are taking advantage of telemedicine and e-health opportunities. But such services are not available for everyone and action is needed in the states to assure that all Americans receive the benefits available through telemedicine.

DEFINITION: “Telemedicine” or “Telehealth” means health care services provided through telecommunications to a patient from a provider who is at a remote location.

PRIVATE COVERAGE: Health insurers, health care subscription plans, health maintenance organizations, disability insurance programs, workers’ compensation programs, and all state employee health plans shall provide coverage for the cost of telemedicine services when the services are appropriately provided through such means.

The requirements of the bill shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

UTILIZATION REVIEW: Decisions denying coverage of services provided via telemedicine shall be subject to utilization review procedures.

MEDICAID: The state’s Medicaid plan shall not deny coverage on the basis that coverage is provided through telemedicine if the health care service would be covered were it provided through in-person consultation between the recipient and a health care provider. Coverage for health care services provided through telemedicine must be determined in a manner consistent with coverage for health care services provided through in-person consultation. Specifically coverage must be statewide coverage and include services originating from a recipients home or wherever else they may be, all health professionals authorized to provide services by a telehealth method to the extent otherwise covered in the Medicaid State Plan, and timely asynchronous telehealth services.

REPORTING: The state’s Department of Health shall lead an interagency study and report to the Legislature within 12 months on comprehensive plans that include telehealth services and multi-payer coverage and reimbursement for stroke diagnosis, high-risk pregnancies and premature births, and emergency services.
PROFESSIONAL LICENSING: “Healthcare provider or professional” shall have the same meaning under current statute.

The state’s health professional licensing boards shall maintain consistent licensure and standards of care requirements between in-person and telemedicine-provided practices with the following exemptions:

(a) A health professional licensed, certified, or registered in another jurisdiction shall be able to consult with a licensed peer health professional in this state, such as a sub-specialist, without the need for an additional license issued by this State, and

(b) A health professional licensed, certified, or registered in another jurisdiction and temporarily located in this state shall be able to consult with established patients from his/her home jurisdiction using telecommunications without the need for an additional license issued by this State.

PROFESSIONAL STANDARDS OF PRACTICE: A healthcare provider who delivers services through the use of telehealth shall be held to the same standard of professional practice as a similar licensee of the same practice area or specialty that is providing the same healthcare services through in-person encounters, and nothing in this section is intended to create any new standards of care.

The board or licensing entity governing any healthcare provider covered by this section shall not establish a more restrictive standard of professional practice for the practice of telehealth than that specifically authorized by the provider's practice act or other specifically applicable statute, including prescribing and dispensing controlled substances.
256B.0625 COVERED SERVICES.

Subdivision 1. Inpatient hospital services. (a) Medical assistance covers inpatient hospital services. A second medical opinion is required prior to reimbursement for elective surgeries requiring a second opinion. The commissioner shall publish in the State Register a list of elective surgeries that require a second medical opinion prior to reimbursement, and the criteria and standards for deciding whether an elective surgery should require a second medical opinion. The list and the criteria and standards are not subject to the requirements of sections 14.001 to 14.69. The commissioner's decision whether a second medical opinion is required, made in accordance with rules governing that decision, is not subject to administrative appeal.

(b) When determining medical necessity for inpatient hospital services, the medical review agent shall follow industry standard medical necessity criteria in determining the following:

1. whether a recipient's admission is medically necessary;
2. whether the inpatient hospital services provided to the recipient were medically necessary;
3. whether the recipient's continued stay was or will be medically necessary; and
4. whether all medically necessary inpatient hospital services were provided to the recipient.

The medical review agent will determine medical necessity of inpatient hospital services, including inpatient psychiatric treatment, based on a review of the patient's medical condition and records, in conjunction with industry standard evidence-based criteria to ensure consistent and optimal application of medical appropriateness criteria.

Subd. 1a. Services provided in a hospital emergency room. Medical assistance does not cover visits to a hospital emergency room that are not for emergency and emergency poststabilization care or urgent care, and does not pay for any services provided in a hospital emergency room that are not for emergency and emergency poststabilization care or urgent care.

Subd. 2. Skilled and intermediate nursing care. (a) Medical assistance covers skilled nursing home services and services of intermediate care facilities, including training and habilitation services, as defined in section 252.41, subdivision 3, for persons with developmental disabilities who are residing in intermediate care facilities for persons with developmental disabilities. Medical assistance must not be used to pay the costs of nursing care provided to a patient in a swing bed as defined in section 144.562, unless (1) the facility in which the swing bed is located is eligible as a sole community provider, as defined in Code of Federal Regulations, title 42, section 412.92, or the facility is a public hospital owned by a governmental entity with 15 or fewer licensed acute care beds; (2) the Centers for Medicare and Medicaid Services approves the necessary state plan amendments; (3) the patient was screened as provided by law; (4) the patient no longer requires acute care services; and (5) no nursing home beds are available within 25 miles of the facility. The commissioner shall exempt a facility from compliance with the sole community provider requirement in clause (1) if, as of January 1, 2004, the facility had an agreement with the commissioner to provide medical assistance swing bed services.

(b) Medical assistance also covers up to ten days of nursing care provided to a patient in a swing bed if: (1) the patient's physician certifies that the patient has a terminal illness or condition that is likely to result in death within 30 days and that moving the patient would not be in the best interests of the patient and patient's family; (2) no open nursing home beds are available within 25 miles of the facility; and (3) no open beds are available in any Medicare hospice program within 50 miles of the facility. The daily medical assistance payment for nursing care for the patient in the swing bed is the statewide average medical assistance skilled nursing care per diem as computed annually by the commissioner on July 1 of each year.
Subd. 2a. Skilled nursing facility and hospice services for dual eligibles. Medical assistance covers skilled nursing facility services for individuals eligible for both medical assistance and Medicare who have waived the Medicare skilled nursing facility room and board benefit and have enrolled in the Medicare hospice program. Medical assistance covers skilled nursing facility services regardless of whether an individual enrolled in the Medicare hospice program prior to, on, or after the date of the hospitalization that qualified the individual for Medicare skilled nursing facility services.

Subd. 3. Physicians' services. (a) Medical assistance covers physicians' services.

(b) Rates paid for anesthesiology services provided by physicians shall be according to the formula utilized in the Medicare program and shall use a conversion factor "at percentile of calendar year set by legislature," except that rates paid to physicians for the medical direction of a certified registered nurse anesthetist shall be the same as the rate paid to the certified registered nurse anesthetist under medical direction.

(c) Medical assistance does not cover physicians' services related to the provision of care related to a treatment reportable under section 144.7065, subdivision 2, clauses (1), (2), (3), and (5), and subdivision 7, clause (1).

(d) Medical assistance does not cover physicians' services related to the provision of care (1) for which hospital reimbursement is prohibited under section 256.969, subdivision 3b, paragraph (c), or (2) reportable under section 144.7065, subdivisions 2 to 7, if the physicians' services are billed by a physician who delivered care that contributed to or caused the adverse health care event or hospital-acquired condition.

(e) The payment limitations in this subdivision shall also apply to MinnesotaCare.

(f) A physician shall not bill a recipient of services for any payment disallowed under this subdivision.

Subd. 3a. Sex reassignment surgery. Sex reassignment surgery is not covered.

Subd. 3b. Telemedicine services. (a) Medical assistance covers medically necessary services and consultations delivered by a licensed health care provider via telemedicine in the same manner as if the service or consultation was delivered in person. Coverage is limited to three telemedicine services per enrollee per calendar week. Telemedicine services shall be paid at the full allowable rate.

(b) The commissioner shall establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service via telemedicine. The attestation may include that the health care provider:

(1) has identified the categories or types of services the health care provider will provide via telemedicine;

(2) has written policies and procedures specific to telemedicine services that are regularly reviewed and updated;

(3) has policies and procedures that adequately address patient safety before, during, and after the telemedicine service is rendered;

(4) has established protocols addressing how and when to discontinue telemedicine services; and

(5) has an established quality assurance process related to telemedicine services.

(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service provided by telemedicine to a medical assistance enrollee. Health care service records for
services provided by telemedicine must meet the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

1. the type of service provided by telemedicine;
2. the time the service began and the time the service ended, including an a.m. and p.m. designation;
3. the licensed health care provider's basis for determining that telemedicine is an appropriate and effective means for delivering the service to the enrollee;
4. the mode of transmission of the telemedicine service and records evidencing that a particular mode of transmission was utilized;
5. the location of the originating site and the distant site;
6. if the claim for payment is based on a physician's telemedicine consultation with another physician, the written opinion from the consulting physician providing the telemedicine consultation; and
7. compliance with the criteria attested to by the health care provider in accordance with paragraph (b).

(d) For purposes of this subdivision, unless otherwise covered under this chapter, "telemedicine" is defined as the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers, or a licensed health care provider and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

(e) For purposes of this section, "licensed health care provider" means a licensed health care provider under section 62A.671, subdivision 6, and a mental health practitioner defined under section 245.462, subdivision 17, or 245.4871, subdivision 26, working under the general supervision of a mental health professional; "health care provider" is defined under section 62A.671, subdivision 3; and "originating site" is defined under section 62A.671, subdivision 7.

Subd. 3c. Health Services Policy Committee. (a) The commissioner, after receiving recommendations from professional physician associations, professional associations representing licensed nonphysician health care professionals, and consumer groups, shall establish a 13-member Health Services Policy Committee, which consists of 12 voting members and one nonvoting member. The Health Services Policy Committee shall advise the commissioner regarding health services pertaining to the administration of health care benefits covered under the medical assistance and MinnesotaCare programs. The Health Services Policy Committee shall meet at least quarterly. The Health Services Policy Committee shall annually elect a physician chair from among its members, who shall work directly with the commissioner's medical director, to establish the agenda for each meeting. The Health Services Policy Committee shall also recommend criteria for verifying centers of excellence for specific aspects of medical care where a specific set of combined services, a volume of patients necessary to maintain a high level of competency, or a specific level of technical capacity is associated with improved health outcomes.

(b) The commissioner shall establish a dental subcommittee to operate under the Health Services Policy Committee. The dental subcommittee consists of general dentists, dental specialists, safety net providers, dental hygienists, health plan company and county and public health representatives, health researchers,
consumers, and a designee of the commissioner of health. The dental subcommittee shall advise the commissioner regarding:

1. the critical access dental program under section 256B.76, subdivision 4, including but not limited to criteria for designating and terminating critical access dental providers;
2. any changes to the critical access dental provider program necessary to comply with program expenditure limits;
3. dental coverage policy based on evidence, quality, continuity of care, and best practices;
4. the development of dental delivery models; and
5. dental services to be added or eliminated from subdivision 9, paragraph (b).

(c) The Health Services Policy Committee shall study approaches to making provider reimbursement under the medical assistance and MinnesotaCare programs contingent on patient participation in a patient-centered decision-making process, and shall evaluate the impact of these approaches on health care quality, patient satisfaction, and health care costs. The committee shall present findings and recommendations to the commissioner and the legislative committees with jurisdiction over health care by January 15, 2010.

(d) The Health Services Policy Committee shall monitor and track the practice patterns of physicians providing services to medical assistance and MinnesotaCare enrollees under fee-for-service, managed care, and county-based purchasing. The committee shall focus on services or specialties for which there is a high variation in utilization across physicians, or which are associated with high medical costs. The commissioner, based upon the findings of the committee, shall regularly notify physicians whose practice patterns indicate higher than average utilization or costs. Managed care and county-based purchasing plans shall provide the commissioner with utilization and cost data necessary to implement this paragraph, and the commissioner shall make this data available to the committee.

(e) The Health Services Policy Committee shall review caesarean section rates for the fee-for-service medical assistance population. The committee may develop best practices policies related to the minimization of caesarean sections, including but not limited to standards and guidelines for health care providers and health care facilities.

Subd. 3d. Health Services Policy Committee members. The Health Services Policy Committee consists of:

1. seven voting members who are licensed physicians actively engaged in the practice of medicine in Minnesota, one of whom must be actively engaged in the treatment of persons with mental illness, and three of whom must represent health plans currently under contract to serve medical assistance recipients;
2. two voting members who are physician specialists actively practicing their specialty in Minnesota;
3. two voting members who are nonphysician health care professionals licensed or registered in their profession and actively engaged in their practice of their profession in Minnesota;
4. one consumer who shall serve as a voting member; and
5. the commissioner's medical director who shall serve as a nonvoting member.

Members of the Health Services Policy Committee shall not be employed by the Department of Human Services, except for the medical director.
Subd. 3e. **Health Services Policy Committee terms and compensation.** Committee members shall serve staggered three-year terms, with one-third of the voting members' terms expiring annually. Members may be reappointed by the commissioner. The commissioner may require more frequent Health Services Policy Committee meetings as needed. An honorarium of $200 per meeting and reimbursement for mileage and parking shall be paid to each committee member in attendance except the medical director. The Health Services Policy Committee does not expire as provided in section 15.059, subdivision 6.

Subd. 3f. **Circumcision.** Circumcision is not covered, unless the procedure is medically necessary.

Subd. 3g. **Evidence-based childbirth program.** (a) The commissioner shall implement a program to reduce the number of elective inductions of labor prior to 39 weeks' gestation. In this subdivision, the term "elective induction of labor" means the use of artificial means to stimulate labor in a woman without the presence of a medical condition affecting the woman or the child that makes the onset of labor a medical necessity. The program must promote the implementation of policies within hospitals providing services to recipients of medical assistance or MinnesotaCare that prohibit the use of elective inductions prior to 39 weeks' gestation, and adherence to such policies by the attending providers.

(b) For all births covered by medical assistance or MinnesotaCare on or after January 1, 2012, a payment for professional services associated with the delivery of a child in a hospital must not be made unless the provider has submitted information about the nature of the labor and delivery including any induction of labor that was performed in conjunction with that specific birth. The information must be on a form prescribed by the commissioner.

(c) The requirements in paragraph (b) must not apply to deliveries performed at a hospital that has policies and processes in place that have been approved by the commissioner which prohibit elective inductions prior to 39 weeks' gestation. A process for review of hospital induction policies must be established by the commissioner and review of policies must occur at the discretion of the commissioner. The commissioner's decision to approve or rescind approval must include verification and review of items including, but not limited to:

(1) policies that prohibit use of elective inductions for gestation less than 39 weeks;

(2) policies that encourage providers to document and communicate with patients a final expected date of delivery by 20 weeks' gestation that includes data from ultrasound measurements as applicable;

(3) policies that encourage patient education regarding elective inductions, and requires documentation of the processes used to educate patients;

(4) ongoing quality improvement review as determined by the commissioner; and

(5) any data that has been collected by the commissioner.

(d) All hospitals must report annually to the commissioner induction information for all births that were covered by medical assistance or MinnesotaCare in a format and manner to be established by the commissioner.

(e) The commissioner at any time may choose not to implement or may discontinue any or all aspects of the program if the commissioner is able to determine that hospitals representing at least 90 percent of births covered by medical assistance or MinnesotaCare have approved policies in place.

(f) The commissioner of human services may discontinue the evidence-based childbirth program and shall discontinue all affiliated reporting requirements established under this subdivision once the commissioner
determines that hospitals representing at least 90 percent of births covered by medical assistance or
MinnesotaCare have approved policies and processes in place that prohibit elective inductions prior to 39
weeks’ gestation.

Subd. 4. **Outpatient and physician-directed clinic services.** Medical assistance covers outpatient
hospital or physician-directed clinic services. The physician-directed clinic staff shall include at least two
physicians and all services shall be provided under the direct supervision of a physician. Hospital outpatient
departments are subject to the same limitations and reimbursements as other enrolled vendors for all services,
except initial triage, emergency services, and services not provided or immediately available in clinics,
physicians' offices, or by other enrolled providers. "Emergency services" means those medical services
required for the immediate diagnosis and treatment of medical conditions that, if not immediately diagnosed
and treated, could lead to serious physical or mental disability or death or are necessary to alleviate severe
pain. Neither the hospital, its employees, nor any physician or dentist, shall be liable in any action arising
out of a determination not to render emergency services or care if reasonable care is exercised in determining
the condition of the person, or in determining the appropriateness of the facilities, or the qualifications and
availability of personnel to render these services consistent with this section.

Subd. 4a. **Second medical opinion for surgery.** Certain surgeries require a second medical opinion to
confirm the necessity of the procedure, in order for reimbursement to be made. The commissioner shall
publish in the State Register a list of surgeries that require a second medical opinion and the criteria and
standards for deciding whether a surgery should require a second medical opinion. The list and the criteria
and standards are not subject to the requirements of sections 14.01 to 14.69. The commissioner's decision
about whether a second medical opinion is required, made according to rules governing that decision, is not
subject to administrative appeal.

Subd. 5. **Community mental health center services.** Medical assistance covers community mental
health center services provided by a community mental health center that meets the requirements in paragraphs
(a) to (j).

(a) The provider is licensed under Minnesota Rules, parts 9520.0750 to 9520.0870.

(b) The provider provides mental health services under the clinical supervision of a mental health
professional who is licensed for independent practice at the doctoral level or by a board-certified psychiatrist
or a psychiatrist who is eligible for board certification. Clinical supervision has the meaning given in
Minnesota Rules, part 9505.0370, subpart 6.

(c) The provider must be a private nonprofit corporation or a governmental agency and have a community
board of directors as specified by section 245.66.

(d) The provider must have a sliding fee scale that meets the requirements in section 245.481, and agree
to serve within the limits of its capacity all individuals residing in its service delivery area.

(e) At a minimum, the provider must provide the following outpatient mental health services: diagnostic
assessment; explanation of findings; family, group, and individual psychotherapy, including crisis intervention
psychotherapy services, multiple family group psychotherapy, psychological testing, and medication
management. In addition, the provider must provide or be capable of providing upon request of the local
mental health authority day treatment services and professional home-based mental health services. The
provider must have the capacity to provide such services to specialized populations such as the elderly,
families with children, persons who are seriously and persistently mentally ill, and children who are seriously
emotionally disturbed.
(f) The provider must be capable of providing the services specified in paragraph (e) to individuals who are diagnosed with both mental illness or emotional disturbance, and chemical dependency, and to individuals dually diagnosed with a mental illness or emotional disturbance and developmental disability.

(g) The provider must provide 24-hour emergency care services or demonstrate the capacity to assist recipients in need of such services to access such services on a 24-hour basis.

(h) The provider must have a contract with the local mental health authority to provide one or more of the services specified in paragraph (e).

(i) The provider must agree, upon request of the local mental health authority, to enter into a contract with the county to provide mental health services not reimbursable under the medical assistance program.

(j) The provider may not be enrolled with the medical assistance program as both a hospital and a community mental health center. The community mental health center's administrative, organizational, and financial structure must be separate and distinct from that of the hospital.

Subd. 5a. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5b. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5c. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5d. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5e. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5f. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5g. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5h. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5i. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5j. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5k. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5l. **Intensive mental health outpatient treatment.** Medical assistance covers intensive mental health outpatient treatment for dialectical behavioral therapy for adults. The commissioner shall establish:

(1) certification procedures to ensure that providers of these services are qualified; and

(2) treatment protocols including required service components and criteria for admission, continued treatment, and discharge.

Subd. 6. [Repealed, 1991 c 292 art 7 s 26]

Subd. 6a. **Home health services.** Home health services are those services specified in Minnesota Rules, part 9505.0295 and sections 256B.0651 and 256B.0653. Medical assistance covers home health services at a recipient's home residence or in the community where normal life activities take the recipient. Medical assistance does not cover home health services for residents of a hospital, nursing facility, or intermediate care facility, unless the commissioner of human services has authorized skilled nurse visits for less than 90 days for a resident at an intermediate care facility for persons with developmental disabilities, to prevent an
admission to a hospital or nursing facility or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the home health services or forgoes the facility per diem for the leave days that home health services are used. Home health services must be provided by a Medicare certified home health agency. All nursing and home health aide services must be provided according to sections 256B.0651 to 256B.0653.

Subd. 7. **Home care nursing.** Medical assistance covers home care nursing services in a recipient’s home. Recipients who are authorized to receive home care nursing services in their home may use approved hours outside of the home during hours when normal life activities take them outside of their home. To use home care nursing services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school. Medical assistance does not cover home care nursing services for residents of a hospital, nursing facility, intermediate care facility, or a health care facility licensed by the commissioner of health, unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the home care nursing services or forgoes the facility per diem for the leave days that home care nursing services are used. Total hours of service and payment allowed for services outside the home cannot exceed that which is otherwise allowed in an in-home setting according to sections 256B.0651 and 256B.0654. All home care nursing services must be provided according to the limits established under sections 256B.0651, 256B.0653, and 256B.0654. Home care nursing services may not be reimbursed if the nurse is the family foster care provider of a recipient who is under age 18, unless allowed under section 256B.0654, subdivision 4.

Subd. 8. **Physical therapy.** (a) Medical assistance covers physical therapy and related services. Specialized maintenance therapy is covered for recipients age 20 and under.

(b) Services provided by a physical therapy assistant shall be reimbursed at the same rate as services performed by a physical therapist when the services of the physical therapy assistant are provided under the direction of a physical therapist who is on the premises. Services provided by a physical therapy assistant that are provided under the direction of a physical therapist who is not on the premises shall be reimbursed at 65 percent of the physical therapist rate.

Subd. 8a. **Occupational therapy.** (a) Medical assistance covers occupational therapy and related services. Specialized maintenance therapy is covered for recipients age 20 and under.

(b) Services provided by an occupational therapy assistant shall be reimbursed at the same rate as services performed by an occupational therapist when the services of the occupational therapy assistant are provided under the direction of the occupational therapist who is on the premises. Services provided by an occupational therapy assistant that are provided under the direction of an occupational therapist who is not on the premises shall be reimbursed at 65 percent of the occupational therapist rate.

Subd. 8b. **Speech-language pathology and audiology services.** (a) Medical assistance covers speech-language pathology and related services. Specialized maintenance therapy is covered for recipients age 20 and under.

(b) Medical assistance covers audiology services and related services. Services provided by a person who has been issued a temporary registration under section 148.5161 shall be reimbursed at the same rate as services performed by a speech-language pathologist or audiologist as long as the requirements of section 148.5161, subdivision 3, are met.

Subd. 8c. **Care management; rehabilitation services.** (a) A care management approach for authorization of rehabilitation services described in subdivisions 8, 8a, and 8b shall be instituted. The care management approach shall require the provider and the department rehabilitation reviewer to work together directly
through written communication, or telephone communication when appropriate, to establish a medically
necessary care management plan. Authorization for rehabilitation services shall include approval for up to
six months of services at a time without additional documentation from the provider during the extended
period, when the rehabilitation services are medically necessary due to an ongoing health condition.

(b) The commissioner shall implement an expedited five-day turnaround time to review authorization
requests for recipients who need emergency rehabilitation services.

Subd. 8d. Home infusion therapy services. Home infusion therapy services provided by home infusion
therapy pharmacies must be paid the lower of the submitted charge or the combined payment rates for
component services typically provided.

Subd. 8e. Chiropractic services. Payment for chiropractic services is limited to one annual evaluation
and 24 visits per year unless prior authorization of a greater number of visits is obtained.

Subd. 8f. Acupuncture services. Medical assistance covers acupuncture, as defined in section 147B.01,
subdivision 3, only when provided by a licensed acupuncturist or by another Minnesota licensed practitioner
for whom acupuncture is within the practitioner's scope of practice and who has specific acupuncture training
or credentialing.

Subd. 9. Dental services. (a) Medical assistance covers dental services.

(b) Medical assistance dental coverage for nonpregnant adults is limited to the following services:

1. comprehensive exams, limited to once every five years;
2. periodic exams, limited to one per year;
3. limited exams;
4. bitewing x-rays, limited to one per year;
5. periapical x-rays;
6. panoramic x-rays, limited to one every five years except (1) when medically necessary for the
diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once every two years for
patients who cannot cooperate for intraoral film due to a developmental disability or medical condition that
does not allow for intraoral film placement;
7. prophylaxis, limited to one per year;
8. application of fluoride varnish, limited to one per year;
9. posterior fillings, all at the amalgam rate;
10. anterior fillings;
11. endodontics, limited to root canals on the anterior and premolars only;
12. removable prostheses, each dental arch limited to one every six years;
13. oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;
14. palliative treatment and sedative fillings for relief of pain; and
15. full-mouth debridement, limited to one every five years.
(c) In addition to the services specified in paragraph (b), medical assistance covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:

1. periodontics, limited to periodontal scaling and root planing once every two years;
2. general anesthesia; and
3. full-mouth survey once every five years.

(d) Medical assistance covers medically necessary dental services for children and pregnant women. The following guidelines apply:

1. posterior fillings are paid at the amalgam rate;
2. application of sealants are covered once every five years per permanent molar for children only;
3. application of fluoride varnish is covered once every six months; and
4. orthodontia is eligible for coverage for children only.

(e) In addition to the services specified in paragraphs (b) and (c), medical assistance covers the following services for adults:

1. house calls or extended care facility calls for on-site delivery of covered services;
2. behavioral management when additional staff time is required to accommodate behavioral challenges and sedation is not used;
3. oral or IV sedation, if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center; and
4. prophylaxis, in accordance with an appropriate individualized treatment plan, but no more than four times per year.

(f) The commissioner shall not require prior authorization for the services included in paragraph (e), clauses (1) to (3), and shall prohibit managed care and county-based purchasing plans from requiring prior authorization for the services included in paragraph (e), clauses (1) to (3), when provided under sections 256B.69, 256B.692, and 256L.12.

Subd. 9a. Volunteer dental services. (a) A dentist not already enrolled as a medical assistance provider who is providing volunteer dental services for an enrolled medical assistance dental provider that is a nonprofit entity or government owned and not receiving payment for the services provided shall complete and submit a volunteer agreement form developed by the commissioner. The volunteer agreement shall be used to enroll the dentist in medical assistance only for the purpose of providing volunteer dental services. The volunteer agreement must specify that a volunteer dentist:

1. will not be listed in the Minnesota health care programs provider directory;
2. will not receive payment for the services the volunteer dentist provides to Minnesota health care program clients; and
3. is not required to serve Minnesota health care program clients when providing nonvolunteer services in a private practice.
(b) A volunteer dentist enrolled under this subdivision as a fee-for-service provider shall not otherwise be enrolled in or receive payments from Minnesota health care programs as a fee-for-service provider.

(c) The volunteer dentist shall be notified by the dental provider for which they are providing services that medical assistance is being billed for the volunteer services provided.

Subd. 9b. Dental services provided by faculty members and resident dentists at a dental school. (a) A dentist who is not enrolled as a medical assistance provider, is a faculty or adjunct member at the University of Minnesota or a resident dentist licensed under section 150A.06, subdivision 1b, and is providing dental services at a dental clinic owned or operated by the University of Minnesota, may be enrolled as a medical assistance provider if the provider completes and submits to the commissioner an agreement form developed by the commissioner. The agreement must specify that the faculty or adjunct member or resident dentist:

(1) will not receive payment for the services provided to medical assistance or MinnesotaCare enrollees performed at the dental clinics owned or operated by the University of Minnesota;

(2) will not be listed in the medical assistance or MinnesotaCare provider directory; and

(3) is not required to serve medical assistance and MinnesotaCare enrollees when providing nonvolunteer services in a private practice.

(b) A dentist or resident dentist enrolled under this subdivision as a fee-for-service provider shall not otherwise be enrolled in or receive payments from medical assistance or MinnesotaCare as a fee-for-service provider.

Subd. 10. Laboratory and x-ray services. Medical assistance covers laboratory and x-ray services.

Subd. 11. Nurse anesthetist services. Medical assistance covers nurse anesthetist services. Rates paid for anesthesiology services provided by a certified registered nurse anesthetist under the direction of a physician shall be according to the formula utilized in the Medicare program and shall use the conversion factor that is used by the Medicare program. Rates paid for anesthesiology services provided by a certified registered nurse anesthetist who is not directed by a physician shall be the same rate as paid under subdivision 3, paragraph (b).

Subd. 12. Eyeglasses, dentures, and prosthetic devices. Medical assistance covers eyeglasses, dentures, and prosthetic devices if prescribed by a licensed practitioner.

Subd. 13. Drugs. (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician, physician assistant, or a nurse practitioner employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

(b) The dispensed quantity of a prescription drug must not exceed a 34-day supply, unless authorized by the commissioner.

(c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical ingredient" is defined as a substance that is represented for use in a drug and when used in the manufacturing, processing, or packaging of a drug becomes an active ingredient of the drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and excipients which are included in the medical assistance formulary. Medical assistance covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions.
when the compounded combination is specifically approved by the commissioner or when a commercially available product:

(1) is not a therapeutic option for the patient;

(2) does not exist in the same combination of active ingredients in the same strengths as the compounded prescription; and

(3) cannot be used in place of the active pharmaceutical ingredient in the compounded prescription.

(d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the formulary committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals. Over-the-counter medications must be dispensed in a quantity that is the lowest of: (1) the number of dosage units contained in the manufacturer's original package; (2) the number of dosage units required to complete the patient's course of therapy; or (3) if applicable, the number of dosage units dispensed from a system using retrospective billing, as provided under subdivision 13e, paragraph (b).

(e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

(f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B covered entities and ambulatory pharmacies under common ownership of the 340B covered entity. Medical assistance does not cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

[See Note.]

Subd. 13a. [Repealed, 2007 c 133 art 2 s 13]

Subd. 13b. [Repealed, 1997 c 203 art 4 s 73]

Subd. 13c. Formulary Committee. The commissioner, after receiving recommendations from professional medical associations and professional pharmacy associations, and consumer groups shall designate a Formulary Committee to carry out duties as described in subdivisions 13 to 13g. The Formulary Committee shall be comprised of four licensed physicians actively engaged in the practice of medicine in Minnesota one of whom must be actively engaged in the treatment of persons with mental illness; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; and one consumer
representative; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the Formulary Committee shall not be employed by the Department of Human Services, but the committee shall be staffed by an employee of the department who shall serve as an ex officio, nonvoting member of the committee. The department's medical director shall also serve as an ex officio, nonvoting member for the committee. Committee members shall serve three-year terms and may be reappointed by the commissioner. The Formulary Committee shall meet at least twice per year. The commissioner may require more frequent Formulary Committee meetings as needed. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance. The Formulary Committee expires June 30, 2018.

Subd. 13d. Drug formulary. (a) The commissioner shall establish a drug formulary. Its establishment and publication shall not be subject to the requirements of the Administrative Procedure Act, but the Formulary Committee shall review and comment on the formulary contents.

(b) The formulary shall not include:

(1) drugs, active pharmaceutical ingredients, or products for which there is no federal funding;
(2) over-the-counter drugs, except as provided in subdivision 13;
(3) drugs or active pharmaceutical ingredients used for weight loss, except that medically necessary lipase inhibitors may be covered for a recipient with type II diabetes;
(4) drugs or active pharmaceutical ingredients when used for the treatment of impotence or erectile dysfunction;
(5) drugs or active pharmaceutical ingredients for which medical value has not been established;
(6) drugs from manufacturers who have not signed a rebate agreement with the Department of Health and Human Services pursuant to section 1927 of title XIX of the Social Security Act; and
(7) medical cannabis as defined in section 152.22, subdivision 6.

(c) If a single-source drug used by at least two percent of the fee-for-service medical assistance recipients is removed from the formulary due to the failure of the manufacturer to sign a rebate agreement with the Department of Health and Human Services, the commissioner shall notify prescribing practitioners within 30 days of receiving notification from the Centers for Medicare and Medicaid Services (CMS) that a rebate agreement was not signed.

Subd. 13e. Payment rates. (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs or the maximum allowable cost by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65 for legend prescription drugs, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. The pharmacy dispensing fee for over-the-counter drugs shall be $3.65, except that the fee shall be $1.31 for retrospectively billing pharmacies when billing for quantities less than the number of units contained in the manufacturer's original package. Actual acquisition cost includes
quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner at wholesale acquisition cost plus four percent for independently owned pharmacies located in a designated rural area within Minnesota, and at wholesale acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently owned" if it is one of four or fewer pharmacies under the same ownership nationally. A "designated rural area" means an area defined as a small rural area or isolated rural area according to the four-category classification of the Rural Urban Commuting Area system developed for the United States Health Resources and Services Administration. Effective January 1, 2014, the actual acquisition cost of a drug acquired through the federal 340B Drug Pricing Program shall be estimated by the commissioner at wholesale acquisition cost minus 40 percent. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) Pharmacies dispensing prescriptions to residents of long-term care facilities using an automated drug distribution system meeting the requirements of section 151.58, or a packaging system meeting the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ retrospective billing for prescription drugs dispensed to long-term care facility residents. A retrospectively billing pharmacy must submit a claim only for the quantity of medication used by the enrolled recipient during the defined billing period. A retrospectively billing pharmacy must use a billing period not less than one calendar month or 30 days.

(c) An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. A pharmacy provider using packaging that meets the standards set forth in Minnesota Rules, part 6800.2700, is required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse, unless the pharmacy is using retrospective billing. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(d) Whenever a maximum allowable cost has been set for a multisource drug, payment shall be the lower of the usual and customary price charged to the public or the maximum allowable cost established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2.

(e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. If average sales price is unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider, the wholesale acquisition cost, the
specialty pharmacy rate, or the maximum allowable cost set by the commissioner. Effective January 1, 2014, the commissioner shall discount the payment rate for drugs obtained through the federal 340B Drug Pricing Program by 20 percent. The payment for drugs administered in an outpatient setting shall be made to the administering facility or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

(f) The commissioner may negotiate lower reimbursement rates for specialty pharmacy products than the rates specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee to develop a list of specialty pharmacy products subject to this paragraph. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

(g) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

[See Note.]

Subd. 13f. Prior authorization. (a) The Formulary Committee shall review and recommend drugs which require prior authorization. The Formulary Committee shall establish general criteria to be used for the prior authorization of brand-name drugs for which generically equivalent drugs are available, but the committee is not required to review each brand-name drug for which a generically equivalent drug is available.

(b) Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The Formulary Committee may recommend drugs for prior authorization directly to the commissioner. The commissioner may also request that the Formulary Committee review a drug for prior authorization. Before the commissioner may require prior authorization for a drug:

(1) the commissioner must provide information to the Formulary Committee on the impact that placing the drug on prior authorization may have on the quality of patient care and on program costs, information regarding whether the drug is subject to clinical abuse or misuse, and relevant data from the state Medicaid program if such data is available;

(2) the Formulary Committee must review the drug, taking into account medical and clinical data and the information provided by the commissioner; and

(3) the Formulary Committee must hold a public forum and receive public comment for an additional 15 days.

The commissioner must provide a 15-day notice period before implementing the prior authorization.

(c) Except as provided in subdivision 13j, prior authorization shall not be required or utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness if:
(1) there is no generically equivalent drug available; and

(2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

(3) the drug is part of the recipient's current course of treatment.

This paragraph applies to any multistate preferred drug list or supplemental drug rebate program established or administered by the commissioner. Prior authorization shall automatically be granted for 60 days for brand name drugs prescribed for treatment of mental illness within 60 days of when a generically equivalent drug becomes available, provided that the brand name drug was part of the recipient's course of treatment at the time the generically equivalent drug became available.

(d) Prior authorization shall not be required or utilized for any antihemophilic factor drug prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available if the prior authorization is used in conjunction with any supplemental drug rebate program or multistate preferred drug list established or administered by the commissioner.

(e) The commissioner may require prior authorization for brand name drugs whenever a generically equivalent product is available, even if the prescriber specifically indicates "dispense as written-brand necessary" on the prescription as required by section 151.21, subdivision 2.

(f) Notwithstanding this subdivision, the commissioner may automatically require prior authorization, for a period not to exceed 180 days, for any drug that is approved by the United States Food and Drug Administration on or after July 1, 2005. The 180-day period begins no later than the first day that a drug is available for shipment to pharmacies within the state. The Formulary Committee shall recommend to the commissioner general criteria to be used for the prior authorization of the drugs, but the committee is not required to review each individual drug. In order to continue prior authorizations for a drug after the 180-day period has expired, the commissioner must follow the provisions of this subdivision.

Subd. 13g. Preferred drug list. (a) The commissioner shall adopt and implement a preferred drug list by January 1, 2004. The commissioner may enter into a contract with a vendor for the purpose of participating in a preferred drug list and supplemental rebate program. The commissioner shall ensure that any contract meets all federal requirements and maximizes federal financial participation. The commissioner shall publish the preferred drug list annually in the State Register and shall maintain an accurate and up-to-date list on the agency Web site.

(b) The commissioner may add to, delete from, and otherwise modify the preferred drug list, after consulting with the Formulary Committee and appropriate medical specialists and providing public notice and the opportunity for public comment.

(c) The commissioner shall adopt and administer the preferred drug list as part of the administration of the supplemental drug rebate program. Reimbursement for prescription drugs not on the preferred drug list may be subject to prior authorization.

(d) For purposes of this subdivision, "preferred drug list" means a list of prescription drugs within designated therapeutic classes selected by the commissioner, for which prior authorization based on the identity of the drug or class is not required.

(e) The commissioner shall seek any federal waivers or approvals necessary to implement this subdivision.

Subd. 13h. Medication therapy management services. (a) Medical assistance covers medication therapy management services for a recipient taking prescriptions to treat or prevent one or more chronic
medical conditions. For purposes of this subdivision, "medication therapy management" means the provision of the following pharmaceutical care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

1. performing or obtaining necessary assessments of the patient's health status;
2. formulating a medication treatment plan;
3. monitoring and evaluating the patient's response to therapy, including safety and effectiveness;
4. performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;
5. documenting the care delivered and communicating essential information to the patient's other primary care providers;
6. providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;
7. providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and
8. coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

Nothing in this subdivision shall be construed to expand or modify the scope of practice of the pharmacist as defined in section 151.01, subdivision 27.

(b) To be eligible for reimbursement for services under this subdivision, a pharmacist must meet the following requirements:

1. have a valid license issued by the Board of Pharmacy of the state in which the medication therapy management service is being performed;
2. have graduated from an accredited college of pharmacy on or after May 1996, or completed a structured and comprehensive education program approved by the Board of Pharmacy and the American Council of Pharmaceutical Education for the provision and documentation of pharmaceutical care management services that has both clinical and didactic elements;
3. be practicing in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in home settings, including long-term care settings, group homes, and facilities providing assisted living services, but excluding skilled nursing facilities; and
4. make use of an electronic patient record system that meets state standards.

(c) For purposes of reimbursement for medication therapy management services, the commissioner may enroll individual pharmacists as medical assistance providers. The commissioner may also establish contact requirements between the pharmacist and recipient, including limiting the number of reimbursable consultations per recipient.

(d) If there are no pharmacists who meet the requirements of paragraph (b) practicing within a reasonable geographic distance of the patient, a pharmacist who meets the requirements may provide the services via
two-way interactive video. Reimbursement shall be at the same rates and under the same conditions that
would otherwise apply to the services provided. To qualify for reimbursement under this paragraph, the
pharmacist providing the services must meet the requirements of paragraph (b), and must be located within
an ambulatory care setting that meets the requirements of paragraph (b), clause (3). The patient must also
be located within an ambulatory care setting that meets the requirements of paragraph (b), clause (3). Services
provided under this paragraph may not be transmitted into the patient's residence.

(e) Medication therapy management services may be delivered into a patient's residence via secure
interactive video if the medication therapy management services are performed electronically during a
covered home care visit by an enrolled provider. Reimbursement shall be at the same rates and under the
same conditions that would otherwise apply to the services provided. To qualify for reimbursement under
this paragraph, the pharmacist providing the services must meet the requirements of paragraph (b) and must
be located within an ambulatory care setting that meets the requirements of paragraph (b), clause (3).

Subd. 13i. **Drug Utilization Review Board; report.** (a) A nine-member Drug Utilization Review Board
is established. The board must be comprised of at least three but no more than four licensed physicians
actively engaged in the practice of medicine in Minnesota; at least three licensed pharmacists actively
engaged in the practice of pharmacy in Minnesota; and one consumer representative. The remainder must
be made up of health care professionals who are licensed in their field and have recognized knowledge in
the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of
the board must be appointed by the commissioner, shall serve three-year terms, and may be reappointed by
the commissioner. The board shall annually elect a chair from among its members.

(b) The board must be staffed by an employee of the department who shall serve as an ex officio nonvoting
member of the board.

(c) The commissioner shall, with the advice of the board:

(1) implement a medical assistance retrospective and prospective drug utilization review program as
required by United States Code, title 42, section 1396r-8, subsection (g), paragraph (3);

(2) develop and implement the predetermined criteria and practice parameters for appropriate prescribing
to be used in retrospective and prospective drug utilization review;

(3) develop, select, implement, and assess interventions for physicians, pharmacists, and patients that
are educational and not punitive in nature;

(4) establish a grievance and appeals process for physicians and pharmacists under this section;

(5) publish and disseminate educational information to physicians and pharmacists regarding the board
and the review program;

(6) adopt and implement procedures designed to ensure the confidentiality of any information collected,
stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the review program
that identifies individual physicians, pharmacists, or recipients;

(7) establish and implement an ongoing process to:

(i) receive public comment regarding drug utilization review criteria and standards; and

(ii) consider the comments along with other scientific and clinical information in order to revise criteria
and standards on a timely basis; and
(8) adopt any rules necessary to carry out this section.

(d) The board may establish advisory committees. The commissioner may contract with appropriate organizations to assist the board in carrying out the board's duties. The commissioner may enter into contracts for services to develop and implement a retrospective and prospective review program.

(e) The board shall report to the commissioner annually on the date the drug utilization review annual report is due to the Centers for Medicare and Medicaid Services. This report must cover the preceding federal fiscal year. The commissioner shall make the report available to the public upon request. The report must include information on the activities of the board and the program; the effectiveness of implemented interventions; administrative costs; and any fiscal impact resulting from the program. An honorarium of $100 per meeting and reimbursement for mileage must be paid to each board member in attendance.

(f) This subdivision is exempt from the provisions of section 15.059.

Subd. 13j. Antipsychotic and attention deficit disorder and attention deficit hyperactivity disorder medications. (a) The commissioner, in consultation with the Drug Utilization Review Board established in subdivision 13i and actively practicing pediatric mental health professionals, must:

1. identify recommended pediatric dose ranges for atypical antipsychotic drugs and drugs used for attention deficit disorder or attention deficit hyperactivity disorder based on available medical, clinical, and safety data and research. The commissioner shall periodically review the list of medications and pediatric dose ranges and update the medications and doses listed as needed after consultation with the Drug Utilization Review Board;

2. identify situations where a collaborative psychiatric consultation and prior authorization should be required before the initiation or continuation of drug therapy in pediatric patients including, but not limited to, high-dose regimens, off-label use of prescription medication, a patient's young age, and lack of coordination among multiple prescribing providers; and

3. track prescriptive practices and the use of psychotropic medications in children with the goal of reducing the use of medication, where appropriate.

(b) Effective July 1, 2011, the commissioner shall require prior authorization and a collaborative psychiatric consultation before an atypical antipsychotic and attention deficit disorder and attention deficit hyperactivity disorder medication meeting the criteria identified in paragraph (a), clause (2), is eligible for payment. A collaborative psychiatric consultation must be completed before the identified medications are eligible for payment unless:

1. the patient has already been stabilized on the medication regimen; or

2. the prescriber indicates that the child is in crisis.

If clause (1) or (2) applies, the collaborative psychiatric consultation must be completed within 90 days for payment to continue.

(c) For purposes of this subdivision, a collaborative psychiatric consultation must meet the criteria described in section 245.4862, subdivision 4.

Subd. 14. Diagnostic, screening, and preventive services. (a) Medical assistance covers diagnostic, screening, and preventive services.

(b) "Preventive services" include services related to pregnancy, including:
services for those conditions which may complicate a pregnancy and which may be available to a pregnant woman determined to be at risk of poor pregnancy outcome;

(2) prenatal HIV risk assessment, education, counseling, and testing; and

(3) alcohol abuse assessment, education, and counseling on the effects of alcohol usage while pregnant. Preventive services available to a woman at risk of poor pregnancy outcome may differ in an amount, duration, or scope from those available to other individuals eligible for medical assistance.

(c) "Screening services" include, but are not limited to, blood lead tests.

(d) The commissioner shall encourage, at the time of the child and teen checkup or at an episodic care visit, the primary care health care provider to perform primary caries preventive services. Primary caries preventive services include, at a minimum:

(1) a general visual examination of the child's mouth without using probes or other dental equipment or taking radiographs;

(2) a risk assessment using the factors established by the American Academies of Pediatrics and Pediatric Dentistry; and

(3) the application of a fluoride varnish beginning at age one to those children assessed by the provider as being high risk in accordance with best practices as defined by the Department of Human Services. The provider must obtain parental or legal guardian consent before a fluoride varnish is applied to a minor child's teeth.

At each checkup, if primary caries preventive services are provided, the provider must provide to the child's parent or legal guardian: information on caries etiology and prevention; and information on the importance of finding a dental home for their child by the age of one. The provider must also advise the parent or legal guardian to contact the child's managed care plan or the Department of Human Services in order to secure a dental appointment with a dentist. The provider must indicate in the child's medical record that the parent or legal guardian was provided with this information and document any primary caries prevention services provided to the child.

Subd. 15. Health plan premiums and co-payments. (a) Medical assistance covers health care prepayment plan premiums, insurance premiums, and co-payments if determined to be cost-effective by the commissioner. For purposes of obtaining Medicare Part A and Part B, and co-payments, expenditures may be made even if federal funding is not available.

(b) Effective for all premiums due on or after June 30, 1997, medical assistance does not cover premiums that a recipient is required to pay under a qualified or Medicare supplement plan issued by the Minnesota Comprehensive Health Association. Medical assistance shall continue to cover premiums for recipients who are covered under a plan issued by the Minnesota Comprehensive Health Association on June 30, 1997, for a period of six months following receipt of the notice of termination or until December 31, 1997, whichever is later.

Subd. 16. Abortion services. Medical assistance covers abortion services, but only if one of the following conditions is met:

(a) The abortion is a medical necessity. "Medical necessity" means (1) the signed written statement of two physicians indicating the abortion is medically necessary to prevent the death of the mother, and (2) the patient has given her consent to the abortion in writing unless the patient is physically or legally incapable
of providing informed consent to the procedure, in which case consent will be given as otherwise provided by law;

(b) The pregnancy is the result of criminal sexual conduct as defined in section 609.342, clauses (c), (d), (e)(i), and (f), and the incident is reported within 48 hours after the incident occurs to a valid law enforcement agency for investigation, unless the victim is physically unable to report the criminal sexual conduct, in which case the report shall be made within 48 hours after the victim becomes physically able to report the criminal sexual conduct; or

(c) The pregnancy is the result of incest, but only if the incident and relative are reported to a valid law enforcement agency for investigation prior to the abortion.

[See Note.]

Subd. 17. Transportation costs. (a) "Nonemergency medical transportation service" means motor vehicle transportation provided by a public or private person that serves Minnesota health care program beneficiaries who do not require emergency ambulance service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

(b) Medical assistance covers medical transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by eligible persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, nonemergency medical transportation company, or other recognized providers of transportation services. Medical transportation must be provided by:

(1) nonemergency medical transportation providers who meet the requirements of this subdivision;

(2) ambulances, as defined in section 144E.001, subdivision 2;

(3) taxicabs that meet the requirements of this subdivision;

(4) public transit, as defined in section 174.22, subdivision 7; or

(5) not-for-hire vehicles, including volunteer drivers.

(c) Medical assistance covers nonemergency medical transportation provided by nonemergency medical transportation providers enrolled in the Minnesota health care programs. All nonemergency medical transportation providers must comply with the operating standards for special transportation service as defined in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840, and in consultation with the Minnesota Department of Transportation. All nonemergency medical transportation providers shall bill for nonemergency medical transportation services in accordance with Minnesota health care programs criteria. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements outlined in this paragraph.

(d) An organization may be terminated, denied, or suspended from enrollment if:

(1) the provider has not initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

(2) the provider has initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

(i) the commissioner has sent the provider a notice that the individual has been disqualified under section 245C.14; and
(ii) the individual has not received a disqualification set-aside specific to the special transportation services provider under sections 245C.22 and 245C.23.

(e) The administrative agency of nonemergency medical transportation must:

(1) adhere to the policies defined by the commissioner in consultation with the Nonemergency Medical Transportation Advisory Committee;

(2) pay nonemergency medical transportation providers for services provided to Minnesota health care programs beneficiaries to obtain covered medical services;

(3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled trips, and number of trips by mode; and

(4) by July 1, 2016, in accordance with subdivision 18e, utilize a Web-based single administrative structure assessment tool that meets the technical requirements established by the commissioner, reconciles trip information with claims being submitted by providers, and ensures prompt payment for nonemergency medical transportation services.

(f) Until the commissioner implements the single administrative structure and delivery system under subdivision 18e, clients shall obtain their level-of-service certificate from the commissioner or an entity approved by the commissioner that does not dispatch rides for clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).

(g) The commissioner may use an order by the recipient's attending physician or a medical or mental health professional to certify that the recipient requires nonemergency medical transportation services. Nonemergency medical transportation providers shall perform driver-assisted services for eligible individuals, when appropriate. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.

Nonemergency medical transportation providers must take clients to the health care provider using the most direct route, and must not exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless the client receives authorization from the local agency.

Nonemergency medical transportation providers may not bill for separate base rates for the continuation of a trip beyond the original destination. Nonemergency medical transportation providers must maintain trip logs, which include pickup and drop-off times, signed by the medical provider or client, whichever is deemed most appropriate, attesting to mileage traveled to obtain covered medical services. Clients requesting client mileage reimbursement must sign the trip log attesting mileage traveled to obtain covered medical services.

(h) The administrative agency shall use the level of service process established by the commissioner in consultation with the Nonemergency Medical Transportation Advisory Committee to determine the client's most appropriate mode of transportation. If public transit or a certified transportation provider is not available to provide the appropriate service mode for the client, the client may receive a onetime service upgrade.

(i) The covered modes of transportation are:

(1) client reimbursement, which includes client mileage reimbursement provided to clients who have their own transportation, or to family or an acquaintance who provides transportation to the client;

(2) volunteer transport, which includes transportation by volunteers using their own vehicle;
unassisted transport, which includes transportation provided to a client by a taxicab or public transit. If a taxicab or public transit is not available, the client can receive transportation from another nonemergency medical transportation provider;

(4) assisted transport, which includes transport provided to clients who require assistance by a nonemergency medical transportation provider;

(5) lift-equipped/ramp transport, which includes transport provided to a client who is dependent on a device and requires a nonemergency medical transportation provider with a vehicle containing a lift or ramp;

(6) protected transport, which includes transport provided to a client who has received a prescreening that has deemed other forms of transportation inappropriate and who requires a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety locks, a video recorder, and a transparent thermoplastic partition between the passenger and the vehicle driver; and (ii) who is certified as a protected transport provider; and

(7) stretcher transport, which includes transport for a client in a prone or supine position and requires a nonemergency medical transportation provider with a vehicle that can transport a client in a prone or supine position.

(j) The local agency shall be the single administrative agency and shall administer and reimburse for modes defined in paragraph (i) according to paragraphs (m) and (n) when the commissioner has developed, made available, and funded the Web-based single administrative structure, assessment tool, and level of need assessment under subdivision 18e. The local agency's financial obligation is limited to funds provided by the state or federal government.

(k) The commissioner shall:

(1) in consultation with the Nonemergency Medical Transportation Advisory Committee, verify that the mode and use of nonemergency medical transportation is appropriate;

(2) verify that the client is going to an approved medical appointment; and

(3) investigate all complaints and appeals.

(l) The administrative agency shall pay for the services provided in this subdivision and seek reimbursement from the commissioner, if appropriate. As vendors of medical care, local agencies are subject to the provisions in section 256B.041, the sanctions and monetary recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.

(m) Payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph (h), not the type of vehicle used to provide the service. The medical assistance reimbursement rates for nonemergency medical transportation services that are payable by or on behalf of the commissioner for nonemergency medical transportation services are:

(1) $0.22 per mile for client reimbursement;

(2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer transport;

(3) equivalent to the standard fare for unassisted transport when provided by public transit, and $11 for the base rate and $1.30 per mile when provided by a nonemergency medical transportation provider;

(4) $13 for the base rate and $1.30 per mile for assisted transport;
(5) $18 for the base rate and $1.55 per mile for lift-equipped/ramp transport;

(6) $75 for the base rate and $2.40 per mile for protected transport; and

(7) $60 for the base rate and $2.40 per mile for stretcher transport, and $9 per trip for an additional attendant if deemed medically necessary.

(n) The base rate for nonemergency medical transportation services in areas defined under RUCA to be super rural is equal to 111.3 percent of the respective base rate in paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation services in areas defined under RUCA to be rural or super rural areas is:

(1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage rate in paragraph (m), clauses (1) to (7); and

(2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage rate in paragraph (m), clauses (1) to (7).

(o) For purposes of reimbursement rates for nonemergency medical transportation services under paragraphs (m) and (n), the zip code of the recipient's place of residence shall determine whether the urban, rural, or super rural reimbursement rate applies.

(p) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means a census-tract based classification system under which a geographical area is determined to be urban, rural, or super rural.

(q) The commissioner, when determining reimbursement rates for nonemergency medical transportation under paragraphs (m) and (n), shall exempt all modes of transportation listed under paragraph (i) from Minnesota Rules, part 9505.0445, item R, subitem (2).

Subd. 17a. Payment for ambulance services. (a) Medical assistance covers ambulance services. Providers shall bill ambulance services according to Medicare criteria. Nonemergency ambulance services shall not be paid as emergencies. Effective for services rendered on or after July 1, 2001, medical assistance payments for ambulance services shall be paid at the Medicare reimbursement rate or at the medical assistance payment rate in effect on July 1, 2000, whichever is greater.

(b) Effective for services provided on or after July 1, 2016, medical assistance payment rates for ambulance services identified in this paragraph are increased by five percent. Capitation payments made to managed care plans and county-based purchasing plans for ambulance services provided on or after January 1, 2017, shall be increased to reflect this rate increase. The increased rate described in this paragraph applies to ambulance service providers whose base of operations as defined in section 144E.10 is located:

(1) outside the metropolitan counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato, Moorhead, St. Cloud, and Rochester; or

(2) within a municipality with a population of less than 1,000.

Subd. 17b. Documentation required. (a) As a condition for payment, nonemergency medical transportation providers must document each occurrence of a service provided to a recipient according to this subdivision. Providers must maintain odometer and other records sufficient to distinguish individual trips with specific vehicles and drivers. The documentation may be collected and maintained using electronic systems or software or in paper form but must be made available and produced upon request. Program funds paid for transportation that is not documented according to this subdivision shall be recovered by the department.
(b) A nonemergency medical transportation provider must compile transportation records that meet the following requirements:

(1) the record must be in English and must be legible according to the standard of a reasonable person;

(2) the recipient's name must be on each page of the record; and

(3) each entry in the record must document:

(i) the date on which the entry is made;

(ii) the date or dates the service is provided;

(iii) the printed last name, first name, and middle initial of the driver;

(iv) the signature of the driver attesting to the following: "I certify that I have accurately reported in this record the trip miles I actually drove and the dates and times I actually drove them. I understand that misreporting the miles driven and hours worked is fraud for which I could face criminal prosecution or civil proceedings."

(v) the signature of the recipient or authorized party attesting to the following: "I certify that I received the reported transportation service.", or the signature of the provider of medical services certifying that the recipient was delivered to the provider;

(vi) the address, or the description if the address is not available, of both the origin and destination, and the mileage for the most direct route from the origin to the destination;

(vii) the mode of transportation in which the service is provided;

(viii) the license plate number of the vehicle used to transport the recipient;

(ix) whether the service was ambulatory or nonambulatory;

(x) the time of the pickup and the time of the drop-off with "a.m." and "p.m." designations;

(xi) the name of the extra attendant when an extra attendant is used to provide special transportation service; and

(xii) the electronic source documentation used to calculate driving directions and mileage.

Subd. 17c. Nursing facility transports. A Minnesota health care program enrollee residing in, or being discharged from, a licensed nursing facility is exempt from a level of need determination and is eligible for nonemergency medical transportation services until the enrollee no longer resides in a licensed nursing facility, as provided in section 256B.04, subdivision 14a.

Subd. 18. Bus or taxicab transportation. To the extent authorized by rule of the state agency, medical assistance covers the most appropriate and cost-effective form of transportation incurred by any ambulatory eligible person for obtaining nonemergency medical care.

Subd. 18a. Access to medical services. (a) Medical assistance reimbursement for meals for persons traveling to receive medical care may not exceed $5.50 for breakfast, $6.50 for lunch, or $8 for dinner.

(b) Medical assistance reimbursement for lodging for persons traveling to receive medical care may not exceed $50 per day unless prior authorized by the local agency.
Regardless of the number of employees that an enrolled health care provider may have, medical assistance covers sign and oral language interpreter services when provided by an enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient with limited English proficiency or who has a hearing loss and uses interpreting services. Coverage for face-to-face oral language interpreter services shall be provided only if the oral language interpreter used by the enrolled health care provider is listed in the registry or roster established under section 144.058.

Subd. 18b. Broker dispatching prohibition. Except for establishing level of service process, the commissioner shall not use a broker or coordinator for any purpose related to nonemergency medical transportation services under subdivision 18.

Subd. 18c. Nonemergency Medical Transportation Advisory Committee. (a) The Nonemergency Medical Transportation Advisory Committee shall advise the commissioner on the administration of nonemergency medical transportation covered under medical assistance. The advisory committee shall meet at least quarterly the first year following January 1, 2015, and at least biannually thereafter and may meet more frequently as required by the commissioner. The advisory committee shall annually elect a chair from among its members, who shall work with the commissioner or the commissioner's designee to establish the agenda for each meeting. The commissioner, or the commissioner's designee, shall attend all advisory committee meetings.

(b) The Nonemergency Medical Transportation Advisory Committee shall advise and make recommendations to the commissioner on:

(1) updates to the nonemergency medical transportation policy manual;

(2) other aspects of the nonemergency medical transportation system, as requested by the commissioner; and

(3) other aspects of the nonemergency medical transportation system, as requested by:

(i) a committee member, who may request an item to be placed on the agenda for a future meeting. The request may be considered by the committee and voted upon. If the motion carries, the meeting agenda item may be developed for presentation to the committee; and

(ii) a member of the public, who may approach the committee by letter or e-mail requesting that an item be placed on a future meeting agenda. The request may be considered by the committee and voted upon. If the motion carries, the agenda item may be developed for presentation to the committee.

(c) The Nonemergency Medical Transportation Advisory Committee shall coordinate its activities with the Minnesota Council on Transportation Access established under section 174.285. The chair of the advisory committee, or the chair's designee, shall attend all meetings of the Minnesota Council on Transportation Access.

(d) The Nonemergency Medical Transportation Advisory Committee shall expire December 1, 2019.

Subd. 18d. Advisory committee members. (a) The Nonemergency Medical Transportation Advisory Committee consists of:

(1) four voting members who represent counties, utilizing the rural urban commuting area classification system. As defined in subdivision 17, these members shall be designated as follows:

(i) two counties within the 11-county metropolitan area;
(ii) one county representing the rural area of the state; and

(iii) one county representing the super rural area of the state.

The Association of Minnesota Counties shall appoint one county within the 11-county metropolitan area and one county representing the super rural area of the state. The Minnesota Inter-County Association shall appoint one county within the 11-county metropolitan area and one county representing the rural area of the state;

(2) three voting members who represent medical assistance recipients, including persons with physical and developmental disabilities, persons with mental illness, seniors, children, and low-income individuals;

(3) four voting members who represent providers that deliver nonemergency medical transportation services to medical assistance enrollees;

(4) two voting members of the house of representatives, one from the majority party and one from the minority party, appointed by the speaker of the house, and two voting members from the senate, one from the majority party and one from the minority party, appointed by the Subcommittee on Committees of the Committee on Rules and Administration;

(5) one voting member who represents demonstration providers as defined in section 256B.69, subdivision 2;

(6) one voting member who represents an organization that contracts with state or local governments to coordinate transportation services for medical assistance enrollees;

(7) one voting member who represents the Minnesota State Council on Disability;

(8) the commissioner of transportation or the commissioner's designee, who shall serve as a voting member;

(9) one voting member appointed by the Minnesota Ambulance Association; and

(10) one voting member appointed by the Minnesota Hospital Association.

(b) Members of the advisory committee shall not be employed by the Department of Human Services. Members of the advisory committee shall receive no compensation.

Subd. 18e. Single administrative structure and delivery system. The commissioner, in coordination with the commissioner of transportation, shall implement a single administrative structure and delivery system for nonemergency medical transportation, beginning the latter of the date the single administrative assessment tool required in this subdivision is available for use, as determined by the commissioner or by July 1, 2016.

In coordination with the Department of Transportation, the commissioner shall develop and authorize a Web-based single administrative structure and assessment tool, which must operate 24 hours a day, seven days a week, to facilitate the enrollee assessment process for nonemergency medical transportation services. The Web-based tool shall facilitate the transportation eligibility determination process initiated by clients and client advocates; shall include an accessible automated intake and assessment process and real-time identification of level of service eligibility; and shall authorize an appropriate and auditable mode of transportation authorization. The tool shall provide a single framework for reconciling trip information with claiming and collecting complaints regarding inappropriate level of need determinations, inappropriate transportation modes utilized, and interference with accessing nonemergency medical transportation. The
Web-based single administrative structure shall operate on a trial basis for one year from implementation and, if approved by the commissioner, shall be permanent thereafter. The commissioner shall seek input from the Nonemergency Medical Transportation Advisory Committee to ensure the software is effective and user-friendly and make recommendations regarding funding of the single administrative system.

Subd. 18f. [Repealed, 2014 c 312 art 24 s 48]

Subd. 18g. Use of standardized measures. Beginning in calendar year 2015, the commissioner shall collect, audit, and analyze performance data on nonemergency medical transportation annually and report this information on the agency's Web site. The commissioner shall periodically supplement this information with the results of consumer surveys of the quality of services, and shall make these survey findings available to the public on the agency Web site.

Subd. 18h. Managed care. (a) The following subdivisions apply to managed care plans and county-based purchasing plans:

1. subdivision 17, paragraphs (a), (b), (i), and (n);
2. subdivision 18; and
3. subdivision 18a.

(b) A nonemergency medical transportation provider must comply with the operating standards for special transportation service specified in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements in this paragraph.

Subd. 19. [Repealed, 1991 c 292 art 7 s 26]

Subd. 19a. Personal care assistance services. Medical assistance covers personal care assistance services in a recipient's home. Effective January 1, 2010, to qualify for personal care assistance services, a recipient must require assistance and be determined dependent in one activity of daily living as defined in section 256B.0659, subdivision 1, paragraph (b), or in a Level I behavior as defined in section 256B.0659, subdivision 1, paragraph (c). Recipients or responsible parties must be able to identify the recipient's needs, direct and evaluate task accomplishment, and provide for health and safety. Approved hours may be used outside the home when normal life activities take them outside the home. To use personal care assistance services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school. Total hours for services, whether actually performed inside or outside the recipient's home, cannot exceed that which is otherwise allowed for personal care assistance services in an in-home setting according to sections 256B.0651 to 256B.0654. Medical assistance does not cover personal care assistance services for residents of a hospital, nursing facility, intermediate care facility, health care facility licensed by the commissioner of health, or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the personal care assistance services or forgoes the facility per diem for the leave days that personal care assistance services are used. All personal care assistance services must be provided according to sections 256B.0651 to 256B.0654. Personal care assistance services may not be reimbursed if the personal care assistant is the spouse or paid guardian of the recipient or the parent of a recipient under age 18, or the responsible party or the family foster care provider of a recipient who cannot direct the recipient's own care unless, in the case of a foster care provider, a county or state case manager visits the recipient as needed, but not less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met. Notwithstanding the provisions of section 256B.0659, the unpaid guardian or conservator of an adult, who

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is not the responsible party and not the personal care provider organization, may be reimbursed to provide personal care assistance services to the recipient if the guardian or conservator meets all criteria for a personal care assistant according to section 256B.0659, and shall not be considered to have a service provider interest for purposes of participation on the screening team under section 256B.092, subdivision 7.

Subd. 19b. **No automatic adjustment.** For fiscal years beginning on or after July 1, 1993, the commissioner of human services shall not provide automatic annual inflation adjustments for home care services. The commissioner of management and budget shall include as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11 annual adjustments in reimbursement rates for home care services.

Subd. 19c. **Personal care.** Medical assistance covers personal care assistance services provided by an individual who is qualified to provide the services according to subdivision 19a and sections 256B.0651 to 256B.0654, provided in accordance with a plan, and supervised by a qualified professional.

"Qualified professional" means a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6); a registered nurse as defined in sections 148.171 to 148.285, a licensed social worker as defined in sections 148E.010 and 148E.055, or a qualified designated coordinator under section 245D.081, subdivision 2. The qualified professional shall perform the duties required in section 256B.0659.

Subd. 20. **Mental health case management.**

(a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face-to-face contact with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

(1) at least a face-to-face contact with the adult or the adult's legal representative or a contact by interactive video that meets the requirements of subdivision 20b; or

(2) at least a telephone contact with the adult or the adult's legal representative and document a face-to-face contact or a contact by interactive video that meets the requirements of subdivision 20b with the adult or the adult's legal representative within the preceding two months.

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

(e) Payment for mental health case management provided by Indian health services or by agencies operated by Indian tribes may be made according to this section or other relevant federally approved rate setting methodology.
(f) Payment for mental health case management provided by vendors who contract with a county or Indian tribe shall be based on a monthly rate negotiated by the host county or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribe may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.

(g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

(h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the recipient's county of responsibility.

(i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance and MinnesotaCare include mental health case management. When the service is provided through prepaid capitation, the nonfederal share is paid by the state and the county pays no share.

(j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency, is responsible for any federal disallowances. The county or tribe may share this responsibility with its contracted vendors.

(k) The commissioner shall set aside a portion of the federal funds earned for county expenditures under this section to repay the special revenue maximization account under section 256.01, subdivision 2, paragraph (o). The repayment is limited to:

(1) the costs of developing and implementing this section; and

(2) programming the information systems.

(l) Payments to counties and tribal agencies for case management expenditures under this section shall only be made from federal earnings from services provided under this section. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors shall include the federal earnings, the state share, and the county share.

(m) Case management services under this subdivision do not include therapy, treatment, legal, or outreach services.

(n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for case management services under this subdivision is limited to the lesser of:
(1) the last 180 days of the recipient's residency in that facility and may not exceed more than six months in a calendar year; or

(2) the limits and conditions which apply to federal Medicaid funding for this service.

(o) Payment for case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

(p) If the recipient is receiving care in a hospital, nursing facility, or residential setting licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week, mental health targeted case management services must actively support identification of community alternatives for the recipient and discharge planning.

[See Note.]

Subd. 20a. Case management; developmental disabilities. To the extent defined in the state Medicaid plan, case management service activities for persons with developmental disabilities as defined in section 256B.092, and rules promulgated thereunder, are covered services under medical assistance.

Subd. 20b. Mental health targeted case management through interactive video. (a) Subject to federal approval, contact made for targeted case management by interactive video shall be eligible for payment if:

(1) the person receiving targeted case management services is residing in:

(i) a hospital;

(ii) a nursing facility; or

(iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging establishment or lodging establishment that provides supportive services or health supervision services according to section 157.17 that is staffed 24 hours a day, seven days a week;

(2) interactive video is in the best interests of the person and is deemed appropriate by the person receiving targeted case management or the person's legal guardian, the case management provider, and the provider operating the setting where the person is residing;

(3) the use of interactive video is approved as part of the person's written personal service or case plan, taking into consideration the person's vulnerability and active personal relationships; and

(4) interactive video is used for up to, but not more than, 50 percent of the minimum required face-to-face contact.

(b) The person receiving targeted case management or the person's legal guardian has the right to choose and consent to the use of interactive video under this subdivision and has the right to refuse the use of interactive video at any time.

(c) The commissioner shall establish criteria that a targeted case management provider must attest to in order to demonstrate the safety or efficacy of delivering the service via interactive video. The attestation may include that the case management provider has:

(1) written policies and procedures specific to interactive video services that are regularly reviewed and updated;
(2) policies and procedures that adequately address client safety before, during, and after the interactive video services are rendered;

(3) established protocols addressing how and when to discontinue interactive video services; and

(4) established a quality assurance process related to interactive video services.

(d) As a condition of payment, the targeted case management provider must document the following for each occurrence of targeted case management provided by interactive video:

(1) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(2) the basis for determining that interactive video is an appropriate and effective means for delivering the service to the person receiving case management services;

(3) the mode of transmission of the interactive video services and records evidencing that a particular mode of transmission was utilized;

(4) the location of the originating site and the distant site; and

(5) compliance with the criteria attested to by the targeted case management provider as provided in paragraph (c).

[See Note.]

Subd. 21. [Repealed, 1989 c 282 art 3 s 98]

Subd. 22. Hospice care. Medical assistance covers hospice care services under Public Law 99-272, section 9505, to the extent authorized by rule, except that a recipient age 21 or under who elects to receive hospice services does not waive coverage for services that are related to the treatment of the condition for which a diagnosis of terminal illness has been made.

Subd. 23. Day treatment services. Medical assistance covers day treatment services as specified in sections 245.462, subdivision 8, and 245.4871, subdivision 10, that are provided under contract with the county board. The commissioner may set authorization thresholds for day treatment for adults according to subdivision 25. Medical assistance covers day treatment services for children as specified under section 256B.0943.

Subd. 24. Other medical or remedial care. Medical assistance covers any other medical or remedial care licensed and recognized under state law unless otherwise prohibited by law, except licensed chemical dependency treatment programs or primary treatment or extended care treatment units in hospitals that are covered under chapter 254B. The commissioner shall include chemical dependency services in the state medical assistance plan for federal reporting purposes, but payment must be made under chapter 254B. The commissioner shall publish in the State Register a list of elective surgeries that require a second medical opinion before medical assistance reimbursement, and the criteria and standards for deciding whether an elective surgery should require a second medical opinion. The list and criteria and standards are not subject to the requirements of sections 14.01 to 14.69.

Subd. 25. Prior authorization required. (a) The commissioner shall publish in the Minnesota health care programs provider manual and on the department's Web site a list of health services that require prior authorization, the criteria and standards used to select health services on the list, and the criteria and standards used to determine whether certain providers must obtain prior authorization for their services. The list of services requiring prior authorization and the criteria and standards used to formulate the list of services or
the selection of providers for whom prior authorization is required are not subject to the requirements of sections 14.001 to 14.69. The commissioner's decision whether prior authorization is required for a health service or is required for a provider is not subject to administrative appeal. Use of criteria or standards to select providers for whom prior authorization is required shall not impede access to the service involved for any group of individuals with unique or special needs due to disability or functional condition.

(b) The commissioner shall implement a modernized electronic system for providers to request prior authorization. The modernized electronic system must include at least the following functionalities:

(1) authorizations are recipient-centric, not provider-centric;

(2) adequate flexibility to support authorizations for an episode of care, continuous drug therapy, or for individual onetime services and allows an ordering and a rendering provider to both submit information into one request;

(3) allows providers to review previous authorization requests and determine where a submitted request is within the authorization process;

(4) supports automated workflows that allow providers to securely submit medical information that can be accessed by medical and pharmacy review vendors as well as department staff; and

(5) supports development of automated clinical algorithms that can verify information and provide responses in real time.

(c) The system described in paragraph (b) shall be completed by March 1, 2012. All authorization requests submitted on and after March 1, 2012, or upon completion of the modernized authorization system, whichever is later, must be submitted electronically by providers, except requests for drugs dispensed by an outpatient pharmacy, services that are provided outside of the state and surrounding local trade area, and services included on a service agreement.

Subd. 25a. Prior authorization of diagnostic imaging services. (a) Effective January 1, 2010, the commissioner shall require prior authorization or decision support for the ordering providers at the time the service is ordered for the following outpatient diagnostic imaging services: computerized tomography (CT), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positive emission tomography (PET), cardiac imaging, and ultrasound diagnostic imaging.

(b) Prior authorization under this subdivision is not required for diagnostic imaging services performed as part of a hospital emergency room visit, inpatient hospitalization, or if concurrent with or on the same day as an urgent care facility visit.

(c) This subdivision does not apply to services provided to recipients who are enrolled in Medicare, the prepaid medical assistance program, or the MinnesotaCare program.

(d) The commissioner may contract with a private entity to provide the prior authorization or decision support required under this subdivision. The contracting entity must incorporate clinical guidelines that are based on evidence-based medical literature, if available. By January 1, 2012, the contracting entity shall report to the commissioner the results of prior authorization or decision support.

Subd. 25b. Authorization with third-party liability. (a) Except as otherwise allowed under this subdivision or required under federal or state regulations, the commissioner must not consider a request for authorization of a service when the recipient has coverage from a third-party payer unless the provider requesting authorization has made a good faith effort to receive payment or authorization from the third-party...
payer. A good faith effort is established by supplying with the authorization request to the commissioner the following:

(1) a determination of payment for the service from the third-party payer, a determination of authorization for the service from the third-party payer, or a verification of noncoverage of the service by the third-party payer; and

(2) the information or records required by the department to document the reason for the determination or to validate noncoverage from the third-party payer.

(b) A provider requesting authorization for services covered by Medicare is not required to bill Medicare before requesting authorization from the commissioner if the provider has reason to believe that a service covered by Medicare is not eligible for payment. The provider must document that, because of recent claim experiences with Medicare or because of written communication from Medicare, coverage is not available for the service.

(c) Authorization is not required if a third-party payer has made payment that is equal to or greater than 60 percent of the maximum payment amount for the service allowed under medical assistance.

Subd. 26. Special education services. (a) Medical assistance covers evaluations necessary in making a determination for eligibility for individualized education program and individualized family service plan services and for medical services identified in a recipient's individualized education program and individualized family service plan and covered under the medical assistance state plan. Covered services include occupational therapy, physical therapy, speech-language therapy, clinical psychological services, nursing services, school psychological services, school social work services, personal care assistants serving as management aides, assistive technology devices, transportation services, health assessments, and other services covered under the medical assistance state plan. Mental health services eligible for medical assistance reimbursement must be provided or coordinated through a children's mental health collaborative where a collaborative exists if the child is included in the collaborative operational target population. The provision or coordination of services does not require that the individualized education program be developed by the collaborative.

The services may be provided by a Minnesota school district that is enrolled as a medical assistance provider or its subcontractor, and only if the services meet all the requirements otherwise applicable if the service had been provided by a provider other than a school district, in the following areas: medical necessity, physician's orders, documentation, personnel qualifications, and prior authorization requirements. The nonfederal share of costs for services provided under this subdivision is the responsibility of the local school district as provided in section 125A.74. Services listed in a child's individualized education program are eligible for medical assistance reimbursement only if those services meet criteria for federal financial participation under the Medicaid program.

(b) Approval of health-related services for inclusion in the individualized education program does not require prior authorization for purposes of reimbursement under this chapter. The commissioner may require physician review and approval of the plan not more than once annually or upon any modification of the individualized education program that reflects a change in health-related services.

(c) Services of a speech-language pathologist provided under this section are covered notwithstanding Minnesota Rules, part 9505.0390, subpart 1, item L, if the person:

(1) holds a masters degree in speech-language pathology;
(2) is licensed by the Professional Educator Licensing and Standards Board as an educational speech-language pathologist; and

(3) either has a certificate of clinical competence from the American Speech and Hearing Association, has completed the equivalent educational requirements and work experience necessary for the certificate or has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(d) Medical assistance coverage for medically necessary services provided under other subdivisions in this section may not be denied solely on the basis that the same or similar services are covered under this subdivision.

(e) The commissioner shall develop and implement package rates, bundled rates, or per diem rates for special education services under which separately covered services are grouped together and billed as a unit in order to reduce administrative complexity.

(f) The commissioner shall develop a cost-based payment structure for payment of these services. Only costs reported through the designated Minnesota Department of Education data systems in distinct service categories qualify for inclusion in the cost-based payment structure. The commissioner shall reimburse claims submitted based on an interim rate, and shall settle at a final rate once the department has determined it. The commissioner shall notify the school district of the final rate. The school district has 60 days to appeal the final rate. To appeal the final rate, the school district shall file a written appeal request to the commissioner within 60 days of the date the final rate determination was mailed. The appeal request shall specify (1) the disputed items and (2) the name and address of the person to contact regarding the appeal.

(g) Effective July 1, 2000, medical assistance services provided under an individualized education program or an individual family service plan by local school districts shall not count against medical assistance authorization thresholds for that child.

(h) Nursing services as defined in section 148.171, subdivision 15, and provided as an individualized education program health-related service, are eligible for medical assistance payment if they are otherwise a covered service under the medical assistance program. Medical assistance covers the administration of prescription medications by a licensed nurse who is employed by or under contract with a school district when the administration of medications is identified in the child's individualized education program. The simple administration of medications alone is not covered under medical assistance when administered by a provider other than a school district or when it is not identified in the child's individualized education program.

Subd. 27. **Organ and tissue transplants.** All organ transplants must be performed at transplant centers meeting united network for organ sharing criteria or at Medicare-approved organ transplant centers. Stem cell or bone marrow transplant centers must meet the standards established by the Foundation for the Accreditation of Hematopoietic Cell Therapy.

Subd. 28. **Certified nurse practitioner services.** Medical assistance covers services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if:

(1) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate;

(2) the service is otherwise covered under this chapter as a physician service; and
(3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171.

Subd. 28a. **Licensed physician assistant services.** (a) Medical assistance covers services performed by a licensed physician assistant if the service is otherwise covered under this chapter as a physician service and if the service is within the scope of practice of a licensed physician assistant as defined in section 147A.09.

(b) Licensed physician assistants, who are supervised by a physician certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry, may bill for medication management and evaluation and management services provided to medical assistance enrollees in inpatient hospital settings, and in outpatient settings after the licensed physician assistant completes 2,000 hours of clinical experience in the evaluation and treatment of mental health, consistent with their authorized scope of practice, as defined in section 147A.09, with the exception of performing psychotherapy or diagnostic assessments or providing clinical supervision.

Subd. 28b. **Doula services.** Medical assistance covers doula services provided by a certified doula as defined in section 148.995, subdivision 2, of the mother's choice. For purposes of this section, "doula services" means childbirth education and support services, including emotional and physical support provided during pregnancy, labor, birth, and postpartum.

Subd. 29. **Public health nursing clinic services.** Medical assistance covers the services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health or registered nurse's license as a registered nurse, as defined in section 148.171.

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, and public health clinic services. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. A federally qualified health center that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, a federally qualified health center shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. Federally qualified health centers that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), a federally qualified health center or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the Department of Health according to section 62Q.19, subdivision 7. For those federally qualified health centers and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For federally qualified health centers and rural health clinics that either do not apply within the time specified...
above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not federally qualified health centers or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring a federally qualified health center or a rural health clinic to make application for an essential community provider designation in order to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

(e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

(f) Effective January 1, 2001, each federally qualified health center and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

(g) For purposes of this section, "nonprofit community clinic" is a clinic that:

(1) has nonprofit status as specified in chapter 317A;

(2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

(3) is established to provide health services to low-income population groups, uninsured, high-risk and special needs populations, underserved and other special needs populations;

(4) employs professional staff at least one-half of which are familiar with the cultural background of their clients;

(5) charges for services on a sliding fee scale designed to provide assistance to low-income clients based on current poverty income guidelines and family size; and

(6) does not restrict access or services because of a client's financial limitations or public assistance status and provides no-cost care as needed.

(h) Effective for services provided on or after January 1, 2015, all claims for payment of clinic services provided by federally qualified health centers and rural health clinics shall be paid by the commissioner. The commissioner shall determine the most feasible method for paying claims from the following options:

(1) federally qualified health centers and rural health clinics submit claims directly to the commissioner for payment, and the commissioner provides claims information for recipients enrolled in a managed care or county-based purchasing plan to the plan, on a regular basis; or

(2) federally qualified health centers and rural health clinics submit claims for recipients enrolled in a managed care or county-based purchasing plan to the plan, and those claims are submitted by the plan to the commissioner for payment to the clinic.

(i) For clinic services provided prior to January 1, 2015, the commissioner shall calculate and pay monthly the proposed managed care supplemental payments to clinics, and clinics shall conduct a timely review of the payment calculation data in order to finalize all supplemental payments in accordance with federal law. Any issues arising from a clinic's review must be reported to the commissioner by January 1,
2017. Upon final agreement between the commissioner and a clinic on issues identified under this subdivision, and in accordance with United States Code, title 42, section 1396a(bb), no supplemental payments for managed care plan or county-based purchasing plan claims for services provided prior to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are unable to resolve issues under this subdivision, the parties shall submit the dispute to the arbitration process under section 14.57.

(j) The commissioner shall seek a federal waiver, authorized under section 1115 of the Social Security Act, to obtain federal financial participation at the 100 percent federal matching percentage available to facilities of the Indian Health Service or tribal organization in accordance with section 1905(b) of the Social Security Act for expenditures made to organizations dually certified under Title V of the Indian Health Care Improvement Act, Public Law 94-437, and as a federally qualified health center under paragraph (a) that provides services to American Indian and Alaskan Native individuals eligible for services under this subdivision.

Subd. 31. Medical supplies and equipment. (a) Medical assistance covers medical supplies and equipment. Separate payment outside of the facility's payment rate shall be made for wheelchairs and wheelchair accessories for recipients who are residents of intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs and wheelchair accessories for ICF/DD recipients shall be subject to the same conditions and limitations as coverage for recipients who do not reside in institutions. A wheelchair purchased outside of the facility's payment rate is the property of the recipient.

(b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies must enroll as a Medicare provider.

(c) When necessary to ensure access to durable medical equipment, prosthetics, orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare enrollment requirement if:

(1) the vendor supplies only one type of durable medical equipment, prosthetic, orthotic, or medical supply;

(2) the vendor serves ten or fewer medical assistance recipients per year;

(3) the commissioner finds that other vendors are not available to provide same or similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

(4) the vendor complies with all screening requirements in this chapter and Code of Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare and Medicaid Services approved national accreditation organization as complying with the Medicare program's supplier and quality standards and the vendor serves primarily pediatric patients.

(d) Durable medical equipment means a device or equipment that:

(1) can withstand repeated use;

(2) is generally not useful in the absence of an illness, injury, or disability; and

(3) is provided to correct or accommodate a physiological disorder or physical condition or is generally used primarily for a medical purpose.

(e) Electronic tablets may be considered durable medical equipment if the electronic tablet will be used as an augmentative and alternative communication system as defined under subdivision 31a, paragraph (a).
To be covered by medical assistance, the device must be locked in order to prevent use not related to communication.

(f) Notwithstanding the requirement in paragraph (e) that an electronic tablet must be locked to prevent use not as an augmentative communication device, a recipient of waiver services may use an electronic tablet for a use not related to communication when the recipient has been authorized under the waiver to receive one or more additional applications that can be loaded onto the electronic tablet, such that allowing the additional use prevents the purchase of a separate electronic tablet with waiver funds.

(g) An order or prescription for medical supplies, equipment, or appliances must meet the requirements in Code of Federal Regulations, title 42, part 440.70.

Subd. 31a. Augmentative and alternative communication systems. (a) Medical assistance covers augmentative and alternative communication systems consisting of electronic or nonelectronic devices and the related components necessary to enable a person with severe expressive communication limitations to produce or transmit messages or symbols in a manner that compensates for that disability.

(b) Augmentative and alternative communication systems must be paid the lower of the:

(1) submitted charge; or

(2)(i) manufacturer's suggested retail price minus 20 percent for providers that are manufacturers of augmentative and alternative communication systems; or

(ii) manufacturer's invoice charge plus 20 percent for providers that are not manufacturers of augmentative and alternative communication systems.

(c) Reimbursement rates established by this purchasing program are not subject to Minnesota Rules, part 9505.0445, item S or T.

Subd. 31b. Preferred diabetic testing supply program. (a) The commissioner shall implement a point-of-sale preferred diabetic testing supply program by January 1, 2014. Medical assistance coverage for diabetic testing supplies shall conform to the limitations established under the program. The commissioner may enter into a contract with a vendor for the purpose of participating in a preferred diabetic testing supply list and supplemental rebate program. The commissioner shall ensure that any contract meets all federal requirements and maximizes federal financial participation. The commissioner shall maintain an accurate and up-to-date list on the department's Web site.

(b) The commissioner may add to, delete from, and otherwise modify the preferred diabetic testing supply program drug list after consulting with the Drug Formulary Committee and appropriate medical specialists and providing public notice and the opportunity for public comment.

(c) The commissioner shall adopt and administer the preferred diabetic testing supply program as part of the administration of the diabetic testing supply rebate program. Reimbursement for diabetic testing supplies not on the preferred diabetic testing supply list may be subject to prior authorization.

(d) All claims for diabetic testing supplies in categories on the preferred diabetic testing supply list must be submitted by enrolled pharmacy providers using the most current National Council of Prescription Drug Plans electronic claims standard.

(e) For purposes of this subdivision, "preferred diabetic testing supply list" means a list of diabetic testing supplies selected by the commissioner, for which prior authorization is not required.
(f) The commissioner shall seek any federal waivers or approvals necessary to implement this subdivision.

Subd. 31c. Preferred incontinence product program. The commissioner shall implement a preferred incontinence product program by July 1, 2018. The program shall require the commissioner to volume purchase incontinence products and related supplies in accordance with section 256B.04, subdivision 14. Medical assistance coverage for incontinence products and related supplies shall conform to the limitations established under the program.

Subd. 32. Nutritional products. Medical assistance covers nutritional products needed for nutritional supplementation because solid food or nutrients thereof cannot be properly absorbed by the body or needed for treatment of phenylketonuria, hyperlysinemia, maple syrup urine disease, a combined allergy to human milk, cow's milk, and soy formula, or any other childhood or adult diseases, conditions, or disorders identified by the commissioner as requiring a similarly necessary nutritional product. Nutritional products needed for the treatment of a combined allergy to human milk, cow's milk, and soy formula require prior authorization. Separate payment shall not be made for nutritional products for residents of long-term care facilities. Payment for dietary requirements is a component of the per diem rate paid to these facilities.

Subd. 33. Child welfare targeted case management. Medical assistance, subject to federal approval, covers child welfare targeted case management services as defined in section 256B.094 to children under age 21 who have been assessed and determined in accordance with section 256F.10 to be:

(1) at risk of placement or in placement as defined in section 260C.212, subdivision 1;

(2) at risk of maltreatment or experiencing maltreatment as defined in section 626.556, subdivision 10e; or

(3) in need of protection or services as defined in section 260C.007, subdivision 6.

Subd. 34. Indian health services facilities. (a) Medical assistance payments and MinnesotaCare payments to facilities of the Indian health service and facilities operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title III of the Indian Self-Determination and Education Assistance Act, Public Law 93-638, for enrollees who are eligible for federal financial participation, shall be at the option of the facility in accordance with the rate published by the United States Assistant Secretary for Health under the authority of United States Code, title 42, sections 248(a) and 249(b). MinnesotaCare payments for enrollees who are not eligible for federal financial participation at facilities of the Indian health service and facilities operated by a tribe or tribal organization for the provision of outpatient medical services must be in accordance with the medical assistance rates paid for the same services when provided in a facility other than a facility of the Indian health service or a facility operated by a tribe or tribal organization.

(b) Effective upon federal approval, the medical assistance payments to a dually certified facility as defined in subdivision 30, paragraph (j), shall be the encounter rate described in paragraph (a) or a rate that is substantially equivalent for services provided to American Indians and Alaskan Native populations. The rate established under this paragraph for dually certified facilities shall not apply to MinnesotaCare payments.

Subd. 35. [Repealed, 1Sp2003 c 14 art 4 s 24]

Subd. 35a. Children's mental health crisis response services. Medical assistance covers children's mental health crisis response services according to section 256B.0944.

Subd. 35b. Children's therapeutic services and supports. Medical assistance covers children's therapeutic services and supports according to section 256B.0943.
Subd. 36. [Repealed, 1Sp2003 c 14 art 4 s 24]

Subd. 37. **Individualized rehabilitation services.** Medical assistance covers individualized rehabilitation services as defined in section 245.492, subdivision 23, that are provided by a collaborative, county, or an entity under contract with a county through an integrated service system, as described in section 245.4931, that is approved by the state coordinating council, subject to federal approval.

Subd. 38. **Payments for mental health services.** Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals shall be 80 percent of the rate paid to doctoral-prepared professionals. Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals employed by community mental health centers shall be 100 percent of the rate paid to doctoral-prepared professionals. Payments for mental health services covered under the medical assistance program that are provided by physician assistants shall be 80.4 percent of the base rate paid to psychiatrists.

Subd. 39. **Childhood immunizations.** Providers who administer pediatric vaccines within the scope of their licensure, and who are enrolled as a medical assistance provider, must enroll in the pediatric vaccine administration program established by section 13631 of the Omnibus Budget Reconciliation Act of 1993. Medical assistance shall pay for administration of the vaccine to children eligible for medical assistance. Medical assistance does not pay for vaccines that are available at no cost from the pediatric vaccine administration program.

Subd. 40. **Tuberculosis related services.** (a) For persons infected with tuberculosis, medical assistance covers case management services and direct observation of the intake of drugs prescribed to treat tuberculosis.

(b) "Case management services" means services furnished to assist persons infected with tuberculosis in gaining access to needed medical services. Case management services include at a minimum:

(1) assessing a person's need for medical services to treat tuberculosis;

(2) developing a care plan that addresses the needs identified in clause (1);

(3) assisting the person in accessing medical services identified in the care plan; and

(4) monitoring the person's compliance with the care plan to ensure completion of tuberculosis therapy. Medical assistance covers case management services under this subdivision only if the services are provided by a certified public health nurse who is employed by a community health board as defined in section 145A.02, subdivision 5.

(c) To be covered by medical assistance, direct observation of the intake of drugs prescribed to treat tuberculosis must be provided by a community outreach worker, licensed practical nurse, registered nurse who is trained and supervised by a public health nurse employed by a community health board as defined in section 145A.02, subdivision 5, or a public health nurse employed by a community health board.

Subd. 41. **Residential services for children with severe emotional disturbance.** Medical assistance covers rehabilitative services in accordance with section 256B.0945 that are provided by a county or an American Indian tribe through a residential facility, for children who have been diagnosed with severe emotional disturbance and have been determined to require the level of care provided in a residential facility.

Subd. 42. **Mental health professional.** Notwithstanding Minnesota Rules, part 9505.0175, subpart 28, the definition of a mental health professional shall include a person who is qualified as specified in section
245.462, subdivision 18, clauses (1) to (6); or 245.4871, subdivision 27, clauses (1) to (6), for the purpose of this section and Minnesota Rules, parts 9505.0170 to 9505.0475.

Subd. 43. Mental health provider travel time. Medical assistance covers provider travel time if a recipient's individual treatment plan requires the provision of mental health services outside of the provider's normal place of business. This does not include any travel time which is included in other billable services, and is only covered when the mental health service being provided to a recipient is covered under medical assistance.

Subd. 44. Targeted case management services. Medical assistance covers case management services for vulnerable adults and adults with developmental disabilities, as provided under section 256B.0924.

Subd. 45. Subacute psychiatric care for persons under 21 years of age. Medical assistance covers subacute psychiatric care for person under 21 years of age when:

1. the services meet the requirements of Code of Federal Regulations, title 42, section 440.160;
2. the facility is accredited as a psychiatric treatment facility by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation; and
3. the facility is licensed by the commissioner of health under section 144.50.

Subd. 45a. Psychiatric residential treatment facility services for persons younger than 21 years of age. (a) Medical assistance covers psychiatric residential treatment facility services, according to section 256B.0941, for persons younger than 21 years of age. Individuals who reach age 21 at the time they are receiving services are eligible to continue receiving services until they no longer require services or until they reach age 22, whichever occurs first.

(b) For purposes of this subdivision, "psychiatric residential treatment facility" means a facility other than a hospital that provides psychiatric services, as described in Code of Federal Regulations, title 42, sections 441.151 to 441.182, to individuals under age 21 in an inpatient setting.

(c) The commissioner shall enroll up to 150 certified psychiatric residential treatment facility services beds at up to six sites. The commissioner shall select psychiatric residential treatment facility services providers through a request for proposals process. Providers of state-operated services may respond to the request for proposals.

[See Note.]

Subd. 46. Mental health telemedicine. Effective January 1, 2006, and subject to federal approval, mental health services that are otherwise covered by medical assistance as direct face-to-face services may be provided via two-way interactive video. Use of two-way interactive video must be medically appropriate to the condition and needs of the person being served. Reimbursement is at the same rates and under the same conditions that would otherwise apply to the service. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.

Subd. 47. Treatment foster care services. Effective July 1, 2011, and subject to federal approval, medical assistance covers treatment foster care services according to section 256B.0946.

Subd. 48. Psychiatric consultation to primary care practitioners. Medical assistance covers consultation provided by a psychiatrist, a psychologist, an advanced practice registered nurse certified in psychiatric mental health, a licensed independent clinical social worker, as defined in section 245.462,
subdivision 18, clause (2), or a licensed marriage and family therapist, as defined in section 245.462, subdivision 18, clause (5), via telephone, e-mail, facsimile, or other means of communication to primary care practitioners, including pediatricians. The need for consultation and the receipt of the consultation must be documented in the patient record maintained by the primary care practitioner. If the patient consents, and subject to federal limitations and data privacy provisions, the consultation may be provided without the patient present.

Subd. 49. **Community health worker.** (a) Medical assistance covers the care coordination and patient education services provided by a community health worker if the community health worker has:

1. received a certificate from the Minnesota State Colleges and Universities System approved community health worker curriculum; or

2. at least five years of supervised experience with an enrolled physician, registered nurse, advanced practice registered nurse, mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), and section 245.4871, subdivision 27, clauses (1) to (5), or dentist, or at least five years of supervised experience by a certified public health nurse operating under the direct authority of an enrolled unit of government.

Community health workers eligible for payment under clause (2) must complete the certification program by January 1, 2010, to continue to be eligible for payment.

(b) Community health workers must work under the supervision of a medical assistance enrolled physician, registered nurse, advanced practice registered nurse, mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), and section 245.4871, subdivision 27, clauses (1) to (5), or dentist, or work under the supervision of a certified public health nurse operating under the direct authority of an enrolled unit of government.

(c) Care coordination and patient education services covered under this subdivision include, but are not limited to, services relating to oral health and dental care.

Subd. 50. [Repealed, 2015 c 21 art 1 s 110]

Subd. 51. **Provider-directed care coordination services.** The commissioner shall develop and implement a provider-directed care coordination program for medical assistance recipients who are not enrolled in the prepaid medical assistance program and who are receiving services on a fee-for-service basis. This program provides payment to primary care clinics for care coordination for people who have complex and chronic medical conditions. Clinics must meet certain criteria such as the capacity to develop care plans; have a dedicated care coordinator; and have an adequate number of fee-for-service clients, evaluation mechanisms, and quality improvement processes to qualify for reimbursement. For purposes of this subdivision, a primary care clinic is a medical clinic designated as the patient's first point of contact for medical care, available 24 hours a day, seven days a week, that provides or arranges for the patient's comprehensive health care needs, and provides overall integration, coordination and continuity over time and referrals for specialty care.

Subd. 52. **Lead risk assessments.** (a) Effective October 1, 2007, or six months after federal approval, whichever is later, medical assistance covers lead risk assessments provided by a lead risk assessor who is licensed by the commissioner of health under section 144.9505 and employed by an assessing agency as defined in section 144.9501. Medical assistance covers a one-time on-site investigation of a recipient's home or primary residence to determine the existence of lead so long as the recipient is under the age of 21 and has a venous blood lead level specified in section 144.9504, subdivision 2, paragraph (a).
(b) Medical assistance reimbursement covers the lead risk assessor's time to complete the following activities:

1. gathering samples;
2. interviewing family members;
3. gathering data, including meter readings; and
4. providing a report with the results of the investigation and options for reducing lead-based paint hazards.

Medical assistance coverage of lead risk assessment does not include testing of environmental substances such as water, paint, or soil or any other laboratory services. Medical assistance coverage of lead risk assessments is not included in the capitated services for children enrolled in health plans through the prepaid medical assistance program and the MinnesotaCare program.

(c) Payment for lead risk assessment must be cost-based and must meet the criteria for federal financial participation under the Medicaid program. The rate must be based on allowable expenditures from cost information gathered. Under section 144.9507, subdivision 5, federal medical assistance funds may not replace existing funding for lead-related activities. The nonfederal share of costs for services provided under this subdivision must be from state or local funds and is the responsibility of the agency providing the risk assessment. When the risk assessment is conducted by the commissioner of health, the state share must be from appropriations to the commissioner of health for this purpose. Eligible expenditures for the nonfederal share of costs may not be made from federal funds or funds used to match other federal funds. Any federal disallowances are the responsibility of the agency providing risk assessment services.

Subd. 53. **Centers of excellence.** For complex medical procedures with a high degree of variation in outcomes, for which the Medicare program requires facilities providing the services to meet certain criteria as a condition of coverage, the commissioner may develop centers of excellence facility criteria in consultation with the Health Services Policy Committee under subdivision 3c. The criteria must reflect facility traits that have been linked to superior patient safety and outcomes for the procedures in question, and must be based on the best available empirical evidence. For medical assistance recipients enrolled on a fee-for-service basis, the commissioner may make coverage for these procedures conditional upon the facility providing the services meeting the specified criteria. Only facilities meeting the criteria may be reimbursed for the procedures in question.

[See Note.]

Subd. 54. **Services provided in birth centers.** (a) Medical assistance covers services provided in a licensed birth center by a licensed health professional if the service would otherwise be covered if provided in a hospital.

(b) Facility services provided by a birth center shall be paid at the lower of billed charges or 70 percent of the statewide average for a facility payment rate made to a hospital for an uncomplicated vaginal birth as determined using the most recent calendar year for which complete claims data is available. If a recipient is transported from a birth center to a hospital prior to the delivery, the payment for facility services to the birth center shall be the lower of billed charges or 15 percent of the average facility payment made to a hospital for the services provided for an uncomplicated vaginal delivery as determined using the most recent calendar year for which complete claims data is available.
(c) Nursery care services provided by a birth center shall be paid the lower of billed charges or 70 percent of the statewide average for a payment rate paid to a hospital for nursery care as determined by using the most recent calendar year for which complete claims data is available.

(d) Professional services provided by traditional midwives licensed under chapter 147D shall be paid at the lower of billed charges or 100 percent of the rate paid to a physician performing the same services. If a recipient is transported from a birth center to a hospital prior to the delivery, a licensed traditional midwife who does not perform the delivery may not bill for any delivery services. Services are not covered if provided by an unlicensed traditional midwife.

(e) The commissioner shall apply for any necessary waivers from the Centers for Medicare and Medicaid Services to allow birth centers and birth center providers to be reimbursed.

Subd. 55. Payment for noncovered services. (a) Except when specifically prohibited by the commissioner or federal law, a provider may seek payment from the recipient for services not eligible for payment under the medical assistance program when the provider, prior to delivering the service, reviews and considers all other available covered alternatives with the recipient and obtains a signed acknowledgment from the recipient of the potential of the recipient's liability. The signed acknowledgment must be in a form approved by the commissioner.

(b) Conditions under which a provider must not request payment from the recipient include, but are not limited to:

(1) a service that requires prior authorization, unless authorization has been denied as not medically necessary and all other therapeutic alternatives have been reviewed;

(2) a service for which payment has been denied for reasons relating to billing requirements;

(3) standard shipping or delivery and setup of medical equipment or medical supplies;

(4) services that are included in the recipient's long term care per diem;

(5) the recipient is enrolled in the Restricted Recipient Program and the provider is one of a provider type designated for the recipient's health care services; and

(6) the noncovered service is a prescription drug identified by the commissioner as having the potential for abuse and overuse, except where payment by the recipient is specifically approved by the commissioner on the date of service based upon compelling evidence supplied by the prescribing provider that establishes medical necessity for that particular drug.

(c) The payment requested from recipients for noncovered services under this subdivision must not exceed the provider's usual and customary charge for the actual service received by the recipient. A recipient must not be billed for the difference between what medical assistance paid for the service or would pay for a less costly alternative service.

Subd. 56. Medical service coordination. (a)(1) Medical assistance covers in-reach community-based service coordination that is performed through a hospital emergency department as an eligible procedure under a state healthcare program for a frequent user. A frequent user is defined as an individual who has frequented the hospital emergency department for services three or more times in the previous four consecutive months. In-reach community-based service coordination includes navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of emergency room and other nonmedically necessary health care utilization.
(2) Medical assistance covers in-reach community-based service coordination that is performed through a hospital emergency department or inpatient psychiatric unit for a child or young adult up to age 21 with a serious emotional disturbance who has frequented the hospital emergency room two or more times in the previous consecutive three months or been admitted to an inpatient psychiatric unit two or more times in the previous consecutive four months, or is being discharged to a shelter.

(b) Reimbursement must be made in 15-minute increments and allowed for up to 60 days posthospital discharge based upon the specific identified emergency department visit or inpatient admitting event. In-reach community-based service coordination shall seek to connect frequent users with existing covered services available to them, including, but not limited to, targeted case management, waiver case management, or care coordination in a health care home. For children and young adults with a serious emotional disturbance, in-reach community-based service coordination includes navigating and arranging for community-based services prior to discharge to address a client's mental health, chemical health, social, educational, family support and housing needs, or any other activity targeted at reducing multiple incidents of emergency room use, inpatient readmissions, and other nonmedically necessary health care utilization. In-reach services shall seek to connect them with existing covered services, including targeted case management, waiver case management, care coordination in a health care home, children's therapeutic services and supports, crisis services, and respite care. Eligible in-reach service coordinators must hold a minimum of a bachelor's degree in social work, public health, corrections, or a related field. The commissioner shall submit any necessary application for waivers to the Centers for Medicare and Medicaid Services to implement this subdivision.

(c)(1) For the purposes of this subdivision, "in-reach community-based service coordination" means the practice of a community-based worker with training, knowledge, skills, and ability to access a continuum of services, including housing, transportation, chemical and mental health treatment, employment, education, and peer support services, by working with an organization's staff to transition an individual back into the individual's living environment. In-reach community-based service coordination includes working with the individual during their discharge and for up to a defined amount of time in the individual's living environment, reducing the individual's need for readmittance.

(2) Hospitals utilizing in-reach service coordinators shall report annually to the commissioner on the number of adults, children, and adolescents served; the postdischarge services which they accessed; and emergency department/psychiatric hospitalization readmissions. The commissioner shall ensure that services and payments provided under in-reach care coordination do not duplicate services or payments provided under section 256B.0753, 256B.0755, or 256B.0625, subdivision 20.

Subd. 56a. **Post-arrest community-based service coordination.** (a) Medical assistance covers post-arrest community-based service coordination for an individual who:

(1) has been identified as having a mental illness or substance use disorder using a screening tool approved by the commissioner;

(2) does not require the security of a public detention facility and is not considered an inmate of a public institution as defined in Code of Federal Regulations, title 42, section 435.1010;

(3) meets the eligibility requirements in section 256B.056; and

(4) has agreed to participate in post-arrest community-based service coordination through a diversion contract in lieu of incarceration.

(b) Post-arrest community-based service coordination means navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing
the incidence of jail utilization and connecting individuals with existing covered services available to them, including, but not limited to, targeted case management, waiver case management, or care coordination.

(c) Post-arrest community-based service coordination must be provided by an individual who is an employee of a county or is under contract with a county to provide post-arrest community-based coordination and is qualified under one of the following criteria:

1. a licensed mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6);

2. a mental health practitioner as defined in section 245.462, subdivision 17, working under the clinical supervision of a mental health professional; or

3. a certified peer specialist under section 256B.0615, working under the clinical supervision of a mental health professional.

(d) Reimbursement is allowed for up to 60 days following the initial determination of eligibility.

(e) Providers of post-arrest community-based service coordination shall annually report to the commissioner on the number of individuals served, and number of the community-based services that were accessed by recipients. The commissioner shall ensure that services and payments provided under post-arrest community-based service coordination do not duplicate services or payments provided under section 256B.0625, subdivision 20, 256B.0753, 256B.0755, or 256B.0757.

(f) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of cost for post-arrest community-based service coordination services shall be provided by the county providing the services, from sources other than federal funds or funds used to match other federal funds.

[See Note.]
Subd. 58. **Early and periodic screening, diagnosis, and treatment services.** Medical assistance covers early and periodic screening, diagnosis, and treatment services (EPSDT). The payment amount for a complete EPSDT screening shall not include charges for health care services and products that are available at no cost to the provider and shall not exceed the rate established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

Subd. 59. **Services provided by advanced dental therapists and dental therapists.** Medical assistance covers services provided by advanced dental therapists and dental therapists when provided within the scope of practice identified in sections 150A.105 and 150A.106.

Subd. 60. **Community paramedic services.** (a) Medical assistance covers services provided by community paramedics who are certified under section 144E.28, subdivision 9, when the services are provided in accordance with this subdivision to an eligible recipient as defined in paragraph (b).

(b) For purposes of this subdivision, an eligible recipient is defined as an individual who has received hospital emergency department services three or more times in a period of four consecutive months in the past 12 months or an individual who has been identified by the individual's primary health care provider for whom community paramedic services identified in paragraph (c) would likely prevent admission to or would allow discharge from a nursing facility; or would likely prevent readmission to a hospital or nursing facility.

(c) Payment for services provided by a community paramedic under this subdivision must be a part of a care plan ordered by a primary health care provider in consultation with the medical director of an ambulance service and must be billed by an eligible provider enrolled in medical assistance that employs or contracts with the community paramedic. The care plan must ensure that the services provided by a community paramedic are coordinated with other community health providers and local public health agencies and that community paramedic services do not duplicate services already provided to the patient, including home health and waiver services. Community paramedic services shall include health assessment, chronic disease monitoring and education, medication compliance, immunizations and vaccinations, laboratory specimen collection, hospital discharge follow-up care, and minor medical procedures approved by the ambulance medical director.

(d) Services provided by a community paramedic to an eligible recipient who is also receiving care coordination services must be in consultation with the providers of the recipient's care coordination services.

(e) The commissioner shall seek the necessary federal approval to implement this subdivision.

Subd. 60a. **Community medical response emergency medical technician services.** (a) Medical assistance covers services provided by a community medical response emergency medical technician (CEMT) who is certified under section 144E.275, subdivision 7, when the services are provided in accordance with this subdivision.

(b) A CEMT may provide a postdischarge visit, after discharge from a hospital or skilled nursing facility, when ordered by a treating physician. The postdischarge visit includes:

1. verbal or visual reminders of discharge orders;
2. recording and reporting of vital signs to the patient's primary care provider;
3. medication access confirmation;
4. food access confirmation; and
5. identification of home hazards.
(c) An individual who has repeat ambulance calls due to falls or has been identified by the individual's primary care provider as at risk for nursing home placement, may receive a safety evaluation visit from a CEMT when ordered by a primary care provider in accordance with the individual's care plan. A safety evaluation visit includes:

(1) medication access confirmation;
(2) food access confirmation; and
(3) identification of home hazards.

(d) A CEMT shall be paid at $9.75 per 15-minute increment. A safety evaluation visit may not be billed for the same day as a postdischarge visit for the same individual.

[See Note.]

Subd. 61. Family psychoeducation services. Effective July 1, 2013, or upon federal approval, whichever is later, medical assistance covers family psychoeducation services provided to a child up to age 21 with a diagnosed mental health condition when identified in the child's individual treatment plan and provided by a licensed mental health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C, who has determined it medically necessary to involve family members in the child's care. For the purposes of this subdivision, "family psychoeducation services" means information or demonstration provided to an individual or family as part of an individual, family, multifamily group, or peer group session to explain, educate, and support the child and family in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience.

Subd. 62. Mental health clinical care consultation. Effective July 1, 2013, or upon federal approval, whichever is later, medical assistance covers clinical care consultation for a person up to age 21 who is diagnosed with a complex mental health condition or a mental health condition that co-occurs with other complex and chronic conditions, when described in the person's individual treatment plan and provided by a licensed mental health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C. For the purposes of this subdivision, "clinical care consultation" means communication from a treating mental health professional to other providers or educators not under the clinical supervision of the treating mental health professional who are working with the same client to inform, inquire, and instruct regarding the client's symptoms; strategies for effective engagement, care, and intervention needs; and treatment expectations across service settings; and to direct and coordinate clinical service components provided to the client and family.

Subd. 63. Payment for multiple services provided on the same day. The commissioner shall not prohibit payment, including supplemental payments, for mental health services or dental services provided to a patient by a clinic or health care professional solely because the mental health or dental services were provided on the same day as other covered health services furnished by the same provider.

Subd. 64. Investigational drugs, biological products, and devices. (a) Medical assistance and the early periodic screening, diagnosis, and treatment (EPSDT) program do not cover costs incidental to, associated with, or resulting from the use of investigational drugs, biological products, or devices as defined in section 151.375.
(b) Notwithstanding paragraph (a), stiripentol may be covered by the EPSDT program if all the following conditions are met:

(1) the use of stiripentol is determined to be medically necessary;

(2) the enrollee has a documented diagnosis of Dravet syndrome, regardless of whether an SCN1A genetic mutation is found, or the enrollee is a child with malignant migrating partial epilepsy in infancy due to an SCN2A genetic mutation;

(3) all other available covered prescription medications that are medically necessary for the enrollee have been tried without successful outcomes; and

(4) the United States Food and Drug Administration has approved the treating physician's individual patient investigational new drug application (IND) for the use of stiripentol for treatment.

This paragraph does not apply to MinnesotaCare coverage under chapter 256L.

History: Ex1967 c 16 s 2; 1969 c 395 s 1; 1973 c 717 s 17; 1975 c 247 s 9; 1975 c 384 s 1; 1975 c 437 art 2 s 3; 1976 c 173 s 56; 1976 c 236 s 1; 1976 c 312 s 1; 1978 c 508 s 2; 1978 c 560 s 10; 1981 c 360 art 2 s 26,54; 1Sp1981 c 2 s 12; 1Sp1981 c 4 art 4 s 22; 3Sp1981 c 2 art 1 s 31; 1982 c 562 s 2; 1983 c 151 s 1,2; 1983 c 312 art 1 s 27; art 3 s 10; art 9 s 4; 1984 c 654 art 5 s 58; 1985 c 21 s 52-54; 1985 c 49 s 41; 1985 c 252 s 19,20; 1Sp1985 c 3 s 19; 1986 c 394 s 17; 1987 c 309 s 24; 1987 c 370 art 1 s 3; art 2 s 4; 1987 c 374 s 1; 1987 c 403 art 2 s 73,74; art 5 s 16; 1988 c 508 s 10; 1988 c 689 art 2 s 141,268; 1989 c 282 art 3 s 54-58; 1990 c 422 s 10; 1990 c 568 art 3 s 43-50,104; 1991 c 199 art 2 s 1; 1991 c 292 art 4 s 41-49; art 6 s 45; art 7 s 5-9,11; 1992 c 391 s 1,2; 1992 c 513 art 7 s 43-49; art 9 s 25; 1993 c 246 s 1,2; 1993 c 247 art 4 s 11; 1993 c 345 art 13 s 1; 1Sp1993 c 1 art 3 s 23; art 5 s 36-49; art 7 s 41-44; art 9 s 71; 1Sp1993 c 6 s 10; 1994 c 465 art 3 s 52; 1994 c 625 art 8 s 72; 1995 c 178 art 2 s 26; 1995 c 207 art 6 s 38-51; art 8 s 33; 1995 c 234 art 6 s 38; 1995 c 263 s 10; 1996 c 451 art 2 s 20; art 5 s 15,16; 1997 c 203 art 2 s 25; art 4 s 25,26; 1997 c 225 art 4 s 3; art 6 s 5,8; 1998 c 398 art 2 s 46; 1998 c 407 art 4 s 20-28; 1999 c 86 art 2 s 4; 1999 c 139 art 4 s 2; 1999 c 245 art 4 s 37-49,121; art 5 s 20; art 8 s 5,87; art 10 s 10; 2000 c 298 s 3; 2000 c 347 s 1; 2000 c 474 s 6,7; 2000 c 488 art 9 s 16; 2001 c 178 art 1 s 44; 2001 c 203 s 9; 1Sp2001 c 9 art 2 s 30-38; art 3 s 16-19; art 9 s 41,42; 2002 c 220 art 15 s 13; 2002 c 277 s 12-14,32; 2002 c 294 s 6; 2002 c 375 art 2 s 13-16; 2002 c 379 art 1 s 113; 2003 c 112 art 2 s 50; 1Sp2003 c 14 art 3 s 25; art 4 s 4-7; 11 s 11; art 12 s 33-36; 2004 c 288 art 5 s 3; art 6 s 22; 2005 c 10 art 1 s 48; 2005 c 56 s 1; 2005 c 98 art 2 s 3,4; 2005 c 147 art 1 s 67; 2005 c 155 art 3 s 2-6; 1Sp2005 c 4 art 2 s 8-10; art 7 s 13,14; art 8 s 29-40; 2006 c 282 art 16 s 6; 2007 c 147 art 4 s 5-7; art 5 s 9; art 6 s 18; art 7 s 6,7; art 8 s 19-21; art 11 s 17; art 15 s 16; 2008 c 326 art 1 s 29-32; 2008 c 363 art 15 s 4; art 17 s 9; 2009 c 79 art 5 s 25-36; art 7 s 18,20; 2009 c 101 art 2 s 109; 2009 c 159 s 89; 2009 c 167 s 13; 2009 c 173 art 1 s 20,21,41; art 3 s 9,10; 2010 c 200 art 1 s 4,5; 2010 c 303 s 4; 2010 c 307 s 1; 2010 c 310 art 1 s 1; art 6 s 2; art 7 s 1; art 8 s 1; art 9 s 10; art 10 s 1; art 11 s 1; art 12 s 1,2; 2010 c 352 art 1 s 7; 1Sp2010 c 1 art 16 s 8-15; art 24 s 4; 2011 c 76 art 1 s 37; 2011 c 86 s 17,18; 1Sp2011 c 9 art 6 s 28-48; art 7 s 8; art 8 s 6; 1Sp2011 c 11 art 3 s 12; 2012 c 169 s 1; 2012 c 181 s 1; 2012 c 187 art 3 s 12; 2012 c 216 art 9 s 11; art 11 s 1; art 12 s 8; art 13 s 7-11; 2012 c 247 art 1 s 3-9,27; 2013 c 81 s 4-10; 2013 c 108 art 4 s 17-20; art 6 s 8-16; art 9 s 10; 2013 c 125 art 1 s 107; 2014 c 262 art 5 s 6; 2014 c 275 art 1 s 58; 2014 c 286 art 7 s 13; art 8 s 31; 2014 c 291 art 9 s 1,5; 2014 c 311 s 18; 2014 c 312 art 4 s 28-35; 2015 c 15 s 2; 2015 c 71 art 2 s 34,35; art 9 s 13-15; art 11 s 19-28; 2015 c 78 art 4 s 52,61; art 5 s 2; 2016 c 99 art 2 s 3; 2016 c 158 art 1 s 111; art 2 s 85-89; 2016 c 164 s 7; 2016 c 189 art 19 s 10-13; 2017 c 53 s 1; 1Sp2017 c 5 art 4 s 8; art 12 s 22; 1Sp2017 c 6 art 1 s 5,6; art 4 s 26-37; art 8 s 68

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NOTE: Subdivision 16 was found unconstitutional with regard to public funding for medical services related to therapeutic abortions. Women of State of Minn. by Doe v. Gomez, 542 N.W.2d 17 (Minn. 1995).

NOTE: The amendment to subdivision 20 by Laws 2017, First Special Session chapter 6, article 4, section 33, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is received. Laws 2017, First Special Session chapter 6, article 4, section 33, the effective date.

NOTE: Subdivision 20b, as added by Laws 2017, First Special Session chapter 6, article 4, section 34, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is received. Laws 2017, First Special Session chapter 6, article 4, section 34, the effective date.

NOTE: Subdivision 45a, as added by Laws 2015, chapter 71, article 2, section 34, is effective July 1, 2017, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2015, chapter 71, article 2, section 34, the effective date.

NOTE: Subdivision 53, as added by Laws 2009, chapter 173, article 3, section 10, is effective August 1, 2009, or upon federal approval, whichever is later. Laws 2009, chapter 173, article 3, section 10, the effective date.

NOTE: Subdivision 56a, as added by Laws 2017, First Special Session chapter 6, article 4, section 36, is effective upon federal approval for services provided on or after July 1, 2017. The commissioner of human services shall notify the revisor of statutes when federal approval is received. Laws 2017, First Special Session chapter 6, article 4, section 36, the effective date.

NOTE: Subdivision 60a, as added by Laws 2016, chapter 189, article 19, section 13, received federal approval and is effective July 1, 2017. Laws 2016, chapter 189, article 19, section 13, the effective date.
A BILL FOR AN ACT

RELATING TO TELEHEALTH.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The legislature finds that telehealth has allowed states to implement innovative health policy reforms that achieve significant cost savings and improve health outcomes. There are many opportunities for improving health care access in Hawaii through the use of telehealth, especially in areas of the State faced with a shortage of health care providers.

However, the legislature further finds that restrictions on telehealth, such as geographical limitations on service, limitations on patient setting, and restrictions on applicable technology, act as barriers that prevent health care providers and patients from realizing the full benefits of telehealth.

Accordingly, the purpose of this Act is to enhance access to care via telehealth by:

(1) Requiring the State's medicaid managed care and fee-for-service programs to cover services provided through telehealth;
(2) Specifying that any telehealth services provided shall be consistent with all federal and state privacy, security, and confidentiality laws;

(3) Specifying medical professional liability insurance policy requirements with regard to telehealth coverage;

(4) Clarifying that reimbursement for services provided through telehealth shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient;

(5) Requiring written disclosure of coverages and benefits associated with telehealth services;

(6) Ensuring that telehealth encompasses store and forward technologies, remote monitoring, live consultation, and mobile health;

(7) Ensuring that telehealth is covered when originating in a patient's home and other non-medical environments;

(8) Clarifying requirements for physicians and out-of-state physicians to establish a physician-patient relationship via telehealth;

(9) Ensuring that reimbursement requirements for telehealth services apply to all health benefits plans under chapter 87A, Hawaii Revised Statutes; and

(10) Making other conforming amendments related to telehealth for clarity.
SECTION 2. Chapter 346, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"§346—Coverage for telehealth. (a) The State's medicaid managed care and fee-for-service programs shall not deny coverage for any service provided through telehealth that would be covered if the service were provided through in-person consultation between a patient and a health care provider.

(b) Reimbursement for services provided through telehealth shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient. Nothing in this section shall require a health care provider to be physically present with the patient at an originating site unless a health care provider at the distant site deems it necessary.

(c) There shall be no geographic restrictions or requirements for telehealth coverage or reimbursement under this section.

(d) There shall be no restrictions on originating site requirements for telehealth coverage or reimbursement under this section.

(e) Services provided by telehealth pursuant to this section shall be consistent with all federal and state privacy, security, and confidentiality laws.

(f) Notwithstanding any other law to the contrary, the provisions of this section shall comply with the applicable federal requirements related to utilization, coverage, and reimbursement for telehealth services.
(g) For the purposes of this section:

"Distant site" means the location of the health care provider delivering services through telehealth at the time the services are provided.

"Health care provider" means a provider of services, as defined in title 42 United States Code section 1395x(u), a provider of medical and other health services, as defined in title 42 United States Code section 1395x(s), other practitioners licensed by the State and working within their scope of practice, and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians licensed under chapter 453, advanced practice registered nurses licensed under chapter 457, psychologists licensed under chapter 465, and dentists licensed under chapter 448.

"Originating site" means the location where the patient is located, whether accompanied or not by a health care provider, at the time services are provided by a health care provider through telehealth, including but not limited to a health care provider's office, hospital, critical access hospital, rural health clinic, federally qualified health center, a patient's home, and other non-medical environments such as school-based health centers, university-based health centers, or the work location of a patient.

"Telehealth" means the use of telecommunications services, as defined in section 269-1, to encompass four modalities: store and forward technologies, remote monitoring, live consultation, and mobile
health; and which shall include but not be limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information while a patient is at an originating site and the health care provider is at a distant site. Standard telephone contacts, facsimile transmissions, or e-mail text, in combination or by itself, does not constitute a telehealth service for the purposes of this section."

SECTION 3. Chapter 457, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"§457- Telehealth; privacy, security, and confidentiality. Services relating to the practice of nursing provided by telehealth pursuant to this chapter shall be consistent with all federal and state privacy, security, and confidentiality laws."

SECTION 4. Chapter 671, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"§671- Professional liability insurance; coverage for telehealth. (a) Every insurer providing professional liability insurance for a health care provider shall ensure that every policy that is issued, amended, or renewed in this State on or after the
effective date of Act , Session Laws of Hawaii 2016, shall provide malpractice coverage for telehealth that shall be equivalent to coverage for the same services provided via face-to-face contact between a health care provider and a patient.

(b) No insurer providing professional liability insurance policies shall require face-to-face contact between a health care provider and a patient as a prerequisite for coverage of services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services were provided. The coverage required in this section may be subject to all terms and conditions of the policy agreed upon between the health care provider and the insurer.

(c) For purposes of this section:

"Distant site" means the location of the health care provider delivering services through telehealth at the time the services are provided.

"Originating site" means the location where the patient is located, whether accompanied or not by a health care provider, at the time services are provided by a health care provider through telehealth, including but not limited to a health care provider's office, hospital, critical access hospital, rural health clinic, federally qualified health center, a patient's home, and other non-medical environments such as school-based health centers, university-based health centers, or the work location of a patient.
"Telehealth" means the use of telecommunications services, as defined in section 269-1, to encompass four modalities: store and forward technologies, remote monitoring, live consultation, and mobile health; and which shall include but not be limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information while a patient is at an originating site and the health care provider is at a distant site. Standard telephone contacts, facsimile transmissions, or e-mail text, in combination or by itself, does not constitute a telehealth service for the purposes of this section.

SECTION 5. Section 209E-2, Hawaii Revised Statutes, is amended by amending the definition of "medical and health care services" to read as follows:

"Medical and health care services" means medical research and clinical trials, but not routine medical treatment or services."

SECTION 6. Section 431:10A-116.3, Hawaii Revised Statutes, is amended to read as follows:

"§431:10A-116.3 Coverage for telehealth. (a) It is the intent of the legislature to recognize the application of telehealth as a reimbursable service by which an individual shall receive medical
services from a health care provider without face-to-face contact with the health care provider.

(b) No accident and health or sickness insurance plan that is issued, amended, or renewed shall require face-to-face contact between a health care provider and a patient as a prerequisite for payment for services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services were provided. The coverage required in this section may be subject to all terms and conditions of the plan agreed upon among the enrollee or subscriber, the insurer, and the health care provider.

(c) Reimbursement for services provided through telehealth shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient. [There shall be no reimbursement for a telehealth consultation between health care providers unless a health care provider-patient relationship exists between the patient and one of the health care providers involved in the telehealth interaction and the patient is accompanied by a treating health care provider at the time telehealth services are provided by the consulting health care provider; provided that when behavioral health services are provided, a second health care provider shall not be required to accompany the patient.

For the purposes of this section, "health care provider" means a provider of services, as defined in 42 U.S.C. 1395x(u), a provider of medical and other health services, as defined in 42 U.S.C. 1395x(s),
and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians licensed under chapter 453, advanced practice registered nurses licensed under chapter 457, psychologists licensed under chapter 465, and dentists licensed under chapter 448. Nothing in this section shall require a health care provider to be physically present with the patient at an originating site unless a health care provider at the distant site deems it necessary.

(d) Notwithstanding chapter 453 or rules adopted pursuant thereto, in the event that a health care provider-patient relationship does not exist between the patient and the health care provider to be involved in a telehealth interaction between the patient and the health care provider, a telehealth mechanism may be used to establish a health care provider-patient relationship.

(e) All insurers shall provide current and prospective insureds with written disclosure of coverages and benefits associated with telehealth services, including information on copayments, deductibles, or coinsurance requirements under a policy, contract, plan, or agreement. The information provided shall be current, understandable, and available prior to the issuance of a policy, contract, plan, or agreement, and upon request after the policy, contract, plan, or agreement has been issued.
(f) Services provided by telehealth pursuant to this section shall be consistent with all federal and state privacy, security, and confidentiality laws.

[(e) (g)] For the purposes of this section, "telehealth":

"Distant site" means the location of the health care provider delivering services through telehealth at the time the services are provided.

"Health care provider" means a provider of services, as defined in title 42 United States Code section 1395x(u), a provider of medical and other health services, as defined in title 42 United States Code section 1395x(s), other practitioners licensed by the State and working within their scope of practice, and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians licensed under chapter 453, advanced practice registered nurses licensed under chapter 457, psychologists licensed under chapter 465, and dentists licensed under chapter 448.

"Originating site" means the location where the patient is located, whether accompanied or not by a health care provider, at the time services are provided by a health care provider through telehealth, including but not limited to a health care provider's office, hospital, health care facility, a patient's home, and other non-medical environments such as school-based health centers, university-based health centers, or the work location of a patient.
"Telehealth" means the use of telecommunications services, as defined in section 269-1, including to encompass four modalities: store and forward technologies, remote monitoring, live consultation, and mobile health; and which shall include but not be limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information [to parties separated by distance.] while a patient is at an originating site and the health care provider is at a distant site. Standard telephone contacts, facsimile transmissions, or e-mail text, in combination or by itself, does not constitute a telehealth service for the purposes of this chapter."

SECTION 7. Section 432:1-601.5, Hawaii Revised Statutes, is amended to read as follows:

"§432:1-601.5 Coverage for telehealth. (a) It is the intent of the legislature to recognize the application of telehealth as a reimbursable service by which an individual shall receive medical services from a health care provider without face-to-face contact with the health care provider.

(b) No mutual benefit society plan that is issued, amended, or renewed shall require face-to-face contact between a health care provider and a patient as a prerequisite for payment for services appropriately provided through telehealth in accordance with generally
accepted health care practices and standards prevailing in the applicable professional community at the time the services were provided. The coverage required in this section may be subject to all terms and conditions of the plan agreed upon among the enrollee or subscriber, the mutual benefit society, and the health care provider.

(c) Reimbursement for services provided through telehealth shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient. [There shall be no reimbursement for a telehealth consultation between health care providers unless a health care provider-patient relationship exists between the patient and one of the health care providers involved in the telehealth interaction and the patient is accompanied by a treating health care provider at the time telehealth services are provided by the consulting health care provider; provided that when behavioral health services are provided, a second health care provider shall not be required to accompany the patient.

For the purposes of this section, "health care provider" means a provider of services, as defined in 42 U.S.C. 1395x(u), a provider of medical or other health services, as defined in 42 U.S.C. 1395x(s), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians licensed under chapter 453, advanced practice registered nurses licensed under chapter 457, psychologists licensed under chapter 465, and dentists
Nothing in this section shall require a health care provider to be physically present with the patient at an originating site unless a health care provider at the distant site deems it necessary.

(d) Notwithstanding chapter 453 or rules adopted pursuant thereto, in the event that a health care provider-patient relationship does not exist between the patient and the health care provider to be involved in a telehealth interaction between the patient and health care provider, a telehealth mechanism may be used to establish a health care provider-patient relationship.

(e) All insurers shall provide current and prospective enrollees or subscribers with written disclosure of coverages and benefits associated with telehealth services, including information on copayments, deductibles, or coinsurance requirements under a policy, contract, plan, or agreement. The information provided shall be current, understandable, and available prior to the issuance of a policy, contract, plan, or agreement, and upon request after the policy, contract, plan, or agreement has been issued.

(f) Services provided by telehealth pursuant to this section shall be consistent with all federal and state privacy, security, and confidentiality laws.

[(e) (g)] For the purposes of this section, "telehealth":

"Health care provider" means a provider of services, as defined in title 42 United States Code section 1395x(u), a provider of medical and other health services, as defined in title 42 United States Code section 1395x(s), other practitioners licensed by the State and
working within their scope of practice, and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians licensed under chapter 453, advanced practice registered nurses licensed under chapter 457, psychologists licensed under chapter 465, and dentists licensed under chapter 448.

"Originating site" means the location where the patient is located, whether accompanied or not by a health care provider, at the time services are provided by a health care provider through telehealth, including but not limited to a health care provider's office, hospital, health care facility, a patient's home, and other non-medical environments such as school-based health centers, university-based health centers, or the work location of a patient.

"Telehealth" means the use of telecommunications services, as defined in section 269-1, [including] to encompass four modalities: store and forward technologies, remote monitoring, live consultation, and mobile health; and which shall include but not be limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information [to parties separated by distance.] while a patient is at an originating site and the health care provider is at a distant
site. Standard telephone contacts, facsimile transmissions, or e-mail text, in combination or by itself, does not constitute a telehealth service for the purposes of this chapter."

SECTION 8. Section 432D-23.5, Hawaii Revised Statutes, is amended to read as follows:

"§432D-23.5 Coverage for telehealth. (a) It is the intent of the legislature to recognize the application of telehealth as a reimbursable service by which an individual shall receive medical services from a health care provider without face-to-face contact with the health care provider.

(b) No health maintenance organization plan that is issued, amended, or renewed shall require face-to-face contact between a health care provider and a patient as a prerequisite for payment for services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services were provided. The coverage required in this section may be subject to all terms and conditions of the plan agreed upon among the enrollee or subscriber, the health maintenance organization, and the health care provider.

(c) Reimbursement for services provided through telehealth shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient. [There shall be no reimbursement for a telehealth consultation between health care providers unless an existing health care provider-patient relationship exists between the patient and one
of the health care providers involved in the telehealth interaction and the patient is accompanied by a treating health care provider at the time telehealth services are provided by the consulting health care provider; provided that when behavioral health services are provided, a second health care provider shall not be required to accompany the patient.

For the purposes of this section, "health care provider" means a provider of services, as defined in 42 U.S.C. 1395x(u), a provider of medical or other health services, as defined in 42 U.S.C. 1395x(s), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians licensed under chapter 453, advanced practice registered nurses licensed under chapter 457, psychologists licensed under chapter 465, and dentists licensed under chapter 448. Nothing in this section shall require a health care provider to be physically present with the patient at an originating site unless a health care provider at the distant site deems it necessary.

(d) Notwithstanding chapter 453 or rules adopted pursuant thereto, in the event that a health care provider-patient relationship does not exist between the patient and the health care provider involved in a telehealth interaction between the patient and the health care provider, a telehealth mechanism may be used to establish a health care provider-patient relationship.
(e) All health maintenance organizations shall provide current and prospective insureds with written disclosure of coverages and benefits associated with telehealth services, including information on copayments, deductibles, or coinsurance requirements under a policy, contract, plan, or agreement. The information provided shall be current, understandable, and available prior to enrollment in a policy, contract, plan, or agreement and upon request after enrollment in the policy, contract, plan, or agreement.

(f) Services provided by telehealth pursuant to this section shall be consistent with all federal and state privacy, security, and confidentiality laws.

(g) For the purposes of this section, "telehealth":

"Distant site" means the location of the health care provider delivering services through telehealth at the time the services are provided.

"Health care provider" means a provider of services, as defined in title 42 United States Code section 1395x(u), a provider of medical and other health services, as defined in title 42 United States Code section 1395x(s), other practitioners licensed by the State and working within their scope of practice, and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians licensed under chapter 453, advanced practice registered nurses licensed under chapter 457, psychologists licensed under chapter 465, and dentists licensed under chapter 448.
"Originating site" means the location where the patient is located, whether accompanied or not by a health care provider, at the time services are provided by a health care provider through telehealth, including but not limited to a health care provider's office, hospital, health care facility, a patient's home, and other non-medical environments such as school-based health centers, university-based health centers, or the work location of a patient.

"Telehealth" means the use of telecommunications services, as defined in section 269-1, to encompass four modalities: store and forward technologies, remote monitoring, live consultation, and mobile health; and which shall include but not be limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information while a patient is at an originating site and the health care provider is at a distant site. Standard telephone contacts, facsimile transmissions, or e-mail text, in combination or by itself, does not constitute a telehealth service for the purposes of this chapter."

SECTION 9. Section 453-1.3, Hawaii Revised Statutes, is amended to read as follows:

"§453-1.3 Practice of telehealth. (a) Subject to section 453-2(b), nothing in this section shall preclude any physician acting
within the scope of the physician's license to practice from practicing telehealth as defined in this section.

[(b)] For the purposes of this section, "telehealth" means the use of telecommunications as that term is defined in section 269-1, including but not limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purposes of delivering enhanced health care services and information to parties separated by distance, establishing a physician-patient relationship, evaluating a patient, or treating a patient.

[(c)] Telehealth services shall include a documented patient evaluation, including history and a discussion of physical symptoms adequate to establish a diagnosis and to identify underlying conditions or contraindications to the treatment recommended or provided.

[(d)] Treatment recommendations made via telehealth, including issuing a prescription via electronic means, shall be held to the same standards of appropriate practice as those in traditional physician-patient settings that do not include a face-to-face visit but in which prescribing is appropriate, including on-call telephone encounters and encounters for which a follow-up visit is arranged. Issuing a prescription based solely on an online questionnaire is not treatment for the purposes of this section and
does not constitute an acceptable standard of care. For the purposes of prescribing opiates or medical marijuana, a physician-patient relationship shall only be established after an in-person consultation between the prescribing physician and the patient.

[(e)] (d) All medical reports resulting from telehealth services are part of a patient's health record and shall be made available to the patient. Patient medical records shall be maintained in compliance with all applicable state and federal requirements including privacy requirements.

[(f)] (e) A physician shall not use telehealth to establish a physician-patient relationship with a patient in this State without a license to practice medicine in Hawaii.

(f) A physician-patient relationship may be established via telehealth if the patient is referred to the telehealth provider by another health care provider who has conducted an in-person consultation and has provided all pertinent patient information to the telehealth provider. Once a provider-patient relationship is established, a patient or physician licensed in this State may use telehealth for any purpose, including consultation with a medical provider licensed in another state, authorized by this section or as otherwise provided by law.

(g) The physician-patient relationship prerequisite under this section shall not apply to telehealth consultations for emergency department services.
(g) Reimbursement for behavioral health services provided through telehealth shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient.

(i) Services provided by telehealth pursuant to this chapter shall be consistent with all federal and state privacy, security, and confidentiality laws.

(j) For the purposes of this section:

"Distant site" means the location of the physician delivering services through telehealth at the time the services are provided.

"Originating site" means the location where the patient is located, whether accompanied or not by a health care provider, at the time services are provided by a physician through telehealth, including but not limited to a physician's office, hospital, health care facility, a patient's home, and other non-medical environments such as school-based health centers, university-based health centers, or the work location of a patient.

"Telehealth" means the use of telecommunications as that term is defined in section 269-1, to encompass four modalities: store and forward technologies, remote monitoring, live consultation, and mobile health; and which shall include but not be limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purposes of: delivering
enhanced health care services and information while a patient is at an originating site and the physician is at a distant site; establishing a physician-patient relationship; evaluating a patient; or treating a patient."

SECTION 10. Section 453-2, Hawaii Revised Statutes, is amended by amending subsection (b) to read as follows:

"(b) Nothing herein shall:

(1) Apply to so-called Christian Scientists; provided that the Christian Scientists practice the religious tenets of their church without pretending a knowledge of medicine or surgery;

(2) Prohibit service in the case of emergency or the domestic administration of family remedies;

(3) Apply to any commissioned medical officer in the United States armed forces or public health service engaged in the discharge of one's official duty, including a commissioned medical officer employed by the United States Department of Defense, while providing direct telehealth support or services to neighbor island beneficiaries within a Hawaii National Guard armory on the island of Kauai, Hawaii, Molokai, or Maui; provided that the commissioned medical officer employed by the United States Department of Defense is credentialed by Tripler Army Medical Center;

(4) Apply to any practitioner of medicine and surgery from another state when in actual consultation, including in-person, mail, electronic, telephonic, fiber-optic, or other
telehealth consultation with a licensed physician or osteopathic physician of this State, if the physician or osteopathic physician from another state at the time of consultation is licensed to practice in the state in which the physician or osteopathic physician resides; provided that:

(A) The physician or osteopathic physician from another state shall not open an office, or appoint a place to meet patients in this State, or receive calls within the limits of the State for the provision of care for a patient who is located in this State;

(B) The licensed physician or osteopathic physician of this State retains control and remains responsible for the provision of care for the patient who is located in this State; and

(C) The laws and rules relating to contagious diseases are not violated;

(5) Prohibit services rendered by any person certified under part II of this chapter to provide emergency medical services, or any physician assistant, when the services are rendered under the direction and control of a physician or osteopathic physician licensed in this State except for final refraction resulting in a prescription for spectacles, contact lenses, or visual training as performed
by an oculist or optometrist duly licensed by the State. The direction and control shall not be construed in every case to require the personal presence of the supervising and controlling physician or osteopathic physician. Any physician or osteopathic physician who employs or directs a person certified under part II of this chapter to provide emergency medical services, or a physician assistant, shall retain full professional and personal responsibility for any act that constitutes the practice of medicine when performed by the certified person or physician assistant;

(6) Prohibit automated external defibrillation by:

(A) Any first responder personnel certified by the department of health to provide automated external defibrillation when it is rendered under the medical oversight of a physician or osteopathic physician licensed in this State; or

(B) Any person acting in accordance with section 663-1.5(e); or

(7) Prohibit a radiologist duly licensed to practice medicine and provide radiology services in another state from using telehealth while located in this State to provide radiology services to a patient who is located in the state in which the radiologist is licensed. For the purposes of this paragraph:
"Distant site" means the location of the radiologist delivering services through telehealth at the time the services are provided.

"Originating site" means the location where the patient is located, whether accompanied or not by a health care provider, at the time services are provided by a radiologist through telehealth, including but not limited to a radiologist's or health care provider's office, hospital, health care facility, a patient's home, and other non-medical environments such as school-based health centers, university-based health centers, or the work location of a patient.

"Radiologist" means a doctor of medicine or a doctor of osteopathy certified in radiology by the American Board of Radiology or the American Board of Osteopathy.

"Telehealth" means the use of telecommunications, as that term is defined in section 269-1, [including] to encompass four modalities: store and forward technologies, remote monitoring, live consultation, and mobile health; and which shall include but not be limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced
health care services and information [to parties separated by distance] while a patient is at an originating site and the radiologist is at a distant site. Standard telephone contacts, facsimile transmissions, or e-mail texts, in combination or by themselves, do not constitute a telehealth service for the purposes of this paragraph."

SECTION 11. Section 457-2, Hawaii Revised Statutes, is amended as follows:

1. By adding two new definitions to be appropriately inserted and to read:

"Distant site" means the location of the nurse delivering services through telehealth at the time the services are provided.

"Originating site" means the location where the patient is located, whether accompanied or not by a health care provider, at the time services are provided by a nurse through telehealth, including but not limited to a nurse's or health care provider's office, hospital, health care facility, a patient's home, and other non-medical environments such as school-based health centers, university-based health centers, or the work location of a patient."

2. By amending the definition of "telehealth" to read:

"Telehealth" means the use of [electronic information and telecommunication technologies] telecommunications as that term is defined in section 269-1, to encompass four modalities: store and forward technologies, remote monitoring, live consultation, and mobile health; and which shall include but not be limited to real-time video conferencing-based communication, secure interactive and non-
interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, to support long-distance clinical health care while a patient is at an originating site and the nurse is at a distant site, patient and professional health-related education, public health and health administration, to the extent that it relates to nursing."

SECTION 12. Section 466J-6, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"(a) Any provision in this chapter to the contrary notwithstanding, a license shall not be required for:

(1) A licensed medical practitioner in radiology;
(2) A licensed practitioner of nuclear medicine;
(3) A licensed physician assistant;
(4) A licensed doctor of dentistry;
(5) A licensed dental technician;
(6) A licensed dental hygienist;
(7) A student in an approved school for radiographers, radiation therapists, or nuclear medicine technologists, or in a school of medicine, podiatry, dentistry, or a chiropractic school; provided that the student is operating x-ray machines under the direct supervision of a licensed radiographer, licensed radiation therapist, licensed nuclear medicine technologist, or a qualified person pursuant to this chapter; and
(8) A radiologist duly licensed to practice medicine and radiology services in another state who uses telehealth while located in this State to provide radiology services to a patient who is located in the state in which the radiologist is licensed[; provided that services provided by telehealth pursuant to this paragraph shall be consistent with all federal and state privacy, security, and confidentiality laws. For the purposes of this paragraph:

"Distant site" means the location of the radiologist delivering services through telehealth at the time the services are provided.

"Originating site" means the location where the patient is located, whether accompanied or not by a health care provider, at the time services are provided by a radiologist through telehealth, including but not limited to a radiologist's or health care provider's office, hospital, health care facility, a patient's home, and other non-medical environments such as school-based health centers, university-based health centers, or the work location of a patient.

"Radiologist" means a doctor of medicine or a doctor of osteopathy certified in radiology by the American Board of Radiology or the American Board of Osteopathy.

"Telehealth" means the use of telecommunications, as that term is defined in section 269-1, [including] to
encompass four modalities: store and forward technologies, remote monitoring, live consultation, and mobile health; and which shall include but not be limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information [to parties separated by distance.] while a patient is at an originating site and the radiologist is at a distant site. Standard telephone contacts, facsimile transmissions, or e-mail texts, in combination or by themselves, do not constitute a telehealth service for the purposes of this paragraph."

SECTION 13. Notwithstanding any other law to the contrary, the reimbursement for telehealth services required under sections 6, 7, and 8 of this Act shall apply to all health benefits plans under chapter 87A, Hawaii Revised Statutes, issued, renewed, modified, altered, or amended on or after the effective date of this Act.

SECTION 14. This Act does not affect rights and duties that matured, penalties that were incurred, and proceedings that were begun before its effective date.

SECTION 15. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 16. This Act shall take effect on January 1, 2017.
Report Title:
Telehealth; Insurance; Medicaid; Covered Services; Liability Insurance; Reimbursement; Disclosure; Requirements; EUTF

Description:
Requires the State's medicaid managed care and fee-for-service programs to cover services provided through telehealth. Specifies that any telehealth services provided shall be consistent with all federal and state privacy, security, and confidentiality laws. Specifies medical professional liability insurance policy requirements with regard to telehealth coverage. Clarifies that reimbursement for services provided through telehealth shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient. Requires written disclosure of coverages and benefits associated with telehealth services. Requires that telehealth encompasses store and forward technologies, remote monitoring, live consultation, and mobile health. Ensures telehealth is covered when originating in a patient's home and other non-medical environments. Clarifies requirements for physicians and out-of-state physicians to establish a physician-patient relationship via telehealth. Requires that reimbursement requirements for telehealth services apply to all health benefits plans under chapter 87A, Hawaii Revised Statutes. Takes effect on 1/1/2017. (CD1)

The summary description of legislation appearing on this page is for informational purposes only and is not legislation or evidence of legislative intent.
AN ACT TO AMEND TITLE 18 AND 24 OF THE DELAWARE CODE RELATING TO TELEMEDICINE SERVICES.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Chapter 33 of Title 18 of the Delaware Code to add new “§ 3370” by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3370. Telemedicine.

(a) As used in this section:

(1) “Distant site” means a site at which a health care provider legally allowed to practice in the state is located while providing health care services by means of telemedicine or telehealth.

(2) “Originating site” means a site in Delaware at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.

(3) “Store and forward transfer” means the transmission of a patient’s medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

(4) “Telehealth” means the use of information and communications technologies consisting of telephones, remote patient monitoring devices or other electronic means which support clinical health care, provider
consultation, patient and professional health-related education, public health, health administration, and other services as described in regulation.

(5) “Telemedicine” means a form of telehealth which is the delivery of clinical health care services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care by a health care provider practicing within his or her scope of practice as would be practiced in-person with a patient, and legally allowed to practice in the state, while such patient is at an originating site and the health care provider is at a distant site.

(b) Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each health service corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the cost of such health care services provided through telemedicine.

(c) Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each health service corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the cost of such health care services provided through telehealth as directed through regulations promulgated by the Department.

(d) An insurer, health service corporation, or health maintenance organization shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through in-person consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.

(e) An insurer, health service corporation, or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis and at least at the rate that the insurer, health service corporation, or health maintenance organization is responsible for coverage for the provision of the same service through in-person consultation or contact. Payment for telemedicine interactions shall include reasonable compensation to the originating or distant site for the transmission cost incurred during the delivery of health care services.
(f) No insurer, health service corporation, or health maintenance organization shall impose any annual or lifetime dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan.

(g) The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended on and after enactment of this section or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

(h) This section shall not apply to short-term travel, accident-only, limited or specified disease, or individual conversion policies or contracts, nor shall it contravene any telehealth requirements made in policies or contracts designed for issuance to persons eligible for coverage under Titles XVIII, XIX, and XXI of the Social Security Act, known as Medicare, Medicaid, or any other similar coverage under state or federal governmental plans.

Section 2. Amend §1702, Title 24 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

(3) "Distant site" means a site at which a health care provider legally allowed to practice in the state is located while providing health care services by means of telemedicine.

(3) "Division" means the Division of Professional Regulation.

(4) "Executive Director" means the Executive Director of the Board of Medical Licensure and Discipline.

(5) "Healthcare institution" means a facility or agency licensed, certified, or otherwise authorized by law to provide, in the ordinary course of business, treatments, services, or procedures to maintain, diagnose, or otherwise affect a person's physical or mental condition.

(6) "Medical group" means 1 or more physicians or other health care practitioners who work together under the name of a professional corporation, a limited liability partnership, or other legal entity.

(7) "Medicine" means the science of restoring or preserving health and includes allopathic medicine and surgery, osteopathic medicine and surgery, and all the respective branches of the foregoing.

(9) “Originating site” means a site in Delaware at which a patient is located at the time health care services are provided to him or her by means of telemedicine, unless the term is otherwise defined with respect to the provision in which
it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative
siting arrangements deemed appropriate by the parties.

(8) "Physician" means an allopathic doctor of medicine and surgery or a doctor of osteopathic medicine and surgery
who is registered and certified to practice medicine pursuant to this chapter.

(9) "Practice of medicine" or "practice medicine" includes:

a. Advertising, holding out to the public, or representing in any manner that one is authorized to practice
   medicine in this State;

b. Offering or undertaking to prescribe, order, give, or administer any drug or medicine for the use of
   another person;

c. Offering or undertaking to prevent or to diagnose, correct, and/or treat in any manner or by any means,
   methods, or devices a disease, illness, pain, wound, fracture, infirmity, defect, or abnormal physical or mental
   condition of another person, including the management of pregnancy and parturition;

d. Offering or undertaking to perform a surgical operation upon another person;

e. Rendering a written or otherwise documented medical opinion concerning the diagnosis or treatment of
   a person or the actual rendering of treatment to a person within the State by a physician located outside the State as
   a result of transmission of the person's medical data by electronic or other means from within the State to the
   physician or to the physician's agent;

f. Rendering a determination of medical necessity or a decision affecting or modifying the diagnosis and/or
   treatment of a person;

g. Using the designation Doctor, Doctor of Medicine, Doctor of Osteopathy, physician, surgeon, physician
   and surgeon, Dr., M.D., or D.O., or a similar designation, or any combination thereof, in the conduct of an occupation
   or profession pertaining to the prevention, diagnosis, or treatment of human disease or condition, unless the
   designation additionally contains the description of another branch of the healing arts for which one holds a valid
   license in the State.

For the purposes of this chapter, in order that the full resources of the State are available for the protection of persons
using the services of physicians, the act of the practice of medicine occurs where a person is located at the time a physician
practices medicine upon the person.

(10) "Registration" means the entry of a certificate to practice medicine into the records of the Board of Medical
Licensure and Discipline pursuant to the regulations of the Board.
(13) “Store and forward transfer” means the transmission of a patient’s medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

(11) "Substantially related" means the nature of criminal conduct for which a person was convicted has a direct bearing on the person's fitness or ability to perform 1 or more of the duties or responsibilities necessarily related to the practice of medicine, the work of a physician assistant, or the practice of respiratory care.

(15) “Telehealth” means the use of information and communications technologies consisting of telephones, remote patient monitoring devices or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services as described in regulation.

(16) “Telemedicine” means a form of telehealth which is the delivery of clinical health care services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care by a health care provider practicing within his or her scope of practice as would be practiced in-person with a patient, legally allowed to practice in the state, while such patient is at an originating site and the health care provider is at a distant site.

Section 3. Amend Chapter 17 of Title 24 of the Delaware Code to include new “§ 1769D” by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 1769D. Telemedicine and Telehealth.

(a) Physicians may practice Telemedicine and Telehealth. Provided that Telemedicine shall not be utilized by a physician with respect to any patient in the absence of a physician-patient relationship, except for the instances in subsection (i).

(b) Physicians who utilize telemedicine shall, if such action would otherwise be required in the provision of the same service not delivered via telemedicine, ensure that a proper physician-patient relationship is established either in-person or through telehealth which includes but is not limited to:

(1) fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient;

(2) disclosing and validating the provider’s identity and applicable credential(s):
(3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including informed consents regarding the use of telemedicine technologies as indicated in subsection (b)(5) of this section;

(4) establishing a diagnosis through the use of acceptable medical practices, such as patient history, mental status examination, physical examination (unless not warranted by the patient’s mental condition), and appropriate diagnostic and laboratory testing to establish diagnoses, as well as identify underlying conditions or contraindications, or both, to treatment recommended or provided;

(5) discussing with the patient the diagnosis and the evidence for it, the risks and benefits of various treatment options; and

(6) ensuring the availability of the distant site provider or coverage of the patient for appropriate follow-up care; and

(7) providing a written visit summary to the patient.

(c) Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional (encounter in person) settings.

(d) The physician treating a patient through telemedicine must maintain a complete record of the patient’s care which must follow all applicable state and federal statutes and regulations for recordkeeping, confidentiality, and disclosure to the patient.

(e) Telemedicine shall include, at such time as feasible and when appropriate, utilizing the Delaware Health Information Network (DHIN) in connection with the practice.

(f) Without a prior and proper patient-provider relationship, as provided in subsection (b) of this section, providers are prohibited from issuing prescriptions solely in response to an Internet questionnaire, an Internet consult, or a telephone consult.

(g) Prescriptions made through telemedicine and under a physician-patient relationship may include controlled substances, subject to limitations as set by the Board.

(h) Physicians using telemedicine technologies to provide medical care to patients located in Delaware must, prior to a diagnosis and treatment, either provide: (1) an appropriate examination in-person, (2) have another Delaware-licensed practitioner at the originating site with the patient at the time of the diagnosis, (3) the diagnosis must be based using both audio and visual communication, or (4) the service meets standards of establishing a patient-physician relationship included
as part of evidenced-based clinical practice guidelines in telemedicine developed by major medical specialty societies, such as those of radiology or pathology.

(i) Telemedicine may be practiced without a physician-patient relationship during:

(1) Informal consultation performed by a physician outside the context of a contractual relationship and on an irregular or infrequent basis without the expectation or exchange of direct or indirect compensation;

(2) Furnishing of medical assistance by a physician in case of an emergency or disaster if no charge is made for the medical assistance; or

(3) Episodic consultation by a medical specialist located in another jurisdiction who provides such consultation services on request to a licensed health care professional.

Section 4. Amend § 1773, Title 24 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

(a) The Council shall adopt rules and regulations which address the following:

(1) The licensing of physician assistants to allow:

a. The performance of delegated medical acts within the education, training, and experience of physician assistants; and

b. The performance of services customary to the practice of the supervising physician;

(2) Delegated medical acts provided by physician assistants to include, but not be limited to:

a. The performance of complete patient histories and physical examinations;

b. The recording of patient progress notes in an outpatient setting;

c. The relaying, transcribing, or executing of specific diagnostic or therapeutic orders;

d. Medical acts of diagnosis and prescription of therapeutic drugs and treatments which have been delegated by the supervising physician; and

e. Prescriptive authority for therapeutic drugs and treatments within the scope of physician assistant practice, as delegated by the supervising physician. The physician assistant's prescriptive authority and authority to practice as a physician assistant are subject to biennial renewal upon application to the Physician Assistant Regulatory Council; and

f. The use of Telemedicine as defined in this Chapter and, as further described in regulation, the use of and participation in Telehealth.
Section 5. Amend § 1776, Title 24 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

(2) "Respiratory care practitioner" or "RCP" means an individual who practices respiratory care in accord with the requirements of this subchapter;

(b) A respiratory care practitioner works under the general supervision of a person certified to practice medicine, whether by direct observation and monitoring, by protocols approved by a person certified to practice medicine, or by orders written or verbally given by a person certified to practice medicine. A respiratory care practitioner may evaluate patients and make decisions within parameters defined by a person certified to practice medicine and by the Board of Medical Licensure and Discipline. The work performed by a respiratory care practitioner includes, but is not limited to:

(1) Collecting samples of blood, secretions, gases, and body fluids for respiratory evaluations;
(2) Measuring cardiorespiratory volumes, flows, and pressures;
(3) Administering pharmacological agents, aerosols, and medical gases via the respiratory route;
(4) Inserting and maintaining airways, natural or artificial, for the flow of respiratory gases;
(5) Controlling the environment and ventilatory support systems such as hyperbaric chambers and ventilators;
(6) Resuscitating individuals with cardiorespiratory failure;
(7) Maintaining bronchopulmonary hygiene;
(8) Researching and developing protocols in respiratory disorders;
(9) Performing pulmonary function studies; and
(10) The use of Telemedicine as defined in this Chapter and, as further described in regulation, the use of and participation in Telehealth.

(c) Nothing in this subchapter is intended to limit, preclude, or otherwise interfere with the professional activities of other individuals and healthcare providers formally trained and licensed by the State.

(d) An individual who is licensed pursuant to this subchapter, who is not being investigated or sanctioned in relation to unprofessional conduct or physical, mental, emotional, or other impairment, and who has passed an examination that includes the subject matter of 1 or more of the professional activities included in subsection (b) of this section may not be prohibited from performing those professional activities passed in the examination, provided that the testing body that administered the examination is approved by the Board.
Section 6. Amend § 1799H, Title 24 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

(9) The "practice of genetic counseling" shall include any or all of the following activities:

a. Obtaining and interpreting individual, family and medical development histories;

b. Determining the mode of inheritance and risk of transmission of genetic conditions;

c. Discussing the inheritance, features, natural history, means of diagnosis;

d. Identifying, coordinating and explaining genetic laboratory tests and other diagnostic studies; provided however, that if in the course of providing a genetic counseling service to any client, a genetic counselor finds any indication of disease or condition that requires medical assessment, the genetic counselor shall refer a client to a physician licensed to practice medicine;

e. Assessing psychosocial factors, recognizing social, educational, and cultural issues;

f. Evaluating the client's or family's responses to the condition or risk of recurrence and provide client-centered counseling and anticipatory guidance;

g. Communicating genetic information to clients in an understandable manner;

h. Facilitating informed decision making about testing and management alternatives;

i. Identifying and effectively utilizing community resources that provide medical, educational, financial, and psychosocial support and advocacy; and

j. Providing accurate written documentation of medical, genetic, and counseling information for families and health care professionals; and

k. The use of Telemedicine as defined in this Chapter and, as further described in regulation, the use of and participation in Telehealth.

Section 7. Amend § 502, Title 24 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

(3) “Distant site” means a site at which a health care provider legally allowed to practice in the state is located while providing health care services by means of telemedicine or telehealth.

(10) “Originating site” means a site in Delaware at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.
(10) "Practice of podiatry" shall mean the diagnosis and the medical, surgical, mechanical, manipulative and electrical treatment of all ailments of the foot and ankle. As appropriate in regulation, these services may be performed with the use of Telemedicine. Podiatry may also include participation in Telehealth, as further defined in regulation. Amputation of the foot shall be restricted to state licensed podiatrists who have completed an American Podiatric Medical Association accredited surgical residency program acceptable to the Board and have current amputation privileges, or have fulfilled the credentialing criteria of the surgical committee of the Joint Committee on Accreditation of Hospitals accredited hospital where the amputation is to be performed.

(11) "State" shall mean the State of Delaware.

(14) “Store and forward transfer” means the transmission of a patient’s medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

(12) "Substantially related" means the nature of the criminal conduct, for which the person was convicted, has a direct bearing on the fitness or ability to perform 1 or more of the duties or responsibilities necessarily related to podiatry.

(13) "Surgical treatment" shall mean the use of any cutting instrument to treat a disease, ailment or condition.

(14) “Telehealth” means the use of information and communications technologies consisting of telephones, remote patient monitoring devices or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services as described in regulation.

(15) “Telemedicine” means the delivery of clinical health care services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care by a licensee practicing within his or her scope of practice as would be practiced in-person with a patient and with other restrictions as defined in regulation.

Section 8. Amend § 701, Title 24 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

(a) "Chiropractic" means a drugless system of health care based on the principle that interference with the transmission of nerve impulses may cause disease.
(b) “Distant site” means a site at which a health care provider legally allowed to practice in the state is located while
providing health care services by means of telemedicine or telehealth.

(c) “Originating site” means a site in Delaware at which a patient is located at the time health care services are
provided to him or her by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the
provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may
agree to alternative siting arrangements deemed appropriate by the parties.

(d) “Store and forward transfer” means the transmission of a patient’s medical information either to or from an
originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in
real time.

(b) “Telehealth” means the use of information and communications technologies consisting of telephones, remote
patient monitoring devices or other electronic means which support clinical health care, provider consultation, patient and
professional health-related education, public health, health administration, and other services as described in regulation.

(c) “Telemedicine” means a form of telehealth which the delivery of clinical health care services by means of real
time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure
video conferencing or store and forward transfer technology to provide or support healthcare delivery, which facilitate the
assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care
by a licensee practicing within his or her scope of practice as would be practiced in-person with a patient and with other
restrictions as defined in regulation.

(d) The practice of chiropractic includes, but is not limited to, the diagnosing and locating of misaligned or displaced
vertebrae (subluxation complex), using x-rays and other diagnostic test procedures. The practice includes the use of
telemedicine and may also include the practice of and participation in Telehealth, as further defined in regulation. Practice of
chiropractic includes the treatment through manipulation/adjustment of the spine and other skeletal structures and the use of
adjunctive procedures not otherwise prohibited by this chapter.

Section 9. Amend § 1101, Title 24 of the Delaware Code by making deletions as shown by strike through and
insertions as shown by underline as follows:

(7) “Distant site” means a site at which a health care provider legally allowed to practice in the state is located while
providing health care services by means of telemedicine or telehealth.

(10) “Originating site” means a site in Delaware at which a patient is located at the time health care services are
provided to him or her by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the
provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.

(12) "Practice of dentistry" is defined as the evaluation, diagnosis, prevention and/or treatment (nonsurgical, surgical or related procedures) of diseases, disorders and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body provided by a dentist within the scope of the dentist's education, training and experience, in accordance with the ethics of the profession and applicable law. The practice includes the use of Telemedicine and may also include participation in Telehealth as further defined in regulation. A person shall be construed to practice dentistry who by verbal claim, sign, advertisement, opening of an office, or in any other way, including use of the words "dentist," "dental surgeon," the letters "D.D.S.," "D.M.D.," or other letters or titles, represents the dentist's person to be a dentist or who holds himself or herself out as able to perform, or who does perform, dental services or work. A person shall be regarded as practicing dentistry who is a manager, proprietor, operator or conductor of a place for performing dental operations or who for a fee, salary or other reward paid, or to be paid either to himself or herself or to another person, performs or advertises to perform dental operations of any kind.

(13) "State" shall mean the State of Delaware.

(15) “Store and forward transfer” means the transmission of a patient’s medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

(14) "Substantially related" means the nature of the criminal conduct, for which the person was convicted, has a direct bearing on the fitness or ability to perform 1 or more of the duties or responsibilities necessarily related to the practice of dentistry or dental hygiene.

(15) “Telehealth” means the use of information and communications technologies consisting of telephones, remote patient monitoring devices or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services as described in regulation.

(16) “Telemedicine” means a form of telehealth which is the delivery of clinical health care services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care by a licensee practicing within his or her scope of practice as would be practiced in-person with a patient and with other restrictions as defined in regulation.
Section 10. Amend § 1902, Title 24 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

(e) “Distant site” means a site at which a health care provider legally allowed to practice in the state is located while providing health care services by means of telemedicine or telehealth.

(l) “Originating site” means a site in Delaware at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.

(n) “Store and forward transfer” means the transmission of a patient’s medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

(h) “Telehealth” means the use of information and communications technologies consisting of telephones, remote patient monitoring devices or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services as described in regulation.

(i) “Telemedicine” means the delivery of clinical health care services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care by a licensee practicing within his or her scope of practice as would be practiced in-person with a patient and with other restrictions as defined in regulation.

(n) "The practice of practical nursing" as a licensed practical nurse means the performance for compensation of nursing services by a person who holds a valid license pursuant to the terms of this chapter and who bears accountability for nursing practices which require basic knowledge of physical, social and nursing sciences. These services, at the direction of a registered nurse or a person licensed to practice medicine, surgery or dentistry, include:

(1) Observation;
(2) Assessment;
(3) Planning and giving of nursing care to the ill, injured and infirm;
(4) The maintenance of health and well being;
(5) The administration of medications and treatments prescribed by a licensed physician, dentist, podiatrist or advanced practice nurse; and

(6) Additional nursing services and supervision commensurate with the licensed practical nurse's continuing education and demonstrated competencies; and

(7) Dispensing activities only as permitted in the Board's Rules and Regulations.

Nothing contained in this chapter shall be deemed to permit acts of surgery or medical diagnosis; nor shall it be deemed to permit dispensing of drugs, medications or therapeutics independent of the supervision of a physician who is licensed to practice medicine and surgery, or those licensed to practice dentistry or podiatry; and

(8) The use of Telemedicine, as defined in this Chapter, and practice of and participation in Telehealth as further defined in regulation.

(o) "The practice of professional nursing" as a registered nurse means the performance of professional nursing services by a person who holds a valid license pursuant to the terms of this chapter, and who bears primary responsibility and accountability for nursing practices based on specialized knowledge, judgment and skill derived from the principles of biological, physical and behavioral sciences. The registered nurse practices in the profession of nursing by the performance of activities, among which are:

(1) Assessing human responses to actual or potential health conditions;

(2) Identifying the needs of the individual and/or family by developing a nursing diagnosis;

(3) Implementing nursing interventions based on the nursing diagnosis;

(4) Teaching health care practices. Nothing contained herein shall limit other qualified persons or agencies from teaching health care practices without being licensed under this chapter;

(5) Advocating the provision of health care services through collaboration with other health service personnel;

(6) Executing regimens, as prescribed by a licensed physician, dentist, podiatrist or advanced practice nurse, including the dispensing and/or administration of medications and treatments;

(7) Administering, supervising, delegating and evaluating nursing activities; and

(8) The use of telemedicine, as defined in this Chapter, and participation in Telehealth, as further defined in regulation.

Nothing contained in this chapter shall be deemed to permit acts of surgery or medical diagnosis; nor shall it be deemed to permit dispensing of drugs, medications or therapeutics independent of the supervision of a physician who is licensed to practice medicine and surgery, or those licensed to practice dentistry or podiatry.
A registered nurse shall have the authority, as part of the practice of professional nursing, to make a pronouncement of death; provided, however, that this provision shall only apply to attending nurses caring for terminally ill patients or patients who have "do not resuscitate" orders in the home or place of residence of the deceased as a part of a hospice program or a certified home health care agency program; in a skilled nursing facility; in a residential community associated with a skilled nursing facility; any licensed assisted living community; in an extended care facility; or in a hospice; and provided that the attending physician of record has agreed in writing to permit the attending registered nurse to make a pronouncement of death in that case.

(p) "The profession of nursing" is an art and process based on a scientific body of knowledge. The practitioner of nursing assists patients in the maintenance of health, the management of illness, injury or infirmity or in the achieving of a dignified death.

Section 11. Amend § 2002, Title 24 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

(2) “Distant site” means a site at which a health care provider legally allowed to practice in the state is located while providing health care services by means of telemedicine or telehealth.

(3) "Occupational therapist" shall mean a person who is licensed to practice occupational therapy pursuant to this chapter and who offers such services to the public under any title incorporating the words "occupational therapy," "occupational therapist" or any similar title or description of occupational therapy services.

(4) "Occupational therapy assistant" shall mean a person licensed to assist in the practice of occupational therapy, under the supervision of an occupational therapist.

(5) "Occupational therapy services" shall mean, but are not limited to:

a. The assessment, treatment and education of or consultation with the individual, family or other persons; or

b. Interventions directed toward developing, improving or restoring daily living skills, work readiness or work performance, play skills or leisure capacities, or enhancing educational performance skills; or

c. Providing for the development, improvement or restoration of sensorimotor, oralmotor, perceptual or neuromuscular functioning, or emotional, motivational, cognitive or psychosocial components of performance.

These services may require assessment of the need for use of interventions such as the design, development, adaptation, application or training in the use of assistive technology devices; the design, fabrication or application of rehabilitative technology such as selected orthotic devices; training in the use of assistive technology, orthotic or
prosthetic devices; the application of thermal agent modalities, including, but not limited to, paraffin, hot and cold packs and fluido therapy, as an adjunct to, or in preparation for, purposeful activity; the use of ergonomic principles; the adaptation of environments and processes to enhance functional performance; or the promotion of health and wellness.

Services may be provided through the use of Telemedicine in a manner deemed appropriate by regulation. Services also may include participation in Telehealth as further defined in regulation.

(7) “Originating site” means a site in Delaware at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.

(6) "Person" shall mean a corporation, company, association and partnership, as well as an individual.

(7) "Practice of occupational therapy" shall mean the use of goal-directed activities with individuals who are limited by physical limitations due to injury or illness, psychiatric and emotional disorders, developmental or learning disabilities, poverty and cultural differences or the aging process, in order to maximize independence, prevent disability and maintain health.

(10) “Store and forward transfer” means the transmission of a patient’s medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

(8) "Substantially related" means the nature of the criminal conduct, for which the person was convicted, has a direct bearing on the fitness or ability to perform 1 or more of the duties or responsibilities necessarily related to the practice of occupational therapy.

(9) "Supervision" shall mean the interactive process between the licensed occupational therapist and the occupational therapy assistant. It shall be more than a paper review or cosignature. The supervising occupational therapist is responsible for insuring the extent, kind and quality of the services rendered by the occupational therapy assistant.

(10) “Telehealth” means the use of information and communications technologies consisting of telephones, remote patient monitoring devices or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services as described in regulation.

(11) “Telemedicine” means a form of telehealth which is the delivery of clinical health care services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare delivery, which facilitate
the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health
care by a licensee practicing within his or her scope of practice as would be practiced in-person with a patient and with other
restrictions as defined in regulation.

Section 12. Amend § 2101, Title 24 of the Delaware Code by making deletions as shown by strike through and
insertions as shown by underline as follows:

(a) The "practice of optometry" is a learned profession and the same privileges, powers and duties shall attach
thereto as the other learned professions. For purpose of this chapter, the "practice of optometry" is defined as the examination,
measurement (by subjective or objective means), diagnosis, treatment and prevention of conditions of the human eye, lid,
adnexa and visual system. The "practice of optometry" includes but is not limited to the adapting and fitting of all types of
lenses or devices, including the dispensing of contact lenses which must be dispensed in accordance with a written, current
contact lens prescription from a licensed physician or optometrist, which includes such information as the Board shall specify
by rule or regulation. The practice of optometry also includes the determination of refractive error and/or visual, muscular,
or anatomical anomalies of the eye; the use of prescription of pharmaceutical agents for the diagnosis and treatment of ocular
disease; the removal of superficial foreign bodies from the human eye and its appendages (appendages shall include cornea,
conjunctiva lid, adnexa or lacrimal system); and the providing of vision, developmental and perceptual therapy, and shall
include the utilization of any method or means which the optometrist is educationally qualified to provide as established by
the Delaware State Board of Examiners in Optometry; provided that the "practice of optometry" does not include surgery or
the use of narcotics, or therapeutic lasers.

(b) For purposes of this chapter, the classifications of the "practice of optometry" shall be defined as:

(1) Nondiagnostically certified optometrist shall be permitted to practice optometry as defined in
subsection (a) of this section. However, a nondiagnostically certified optometrist may not utilize any diagnostic or
therapeutic pharmaceutical agent or remove superficial foreign bodies from the eye and its appendages.

(2) Diagnostically certified optometrists shall be permitted or perform the duties of a nondiagnostically
certified optometrist. In addition, a diagnostically certified optometrist may use the following drug groups:

a. Topical anesthetics.
b. Mydriatics.
c. Cycloplegics.
d. Miotics.
(3) Therapeutically certified optometrists shall be permitted to perform the duties of a diagnostically certified optometrist. In addition, a therapeutically certified optometrist may use and/or prescribe the following pharmaceutical agents for the treatment of ocular diseases and conditions:

a. Topical and oral administration:
   1. Antihistamines and decongestants.
   2. Antiglaucoma.
   3. Analgesics (noncontrolled).
   4. Antibiotics.

b. Topical administration only:
   1. Autonomics.
   2. Anesthetics.
   3. Anti-infectives, including antivirals and antiparasitics.
   4. Anti-inflammatories.

In administering this chapter, the State Board shall, by rule or regulation, specify those acts, services, procedures and practices which constitute the "practice of optometry" within the definitions of this section.

(c) For purposes of disability insurance, workers' compensation, standard health and accident, sickness and other insurance policies, programs and plans, if the optometrist is authorized by law to perform the particular services, the optometrist shall be entitled to compensation for services under the said programs. Individuals entitled to such services shall have freedom to choose between any optometrist and any physician skilled in diseases of the eye.

(d) The practice of optometry also includes services provided by Telemedicine and participation in Telehealth. For the purposes of this section, “Telehealth” is defined as the use of information and communications technologies consisting of telephones, remote patient monitoring devices or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services as described in regulation. “Telemedicine” means a form of Telehealth which is the delivery of clinical health care services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care by a licensee practicing within his or her scope of practice as would be practiced in-person with a patient and with other restrictions as defined in regulation. “Distant site” means a site at which a health care provider legally allowed
to practice in the state is located while providing health care services by means of telemedicine or telehealth. “Originating site” means a site in Delaware at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties. “Store and forward transfer” means the transmission of a patient’s medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

Section 13. Amend § 2502, Title 24 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

(6) “Distant site” means a site at which a health care provider legally allowed to practice in the state is located while providing health care services by means of telemedicine or telehealth.

(17) “Originating site” means a site in Delaware at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.

(21) "Practice of pharmacy" means the interpreting, evaluating, and dispensing of a practitioner's or prescriber's order. The practice of pharmacy includes, but is not limited to, the proper compounding, labeling, packaging, and dispensing of a drug to a patient or the patient's agent, and administering a drug to a patient. The practice of pharmacy includes the application of the pharmacist's knowledge of pharmaceutics, pharmacology, pharmacokinetics, drug and food interactions, drug product selection, and patient counseling. It also includes:

a. Participation in drug utilization and/or drug regimen reviews;

b. Participation in therapeutic drug selection, substitution of therapeutically equivalent drug products;

c. Advising practitioners and other health care professionals, as well as patients, regarding the total scope of drug therapy, so as to deliver the best care possible;

d. Monitoring drug therapy;

e. Performing and interpreting capillary blood tests to screen and monitor disease risk factors or facilitate patient education, the results of which must be reported to the patient's health care practitioner; screening results to be reported only if outside normal limits;
f. Conducting or managing a pharmacy or other business establishment where drugs are compounded or dispensed; and

g. The use of Telemedicine and participation in Telehealth in a manner deemed appropriate by regulation; and

gh. Administration of injectable medications, biologicals and adult immunizations pursuant to a valid prescription or physician-approved protocol approved by a physician duly licensed in the State under subchapter III of Chapter 17 of this title. Pharmacists shall request which physician or physicians and notify the physician or physicians as designated by the patient of such administration within 24 hours. The notice shall include the patient's name, the name of the immunizations, inoculations or vaccinations administered, and the date of administration and may be submitted by phone, fax, post or electronically. Upon request a copy of the protocol will be made available to the designated physician or physicians without costs.

(22) "Practitioner" or "prescriber" means an individual who is authorized by law to prescribe drugs in the course of professional practice or research in any state.

(23) "Preceptor" means a licensed pharmacist who is approved by the Board to supervise an intern.

(24) "Prescription drug" or "legend drug" means a drug required by federal or state law or regulation to be dispensed only by a prescription, including finished dosage forms and active ingredients, subject to § 503(b) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. § 353(b)).

(25) "Prescription drug order" or "prescription" means the lawful written or verbal order of a practitioner for a drug.

(26) "Reference product" means a product as defined by the Federal Food and Drug Administration pursuant to 42 U.S.C. § 262.

(27) "State" means the State of Delaware.

(28) “Store and forward transfer” means the transmission of a patient’s medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

(28) "Substantially related" means the nature of the criminal conduct, for which the person was convicted, has a direct bearing on the fitness or ability to perform 1 or more of the duties or responsibilities necessarily related to the practice of pharmacy.

(29) "Substitution" or "substitute" means pharmacist's selection of prescriber authorized generic or therapeutically equivalent prescription medications or, in the case of biologicals, pharmacist selection of an interchangeable biological
product in place of the prescribed product. Generic substitution means a drug that is the same active ingredient, equivalent in strength to the strength written on the prescription and which is classified as being therapeutically equivalent to another drug in the latest edition or supplement of the Federal Food and Drug Administration (FDA) Approved Drug Products with Therapeutic Equivalence Evaluations, sometimes referred to as the "Orange Book."

(30) “Telehealth” means the use of information and communications technologies consisting of telephones, remote patient monitoring devices or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services as described in regulation.

(31) “Telemedicine” means a form of telehealth which is the delivery of clinical health care services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care by a licensee practicing within his or her scope of practice as would be practiced in-person with a patient and with other restrictions as defined in regulation.

Section 14. Amend § 3002, Title 24 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

(1) "Board" means the Board of Mental Health and Chemical Dependency Professionals.

(2) “Distant site” means a site at which a health care provider legally allowed to practice in the state is located while providing health care services by means of telemedicine or telehealth.

(2) "Division" means the Division of Professional Regulation of the State of Delaware.

(3) "Excessive use or abuse of drugs" means any use of narcotics, controlled substances or illegal drugs without a prescription from a licensed physician, or the abuse of alcoholic beverage such that it impairs a licensee's ability to perform the work of a licensed mental health or chemical dependency professional.

(5) “Originating site” means a site in Delaware at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.

(4) "Person" means a corporation, company, association and partnership, as well as an individual.
(7) “Store and forward transfer” means the transmission of a patient’s medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

(5) "Substantially related" means the nature of the criminal conduct, for which a person was convicted, has a direct bearing on the fitness or ability of the person to perform 1 or more of the duties or responsibilities of a licensed mental health or chemical dependency professional.

(6) “Telehealth” means the use of information and communications technologies consisting of telephones, remote patient monitoring devices or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services as described in regulation.

(7) “Telemedicine” means a form of telehealth which is the delivery of clinical health care services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care by a licensee practicing within his or her scope of practice as would be practiced in-person with a patient and with other restrictions as defined in regulation.

Section 15. Amend § 3031, Title 24 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

(1) "Direct supervision" is face to face consultation, on a regularly scheduled basis, between a licensed associate counselor of mental health (LACMH) and a licensed professional counselor of mental health (LPCMH) as required by the nature of the work of the LACMH. The supervising LPCMH is responsible for insuring that the extent, kind and quality of the services rendered by the LACMH are consistent with the person's education, training and experience.

(2) "Licensed associate counselor of mental health" (LACMH) is an individual licensed as an associate counselor of mental health under this chapter who is obtaining experience under the professional direct supervision of a LPCHM or other health professional approved by the Board for the purpose of becoming licensed as a professional counselor of mental health.

(3) "Licensed professional counselor of mental health" (LPCMH) is an individual licensed as a professional counselor of mental health under this chapter who publicly offers to render to individuals, groups, organizations or the general public a service involving the application of clinical counseling principles, methods or procedures and the diagnosis and treatment of mental and emotional disorders to assist individuals in achieving more effective personal and social
adjustment. Such services may be provided through the use of Telemedicine in a manner deemed appropriate by regulation.

Services also may include participation in Telehealth as further defined in regulation.

Section 16. Amend § 3041, Title 24 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

(1) "Chemical dependency professional" is a person who uses addiction counseling methods to assist an individual or group to develop an understanding of alcohol and drug dependency problems, define goals, and plan action reflecting the individual's or group's interest, abilities and needs as affected by addiction problems. Such services may be provided through the use of Telemedicine in a manner deemed appropriate by regulation. Services also may include participation in Telehealth as further defined in regulation.

(2) "Counseling experience" is a formal, systematic process that focuses on skill development and integration of knowledge related to addiction counseling and reflects the accumulation of hours spent providing substance abuse counseling services while under the supervision of an approved clinical supervisor.

(3) "Licensed chemical dependency professional" is a person who holds a current, valid license issued pursuant to this chapter.

(4) "Professional counseling experience" is the accumulation of hours spent providing chemical dependency counseling services in a substance abuse counseling setting, including face to face interaction with clients and other services directly related to the treatment of clients.

(5) "Supervised counseling experience" is the overseeing of a supervisee's application of chemical dependency counseling principles, methods or procedures to assist clients in achieving more effective personal and social adjustment.

(6) "Uncompensated addictions services" are services offered to chemical dependent individuals free of charge.

Section 17. Amend § 3051, Title 24 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

(a) "Direct supervision" is face to face consultation, on a regularly scheduled basis, between a licensed associate marriage and family therapist (LAMFT) and a licensed marriage and family therapist (LMFT) as required by the nature of the work of the LAMFT. The supervising LMFT is responsible for insuring that the extent, kind and quality of the services rendered by the LAMFT are consistent with the person's education, training and experience.

(b) "Licensed associate marriage and family therapist" (LAMFT) is an individual licensed as an associate marriage and family therapist under this chapter who is obtaining experience under direct professional supervision for the purpose of becoming licensed as a marriage and family therapist (LMFT).
(c) "Licensed marriage and family therapist" (LMFT) is an individual licensed as a marriage and family therapist under this chapter who offers to individuals, couples, families or groups professional marriage and family services either directly to the general public or through public or private organizations.

(d) "Marriage and family therapy services" includes the diagnosis and treatment of mental and emotional disorders, whether cognitive, affective, or behavioral, within the context of interpersonal relationships, including marriage and family systems, and involves the professional application of psychotherapy, assessment instruments, counseling, consultation, treatment planning, and supervision in the delivery of services to individuals, couples and families. Such services may be provided through the use of Telemedicine in a manner deemed appropriate by regulation. Services also may include participation in Telehealth as further defined in regulation.

(e) "Professional direct supervision" is supervision by a licensed marriage and family therapist, or an individual holding the "approved supervisor" designation from the American Association for Marriage and Family Therapy (AAMFT) or a candidate for the "approved supervisor" designation who is acceptable to the Board.

Section 18. Amend § 3502, Title 24 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

(2) “Distant site” means a site at which a health care provider legally allowed to practice in the state is located while providing health care services by means of telemedicine or telehealth.

(4) “Originating site” means a site in Delaware at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.

(4) "Practice of psychology" shall mean the observation, description, evaluation, interpretation and/or modification of human behavior by the application of psychological principles, methods, and/or procedures, for the purpose of preventing or eliminating symptomatic, maladaptive or undesired behavior, and of enhancing interpersonal relationships, work and life adjustment, personal effectiveness, behavioral health and mental health.

The practice of psychology includes, but is not limited to, psychological testing and the evaluation or assessment of personal characteristics, such as intelligence, personality, abilities, interests, aptitudes and neuropsychological function; counseling, psychoanalysis, psychotherapy, hypnosis, biofeedback, and behavior analysis and therapy; diagnosis and treatment of mental and emotional disorder or disability, alcoholism and substance abuse, disorders of habit or conduct, as well as the psychological aspects of physical illness, accident, injury or disability; and psychoeducational evaluation, therapy,
remediation, and consultation. Psychological services may be rendered to individuals, families, groups, organizations, institutions and the public. The practice of psychology shall be construed within the meaning of this definition without regard to whether or not payment is received for services rendered.

The practice of psychology may be provided through the use of Telemedicine in a manner deemed appropriate by Regulation. Services also may include participation in Telehealth as further defined in regulation.

a. "Psychological testing" shall mean, but not be limited to: Administration and interpretation of standardized intelligence and neuropsychological tests which yield an intelligence quotient and/or are the basis for a diagnosis of organic brain syndromes for the purposes of classification and/or disability determination; and

b. The administration and interpretation of psychological tests which are the basis of a diagnosis of mental or emotional disorder.

(5) "Psychological assistant" shall mean a person who is registered with the Board to perform certain functions within the practice of psychology, only under the direct supervision of a supervising psychologist, and who is authorized by the Board to use the title "psychological assistant." The Board in its rules and regulations will specify the arrangements for supervision by the licensed psychologist.

(6) "Psychologist" shall mean a person who makes representations to the public by any title or description of services incorporating the words "psychology," "psychological," "psychologist," or who engages in the practice of psychology.

(9) "Store and forward transfer" means the transmission of a patient’s medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

(7) "Substantially related" means the nature of the criminal conduct, for which the person was convicted, has a direct bearing on the fitness or ability to perform 1 or more of the duties or responsibilities necessarily related to the practice of psychology.

(8) "Supervising psychologist" shall mean a psychologist licensed in this State who has practiced as a licensed psychologist for 2 years in this or any other jurisdiction and who applies to the Board for the registration of a psychological assistant.

(9) "Supervision" shall mean the face-to-face consultation between the registered psychological assistant and the supervising psychologist as required by the nature of the work of the psychological assistant. The supervising psychologist
is responsible for insuring that the extent, kind and quality of the services rendered by the psychological assistant are consistent with the person's education, training and experience.

(10) “Telehealth” means the use of information and communications technologies consisting of telephones, remote patient monitoring devices or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services as described in regulation.

(11) “Telemedicine” means a form of telehealth which is the delivery of clinical health care services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care by a licensee practicing within his or her scope of practice as would be practiced in-person with a patient and with other restrictions as defined in regulation.

Section 19. Amend § 3802, Title 24 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

(2) "Dietetic and nutrition therapy" shall mean the scope of services utilized in the delivery of preventive nutrition services and/or nutrition therapy. It involves an assessment of the individual's specific nutritional needs and the development and implementation of an intervention plan. The intervention plan can include nutrition education, counseling, administration and monitoring of specialized nutrition support and/or referrals for additional services. This application and practice of "dietetic and nutrition therapy" shall include the following Scope of Practice:

Scope of Practice:

(a) Nutrition assessment to include the establishment of nutritional care plans, including the development of nutritional related priorities, goals and objectives.

(b) Provision of nutrition counseling or education as components of preventive, and restorative health care.

(c) Evaluation and maintenance of appropriate standards of quality in food and nutrition.

(d) Evaluation and education of nutrient-drug interactions.

(e) Interpreting and recommending interventions to meet nutrient needs relative to individual health status, including but not limited to medically prescribed diets, tube feedings and specialized intravenous solutions.

(f) Development, administration, evaluation and consultation regarding nutritional care standards.
(g) Conduct independent research or collaborate in research areas including, but not limited to food and pharmaceutical companies, universities and hospitals by directing or conducting experiments to answer critical nutrition and food science questions and develop nutrition recommendations for the public.

(h) Direct supervision of registered dietetic technicians.

(i) The use of Telemedicine in a manner deemed appropriate by regulation. This also may include participation in Telehealth as further defined in regulation.

(3) "Dietetics/nutrition" shall mean the integration and application of principles derived from the sciences of food, nutrition, biochemistry, physiology and behavior as an integral part of health care delivery to achieve and maintain a person's health throughout the life cycle. Its application to health care is both preventive and in response to an illness, injury or condition. The application of dietetics/nutrition to health care shall be called "dietetic and nutrition therapy." The terms "dietetics" and "nutrition" are used interchangeably in this chapter.

(4) "Dietitian" and/or "nutritionist" shall mean a person who engages in the provision of nutrition services. The terms "nutritionist" and "dietitian" are used interchangeably in this chapter.

(8) “Originating site” means a site in Delaware at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.

(9) “Store and forward transfer” means the transmission of a patient’s medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

(5) "L.D.N." shall be the abbreviation for the title "Licensed Dietitian/Nutritionist".

(6) "License" shall mean any document which indicates that a person is currently licensed by the Board of Dietetics/Nutrition.

(7) "Licensed Dietitian/Nutritionist" shall mean a person holding a current license under this chapter.

(5) “Distant site” means a site at which a health care provider legally allowed to practice in the state is located while providing health care services by means of telemedicine or telehealth.

(8) "Substantially related" means the nature of the criminal conduct, for which the person was convicted, has a direct bearing on the fitness or ability to perform 1 or more of the duties or responsibilities necessarily related to the provision of dietetics/nutrition therapy services.
(9) “Telehealth” means the use of information and communications technologies consisting of telephones, remote patient monitoring devices or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services as described in regulation.

(10) “Telemedicine” means a form of telehealth which is the delivery of clinical health care services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care by a licensee practicing within his or her scope of practice as would be practiced in-person with a patient and with other restrictions as defined in regulation.

Section 20. Amend § 3902, Title 24 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

(1) "Board" shall mean the Board of Clinical Social Work Examiners.

(2) "Clinical social work" shall mean the application of social work theory and methods, which may include the person-in-environment perspective, to the assessment, diagnosis, prevention and treatment of biopsychosocial dysfunction, disability and impairment, including mental and emotional disorders, developmental disabilities and substance abuse. The application of social work method and theory includes, but is not restricted to, assessment (excluding administration of the psychological tests which are reserved exclusively for use by licensed psychologists pursuant to Chapter 35 of this title), diagnosis, treatment planning and psychotherapy with individuals, couples, families and groups, case management, advocacy, crisis intervention and supervision of and consultation about clinical social work practice. Such application and services may be provided through the use of Telemedicine in a manner deemed appropriate by regulation. Services also may include participation in Telehealth as further defined in regulation.

(3) “Distant site” means a site at which a health care provider legally allowed to practice in the state is located while providing health care services by means of telemedicine or telehealth.

(3) "Independent practice" means the practice of clinical social work services by a clinical social work practitioner who assumes responsibility for the nature and quality of the services provided to the client in exchange for direct payment or third-party payment.

(4) "Licensed clinical social worker" shall mean any individual duly licensed under this chapter.

(5) "Practitioner," as used in this chapter, shall mean any individual engaged in the practice of clinical social work.
(6) “Originating site” means a site in Delaware at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.

(7) “Store and forward transfer” means the transmission of a patient’s medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

(6) "Substantially related" means the nature of the criminal conduct, for which the person was convicted, has a direct bearing on the fitness or ability to perform 1 or more of the duties or responsibilities necessarily related to clinical social work.

(7) “Telehealth” means the use of information and communications technologies consisting of telephones, remote patient monitoring devices or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services as described in regulation.

(8) “Telemedicine” means a form of telehealth which is the delivery of clinical health care services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care by a licensee practicing within his or her scope of practice as would be practiced in-person with a patient and with other restrictions as defined in regulation.
Section 21. Amend Chapter 35 of Title 18 of the Delaware Code to add new “§ 3571R” by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3571R. Telemedicine.

(a) As used in this section:

(1) “Distant site” means a site at which a health care provider legally allowed to practice in the state is located while providing health care services by means of telemedicine or telehealth.

(2) “Originating site” means a site in Delaware at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.

(3) “Store and forward transfer” means the transmission of a patient’s medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

(4) “Telehealth” means the use of information and communications technologies consisting of telephones, remote patient monitoring devices or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services as described in regulation.

(5) “Telemedicine” means a form of telehealth which is the delivery of clinical health care services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care by a health care provider practicing within his or her scope of practice as would be practiced in-person with a patient, and legally allowed to practice in the state, while such patient is at an originating site and the health care provider is at a distant site.

(b) Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the cost of such health care services provided through telemedicine.
(c) Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the cost of such health care services provided through telehealth as directed through regulations promulgated by the Department.

(d) An insurer, health service corporation, or health maintenance organization shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through in-person consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.

(e) An insurer, health service corporation, or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis and at least at the rate that the insurer, health service corporation, or health maintenance organization is responsible for coverage for the provision of the same service through in-person consultation or contact. Payment for telemedicine interactions shall include reasonable compensation to the originating or distant site for the transmission cost incurred during the delivery of health care services.

(f) No insurer, health service corporation, or health maintenance organization shall impose any annual or lifetime dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan.

(g) The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended on and after enactment of this section or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

(h) This section shall not apply to short-term travel, accident-only, limited or specified disease, or individual conversion policies or contracts, nor shall it contravene any telehealth requirements made in policies or contracts designed for issuance to persons eligible for coverage under Titles XVIII, XIX, and XXI of the Social Security Act, known as Medicare and Medicaid, or any other similar coverage under state or federal governmental plans.
Section 22. Amend Chapter 19 of Title 24 of the Delaware Code to include a new section “§1932” by making deletions as shown by strike through and additions as shown by underline as follows:

§1932. Telemedicine

(a) Telemedicine shall not be utilized by an APRN with respect to any patient in the absence of an APRN-patient relationship.

(b) APRNs who utilize telemedicine shall, if such action would otherwise be required in the provision of the same service not delivered via telemedicine, ensure that a proper APRN-patient relationship is established which includes but is not limited to:

(1) fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient;

(2) disclosing and validating the provider’s identity and applicable credential(s);

(3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including informed consents regarding the use of telemedicine technologies as indicated in subsection (b)(5);

(4) establishing a diagnosis through the use of acceptable medical practices, as patient history, mental status examination, physical examination (unless not warranted by the patient’s mental condition), and appropriate diagnostic and laboratory testing to establish diagnoses, as well as identify underlying conditions or contraindications, or both, to treatment recommended or provided;

(5) discussing with the patient the diagnosis and the evidence for it, the risks and benefits of various treatment options; and

(6) ensuring the availability of the distant site provider or coverage of the patient for appropriate follow-up care; and

(7) providing a written visit summary to the patient.

(c) Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional (encounter in person) settings.

(d) The APRN treating a patient through telemedicine must maintain a complete record of the patient’s care which must follow all applicable state and federal statutes and regulations for recordkeeping, confidentiality, and disclosure to the patient.
(e) Telemedicine shall include, at such time as feasible and when appropriate, utilizing the Delaware Health Information Network (DHIN) in connection with the practice.

(f) Without a prior and proper patient-provider relationship, as provided in subsection (b)(5), providers are prohibited from issuing prescriptions solely in response to an Internet questionnaire, an Internet consult, or a telephone consult.

(g) Prescriptions made through telemedicine and under an APRN-patient relationship may include controlled substances, subject to limitations as set by the Board.

(h) This section does not apply to any of the following:

   (1) informal consultation performed by a APRN outside the context of a contractual relationship and on an irregular or infrequent basis without the expectation or exchange of direct or indirect compensation;

   (2) Furnishing of medical assistance by a APRN in case of an emergency or disaster if no charge is made for the medical assistance;

   (3) Episodic consultation by a medical specialist located in another jurisdiction who provides such consultation services on request to a person licensed in this state.

Section 23. This Act shall be effective on January 1 of the year after its enactment.
A bill to be entitled
An act relating to telehealth; amending s. 110.123, F.S.; encouraging the state group health insurance program to offer health insurance plans that include telehealth coverage for state employees; amending s. 409.906, F.S.; authorizing the Agency for Health Care Administration to pay for certain telehealth services as optional Medicaid services; creating s. 456.4501, F.S.; defining terms; establishing the standard of care for telehealth providers; authorizing telehealth providers to use telehealth to perform patient evaluations; providing that telehealth providers, under certain circumstances, are not required to research a patient’s history or conduct physical examinations before providing services through telehealth; providing that a nonphysician telehealth provider using telehealth acting within her or her relevant scope of practice is not deemed to be practicing medicine without a license; authorizing certain telehealth providers to use telehealth to prescribe specified controlled substances; providing for construction; requiring the Department of Health to develop and disseminate certain educational materials to specified licensees by a specified date; providing requirements for recordkeeping by telehealth providers; providing requirements for patient consent for telehealth treatment; amending s. 627.0915, F.S.; encouraging insurers offering certain rating plans for workers’ compensation and employer’s liability
insurance, which are approved by the Office of Insurance Regulation, to include in the plans services provided through telehealth; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (b) of subsection (3) of section 110.123, Florida Statutes, is amended to read:

110.123 State group insurance program.—
(3) STATE GROUP INSURANCE PROGRAM.—
(b) It is the intent of the Legislature to offer a comprehensive package of health insurance and retirement benefits and a personnel system for state employees which are provided in a cost-efficient and prudent manner, and to allow state employees the option to choose benefit plans that best suit their individual needs. The state group insurance program may include the state group health insurance plan or plans, health maintenance organization plans, group life insurance plans, TRICARE supplemental insurance plans, group accidental death and dismemberment plans, group disability insurance plans, other group insurance plans or coverage choices, and other benefits authorized by law. While not mandated to do so, the state group health insurance program is encouraged to offer a selection of plans that include coverage of services provided through telehealth.

Section 2. Subsection (28) is added to section 409.906, Florida Statutes, to read:

409.906 Optional Medicaid services.—Subject to specific
appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state’s systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as “Intermediate Care Facilities for the Developmentally Disabled.” Optional services may include:

(28) TELEHEALTH.—The agency may pay for live video conferencing, store and forward, as defined in s. 456.4501(1), and remote patient monitoring of a covered service delivered by or under the direction of a licensed health care practitioner.

Section 3. Section 456.4501, Florida Statutes, is created to read:

456.4501 Use of telehealth to provide services.—

(1) DEFINITIONS.—As used in this section, the term:
(a) “Information and telecommunications technologies” means those secure electronic applications used by health care practitioners and health care providers to provide health care services, evaluate health care information or data, provide remote patient monitoring, or promote healthy behavior through interactions that include, but are not limited to, live video interactions, text messages, or store and forward transmissions.

(b) “Store and forward” means the type of telehealth encounter which uses still images of patient data for rendering a medical opinion or patient diagnosis. The term includes the asynchronous transmission of clinical data from one site to another site.

(c) “Synchronous” means live or two-way interactions using a telecommunications system between a provider and a person who is a patient, caregiver, or provider.

(d) “Telecommunications system” means the transfer of health care data through advanced information technology using compressed digital interactive video, audio, or other data transmission; clinical data transmission using computer image capture; and other technology that facilitates access to health care services or medical specialty expertise.

(e) “Telehealth” means the mode of providing health care services and public health services by a Florida licensed practitioner, within the scope of his or her practice, through synchronous and asynchronous information and telecommunications technologies where the practitioner is located at a site other than the site where the recipient, whether a patient or another licensed practitioner, is located.

(f) “Telehealth provider” means a person who provides
health care services and related services through telehealth and who is licensed under chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 462; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part III, part IV, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; parts III and IV of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491; or who is certified under s. 393.17 or part III of chapter 401.

(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.

(b) A telehealth provider and a patient may be in separate locations when telehealth is used to provide health care services to the patient.

(c) A nonphysician telehealth provider using telehealth and acting within his or her relevant scope of practice is not deemed to be practicing medicine without a license under any provision of law listed in paragraph (1)(f).

(d) A telehealth provider who is authorized to prescribe a controlled substance named or described in Schedules I through V of s. 893.03 may use telehealth to prescribe a controlled substance.
substance, except that telehealth may not be used to prescribe a controlled substance to treat chronic nonmalignant pain as defined in s. 458.3265(1)(a) or to issue a physician certification for marijuana pursuant to s. 381.986. This paragraph does not prohibit a physician from using telehealth to order a controlled substance for an inpatient admitted to a facility licensed under chapter 395 or a patient of a hospice licensed under chapter 400.

(e) By January 1, 2019, the department, in coordination with the applicable boards, shall develop and disseminate educational materials for the licensees listed in paragraph (1)(f) on the use of telehealth modalities to treat patients.

(3) RECORDS.—A telehealth provider shall document in the patient’s medical record the health care services rendered using telehealth according to the same standard used for in-person health care services pursuant to ss. 395.3025(4) and 456.057.

(4) CONSENT.—Patients are not required to provide specific authorization for treatment through telehealth, but must authorize treatment that meets the requirements of the applicable practice acts and s. 766.103, and must be allowed to withhold consent for any specific procedure or treatment through telehealth.

Section 4. Section 627.0915, Florida Statutes, is amended to read:

627.0915 Rate filings; workers’ compensation, drug-free workplace, and safe employers; consideration of telehealth.—

(1) The office shall approve rating plans for workers’ compensation and employer’s liability insurance that give specific identifiable consideration in the setting of rates to
employers that either implement a drug-free workplace program pursuant to s. 440.102 and rules adopted under such section or implement a safety program pursuant to provisions of the rating plan or implement both a drug-free workplace program and a safety program. The plans must be actuarially sound and must state the savings anticipated to result from such drug-testing and safety programs.

(2) An insurer offering a rate plan approved under this section shall notify the employer at the time of the initial quote for the policy and at the time of each renewal of the policy of the availability of the premium discount where a drug-free workplace plan is used by the employer pursuant to s. 440.102 and rules adopted under such section. The Financial Services Commission may adopt rules to implement the provisions of this subsection.

(3) An insurer offering a rate plan approved under this section is encouraged to include in the plan services provided through telehealth.

Section 5. This act shall take effect July 1, 2018.
Tab 5 – Other Reference Materials

TELEMEDICINE FEASIBILITY STUDY REPORT AND BUSINESS CASE

Prepared for:

Eric Kelly, President,
and
Randy Scheid, Vice President,
Quantum Foundation

Prepared by:

Aneel Irfan, Founder and President,
and
Heather Zumpano, Founder and Project Director,
IMST Telehealth Consulting

October 17, 2016
1. Executive Summary

Telehealth offers new and effective tools for delivering healthcare services, and opens opportunities to expand the reach and availability of services, while also developing creative new delivery methods. Quantum’s executives want to learn if a valid business case exists for telehealth program development to increase access to health services for those served by Palm Beach County’s Federally Qualified Health Centers (FQHCs). Furthermore, they want to know the feasibility of collaborating efforts among disparate providers to meet the needs of the community served by the FQHCs via telemedicine technologies. IMST Telehealth Consulting was commissioned to research the opportunity.

IMST conducted research in accordance with industry best practices to assess and define the model for telehealth that would optimize healthcare delivery services. We conducted surveys and focus groups to include the administrative, clinical and information technology stakeholders at three Federally Qualified Health Centers and one site which essentially operates as a ‘look-alike’ FQHC in Palm Beach County. We also conducted 10 clinical site visits for the organizations included in this research, assessed their current state, and defined the desired future state. For the purposes of this report, the survey and focus group responses have been aggregated so as to de-identify any one FQHC or site. We also refer to FQHC’s as ‘organizations,’ ‘entities’ or ‘sites.’

This business case summarizes our findings and reports our evidence-based recommendations. Our analysis of the Palm Beach County FQHC market has informed the development of the business case, which validates an effective demand, exists for telehealth program development.

1.1. Problem Statement

Quantum Foundation takes great pride in their mission to help underserved populations of Palm Beach County obtain access to high quality health care. They do this by funding an array of initiatives. Even with the robust FQHC network, there are gaps in the types of services being provided, as well as geographic and financial barriers for patients and physicians.

Through our research, we discovered that across all of the organizations, an estimated 7,929 patient encounters per month result in referrals for specialty care. There was consensus among the organizations that about 30% of patients don’t follow up to receive the specialty care they are referred for. The primary barriers to health care access for the underserved population of Palm Beach County are lack of transportation; long wait times for appointments; language barriers; and prohibitive costs for care. Low levels of health literacy and restrictive clinical availability compound the problem, because people do not realize the severity of their illness by the time they seek health care, and when they have to wait for a long time to be seen, it deters their incentive to go to the clinics.
1.2. Anticipated Outcomes

Establishing a county-wide network of high-bandwidth connectivity can significantly increase the ability for FQHC clinics to use telehealth to connect patients and specialists in rural and urban communities. Developing a telehealth network of specialty physicians, accessible via live video conferencing at each of the clinics can make a significant positive impact on access to health services in Palm Beach County. Providing remote access to specialists at the clinics would generate new revenue sources for the clinics and specialists alike. Patients will also experience better health outcomes.

We anticipate that cost-sharing for the development of the telehealth network can maximize purchasing power and lower overall costs of increasing the number and availability of specialty providers to the safety net populations of Palm Beach County. With proper legal oversight to overcome the special rules for FQHCs as outlined in the Federal Tort Claims Act, we believe using telehealth as a tool for better patient access will yield better health management, with opportunities for expansion of services to outside institutions through strategic partnerships (i.e. prisons, homeless shelters, and schools), leading to increased ROI.

1.3. Recommendations

Short-Term

In the short term, we recommend working with each organization to meet them where they are, according to their current state of organizational readiness. This involves getting those who scored lower on their Telehealth Capacity Assessment ready for future program development and moving forward with developing and planning a pilot program with those who scored higher. We recommend planning to purchase the minimum viable technology for live video conference visits to cover the overwhelming need for psychiatry services. This way, more money is available to invest in resources needed for education, training, and workflow development.

Eventually, as the comfort level with telehealth tools increases, the full range of medical specialists can become available through the network. As telehealth laws evolve in the state of Florida, more modalities of telehealth can be employed, specifically store and forward methods that do not require in-person visits and remote patient monitoring, that empowers patients to be more involved in their health care from their home.

1.4. Justification

Telehealth program development aligns with the organizational missions, vision, values, and strategic plans of all the FQHCs we researched. Overall responses from the stakeholders were positive, with a unanimous expression of need for specialty services, including psychiatric care, endocrinology, gastroenterology, etc. for their underserved and rural populations. It was also unanimous that transportation, financial, and language barriers impede access to care. All the organizations stated long wait times to be seen by specialists. This long waiting list imposes burdens on the patients, their families, the primary care clinics, and overall population health.
Visits to the clinical sites revealed they all have adequate space to accommodate telehealth equipment, despite the need for connectivity upgrades in the rural areas of Belle Glade, Pahokee, and Indiantown. Video conferencing solutions require minimum space, and often a freestanding monitor or laptop computer can be used with a high definition maneuverable camera, to maximize portability. This is because many software solutions have advanced to an encrypted, cloud-based platform, providing clinicians with quick and easy access.

Other uses for the video conferencing equipment are conducting peer to peer consultations; administrative and clinical meetings among team members who work at different sites; and educational in-services for medical residents and nursing students. This adds value by reducing the need for transportation, saving time and improving operational efficiency. We assessed current use of videoconferencing in the FQHCs and report our findings in Subsection 3.1.5.

2. Organizational Readiness Assessment

It is best practice to begin any telehealth initiative with an Organizational Readiness Assessment to assure that a new telehealth program will be successfully adopted and utilized. The decision to implement a telehealth program involves organizational change, and success depends on the administrators, clinicians, and IT personnel having a willingness and ability to move in a new direction. Sustainability depends on alignment of the program with business and clinical goals, which comes from establishing a shared vision that becomes the foundation for all their subsequent decisions. The following subsections summarize the information we learned from the Organizational Readiness Assessment regarding alignment with their current mission, vision, values, and culture; resource availability; stakeholder support and authority; a SWOT analysis, and readiness for technology.

2.1. How Telehealth Adoption Aligns With Each Organization

A key component of assessing organizational readiness is determining how the current state of each organization relates to the desired new program. Our survey and focus group questions were designed to assess various organizational qualities that are critical to telehealth program success. The site visits allowed for preliminary technology assessment, as well as an understanding of current clinical workflows. Discussions about the results are based on the combination of survey results, focus groups, and site visits. The results vary among the organizations, and the discussions provide critical insights into the changes needed to improve organizational readiness for telehealth adoption.

2.1.1. Vision/Mission and Strategic Plan

This section of the assessment inquired about the alignment of telehealth program development with each organization’s current mission, vision, and strategic plan. The questions asked if a telehealth project supports the vision for their desired future; if the project aligns with the organization’s belief of who it is, what it does, and how it serves; and if telehealth supports their approach to achieving goals and objectives. All four organizations are in alignment in these areas.
2.1.1.a. Vision/Mission and Strategic Plan Examples From Each Site

One site is currently employing live video conference telehealth for diabetes education and mental health services. This site educates nurses who do clinical rotations through their site. They have a real opportunity to develop telehealth education and provide their graduates with the skills to lead the effort to integrate telehealth services across the healthcare continuum. In addition, expansion of their telehealth-based services can increase range of services provided, and allow them to receive more patients. Successful implementation of an optimized telehealth program aligns with their strategy to improve revenues, quality scores, and patient outcomes.

Another site is currently providing telemental health visits for some patients in cooperation with a separate entity. They want to enhance their workflows, and have a successful pilot using best practices. Then, they want to increase of specialty services they can provide in the clinic, to maximize value to their rurally located patients.

Another entity operates 10 clinics throughout the county and continuously assesses patient needs through Satisfaction Surveys, Patient Tracers, and open communication with patients. Goals to reduce barriers to care and increase patient access is routinely incorporated into strategic planning efforts. They strive to provide the highest quality healthcare to all Palm Beach County residents, including the homeless and migrant populations. The site stakeholders we worked with envision telemedicine as a tool to overcome distance as a barrier to specialty health care access.

2.1.2. Organizational Values and Culture

This section of the assessment focused on the alignment between telehealth adoption and organizational values and culture. The inquiries focused on consistency with guiding principles; alignment with existing beliefs, assumptions, and expectations; and whether each organization’s culture supported innovation and clinical technology applications. Two sites have already invested in video conferencing solutions and the stakeholders expressed initial success. Another site has invested in new Laptops with webcam capabilities.

2.1.3. Resource Availability

The questions for this section evaluated whether funding was available for initial planning activities; if staff were available to work on the project; and whether leadership groups were in place to foster support for program development. All of the entities indicated adequate resource availability.

Available Staff

The nurse practitioners at one site think their program can benefit from a designated telehealth coordinator, to foster their program expansion strategy. The practice managers and office staff at multiple sites expressed willingness to cross-train in appropriate telehealth education according to their roles.
A concern from many organizations is the availability of staff to conduct project activities such as program planning, development, and implementation. One organization stated they are currently implementing other projects, and want to exercise caution about overwhelming their staff. All organizations expressed a desire to ensure the best decisions are made regarding capital expenditures, education, training, and workflow development.

2.1.4. SWOT Analysis - Internal and External Factors
A SWOT analysis is beneficial, because it identifies the strengths and weaknesses of each FQHC, and helps identify areas in need of change to move forward with program planning and development. The SWOT analysis also helps identify opportunities that will contribute to success, as well as threats or barriers that can inhibit success.

We begin with the internal factors. One site stated their primary strength as helping to initiate telehealth services to assist with diabetes education and mental health counseling, to supplement the significant number of needs in the rural communities served by another site. Right now they are seeing patients at on-site.

The weaknesses at a few sites were related to the need for better clinical and administrative education on the nuances of telehealth best practices, along with a strong business case and marketing program; for increased community awareness and utilization. These weaknesses were communicated by a few sites in all of the clinical focus group sessions, which is to be expected at this early stage of investigation.

The primary external factor that was discussed among all the organizations was the stringent rules of FQHC operations specifically related to the requirements established by the Federal Tort Claims Act. Two sites reported on their surveys that they felt the laws were a major barrier to cooperation among the disparate organizations. Other external factors arose among the organizations. These included defining the originating and distant sites; clinical workflow modification; identification of increased access to specialty practitioners. Most stakeholders expressed excitement about the potential for telehealth programs to reduce wait times and transportation barriers for their patients and opportunities to increase revenues in their clinics.

2.1.5. Preliminary Technology Assessment
Two sites have a Polycom live video platform with a monitor, HD camera, and speaker unit. The software platform allows for secure interaction.

One site does not have any telehealth equipment but their practitioners carry laptops to the patient exam room.

All the organizations are also using some form of an electronic medical records (EMR) system. Many telehealth programs are able to integrate with EMR, but it isn’t a requirement to conduct telehealth visits.
3. Needs Assessment

A needs assessment is a process used to identify the health care needs of the community. The process involves collecting and analyzing data to determine the gap between the current and desired level of service availability. Using data to identify needs allows the FQHC administrative, clinical, and technology stakeholders to better evaluate the rationale for telehealth program development. There are many benefits to conducting a needs assessment, including: gaining a clear understanding of community need; a foundation for program development; clear objectives and shared expectations among stakeholders; improved service coordination; rational resource allocation; the ability to evaluate effectiveness; and gathering information for the market analysis and business case. This section of the report provides our Needs Assessment findings from our combined external research, surveys, focus groups, and site visits. We will also discuss the current and desired state, gap analysis, and identified barriers.

3.1. Needs Assessment Summary

Focus groups and guided interviews were the sources of primary quantitative and qualitative data, and published state and county government data were the sources of secondary quantitative and qualitative information. Involving the decision makers and end users in the assessment process has been proven to increase buy-in and team building for future telemedicine program development. Subsections 3.1.1. through 3.1.5 demonstrate our findings from the four organizations included in our study. These subsections cover demographic and socioeconomic factors, health status, service availability, referral patterns, administration and educational events, and payer mix.

3.1.1. Demographic and Socioeconomic Needs

It’s important to know who the FQHCs serve, in order to develop a telehealth program suited to meet their needs. In order to discover more about the population served, we turned to Florida Charts and the data collected by the Florida Legislature, Office of Economic and Demographic Research. Understanding age, race, and ethnicity characteristics allows us to understand their affinity for technology, and develop education and marketing messages that align with the community’s culture and language. Table 1 summarizes the 2015 population data for Palm Beach County and the state of Florida, including the division by race and ethnicity. In 2014, the Florida Legislature, Office of Economic and Demographic Research reported 51% of people in both the county and state fell between the ages of 25 and 54, and they were almost equally split between males and females. Through our surveys, we learned that special language considerations are needed for Bangladeshi, Brazilian, Creole, Haitian, and Mayan patients, which contribute to the 4.9% calculation in Table 1.

<table>
<thead>
<tr>
<th>2015 Population Data for Palm Beach County and the State of Florida</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>------------------------</td>
</tr>
<tr>
<td><strong>County</strong></td>
</tr>
</tbody>
</table>
Table 1 - Population Data for Palm Beach County and the State of Florida

Data Sources: Florida Charts and the Florida Legislature, Office of Economic and Demographic Research

The socioeconomic indicators that correlate with demand for the Palm Beach County FQHC services are the ability to speak English, the percentage of the population living below the poverty level, and the number of unemployed in the population. These factors are related, because people in these categories are more likely to be uninsured or underinsured, and they are eligible to receive services at the Palm Beach County FQHCs. Many of the non-English speaking people in Palm Beach County are migrant farm workers. Low education levels, a sluggish economy, and slow job growth are contributing factors to unemployment and poverty.

Table 2 shows the 2014 socioeconomic indicator data from the Florida Legislature, Office of Economic and Demographic Research. When we totaled the percentages and converted them to the number of people in these three categories, the results brought clarity to the staggering potential demand for health services at the Palm Beach County FQHCs.

<table>
<thead>
<tr>
<th></th>
<th>Pop. Over Age 5 with Little to no English (%)</th>
<th>Total Poverty Rate (%)</th>
<th>Unemployment Rate (%)</th>
<th>Total Potential for FQHC Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>County</td>
<td>12.9</td>
<td>14.6</td>
<td>10.8</td>
<td>522,670 (38.3%)</td>
</tr>
<tr>
<td>State</td>
<td>11.7</td>
<td>16.7</td>
<td>10.9</td>
<td>7,693,328 (39.9%)</td>
</tr>
</tbody>
</table>

Table 2 - Socioeconomic Data for Palm Beach County and the State of Florida

Data Sources: Florida Charts and the Florida Legislature, Office of Economic and Demographic Research

3.1.2. Health Status

People with chronic diseases and behavioral risk factors utilize more health services than their healthier counterparts. It is important to note, the Pareto Rule applies to health care, meaning 20% of the population utilizes 80% of the health care services. We researched the data provided by Florida Charts to learn how these factors impact the types of services needed in Palm Beach County. Mental health and psychiatric disorders can also lead to substance abuse, violent crimes, and sexually transmitted diseases.

To gain strong insights on chronic disease, the American Telemedicine Association and California Telehealth Resource Centers suggest measuring the heart disease and stroke mortality rates, and the diabetes and asthma hospitalization rates in both the county and the state. This provides a good perspective on the degree of need for the population being served. Table 3 presents the data for chronic diseases. Heart disease and stroke mortality and rates
are slightly higher in the county versus the state, whereas diabetes and asthma hospitalization are slightly lower.

<table>
<thead>
<tr>
<th>Chronic Disease Indicators</th>
<th>County</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease Mortality Rate*</td>
<td>10,375 (0.75%)</td>
<td>131,195 (0.66%)</td>
</tr>
<tr>
<td>Stroke Mortality Rate*</td>
<td>2,488 (0.18%)</td>
<td>29,626 (0.15%)</td>
</tr>
<tr>
<td>Age-Adjusted Diabetes Hosp. Rate*</td>
<td>104,031 (7.53%)</td>
<td>1,730,376 (8.71%)</td>
</tr>
<tr>
<td>Age-Adjusted Asthma Hosp. Rate*</td>
<td>28,208 (2.04%)</td>
<td>442,076 (2.22%)</td>
</tr>
</tbody>
</table>

Table 3 - Chronic Disease Indicators for Palm Beach County and the State of Florida

Data Sources: Florida Charts, *Florida Department of Health, Bureau of Vital Statistics, and ✦The Agency for Healthcare Administration

The behavioral risk factors we investigated were cigarette smoking, hypertension, high cholesterol, and sedentary lifestyle. These risk factors can lead to chronic disease. Table 4 summarizes the county and state behavioral risk factors. Palm Beach County has less cigarette smokers than the whole state. However, the percentage of the population with hypertension, high cholesterol, and sedentary lifestyles in the county, almost mirrors or surpasses the levels across the state. This suggests significant risk exists in the county for people to develop heart disease, diabetes, and asthma, and utilize more health resources at the same rate as the whole state into the future.

<table>
<thead>
<tr>
<th>Behavioral Risk Factors (%)</th>
<th>County (%)</th>
<th>State (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigarette Smoking</td>
<td>9.5</td>
<td>16.8</td>
</tr>
<tr>
<td>Hypertension</td>
<td>34.4</td>
<td>34.6</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>38.4</td>
<td>33.4</td>
</tr>
<tr>
<td>Sedentary Lifestyle (Combined Overweight and Obesity)</td>
<td>60.1</td>
<td>62.8</td>
</tr>
</tbody>
</table>

Table 4 - Behavioral Risk Factors for Palm Beach County and the State of Florida

Data Sources: Florida Charts, Florida Department of Health, Bureau of Epidemiology, Florida BRFSS survey

A large demand for mental health and psychiatry services exists in the county. We investigated suicide death rates, violent crimes (murder, aggravated assault, and forcible sex offenses),
alcohol-suspected motor vehicle crashes and HIV Infection cases. Table 5 displays the county and statewide data for mental health and psychiatric indicators. The frequency of these indicators in the county is nearly identical to the state.

### Table 5 - Mental Health and Psychiatric Indicators for Palm Beach County and the State of Florida

<table>
<thead>
<tr>
<th>Mental Health and Psychiatric Indicators</th>
<th>County</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide Deaths</td>
<td>679 (0.05%)</td>
<td>9,005 (0.04%)</td>
</tr>
<tr>
<td>Murders</td>
<td>249 (0.02%)</td>
<td>2,991 (0.02%)</td>
</tr>
<tr>
<td>Aggravated Assaults</td>
<td>11,977 (0.87%)</td>
<td>179,700 (0.9%)</td>
</tr>
<tr>
<td>Forcible Sex Offenses</td>
<td>1,950 (0.14%)</td>
<td>30,831 (0.15%)</td>
</tr>
<tr>
<td>Alcohol-Suspected Motor Vehicle Crashes</td>
<td>3,552 (0.25%)</td>
<td>49,872 (0.25%)</td>
</tr>
<tr>
<td>HIV Infection Cases</td>
<td>932 (0.07%)</td>
<td>13,842 (0.07%)</td>
</tr>
</tbody>
</table>

Table 5- Mental Health and Psychiatric Indicators for Palm Beach County and the State of Florida

**Data Sources:** Florida Behavioral Risk Factor Surveillance System county-level telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Bureau of Epidemiology

### 3.1.3. Service Availability

In the surveys we distributed to the clinical and administrative stakeholders, we included questions designed to assess service availability for each organization. They were designed to discover patient barriers to access, such as transportation, hours of operation, long wait times, and lack of insurance. We discovered what specialty services are needed but not available to the community served by the FQHCs. We identified populations with language and cultural barriers that can strain patient and provider relationships. Finally, we learned what the gaps are between health care service needs and available resources, as well as where the demand for services regularly exceeds resources. Table 6 illustrates our service availability findings for each organization.

### Service Availability Assessment

<table>
<thead>
<tr>
<th>Access Restrictions</th>
<th>Site 1</th>
<th>Site 2</th>
<th>Site 3</th>
<th>Site 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Long wait times</td>
<td>Location</td>
<td>Rural locations</td>
<td>Lack of transport</td>
</tr>
<tr>
<td></td>
<td>Lack of transport</td>
<td>Lack of transport</td>
<td>Costs</td>
<td>Costs</td>
</tr>
<tr>
<td></td>
<td>Space constraints</td>
<td>Lack of specialty care</td>
<td>Lack of providers that accept Medicaid and sliding scale fees</td>
<td>Lack of health literacy</td>
</tr>
<tr>
<td></td>
<td>In one site, the few specialists in town have limited office hours (once or twice a week)</td>
<td>Lack of providers that accept Medicaid and sliding scale fees</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 6 - Service Availability Assessment
### Table 6 - Service Availability among Palm Beach County FQHCs Based on Survey Results

<table>
<thead>
<tr>
<th>Lack of Insurance</th>
<th>✔ (55% self-pay)</th>
<th>✔ (65% self-pay)</th>
<th>✔ (20% self-pay)</th>
<th>✔ (70% self-pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needed Services That Are Not Available</td>
<td>OB/Gyn Psychiatry HIV Services Hematology Endocrinology Radiology Dietician Optometry Dental specialties</td>
<td>Substance Abuse Treatment Psychiatry Cardiology Prenatal care Dental Gastro-Intestinal Podiatry Ophthalmology Radiology Pharmacy dispensary</td>
<td>All specialties Priorities are Mental health Radiology Lab Orthopedics</td>
<td>Gastro-Intestinal Cardiology Oncology Pharmacy Radiology Psychiatry Mental health Substance abuse Pediatric Orthopedists and Optometry/Ophthalmology for uninsured</td>
</tr>
<tr>
<td>Services That Are Available</td>
<td>Primary Care Immunizations Dental Mental Health (therapy and LCSW) Lab Women’s Health (1 site) Financial counseling Pharmacy (1 site)</td>
<td>Diabetes self-management Psych. Evalu. Medication management Primary care Preventative care Immunization Gynecology Wellness</td>
<td>Primary Care Dental Pediatrics OB/Gyn</td>
<td>Pediatrics Primary Care OB/Gyn Perinatal HIV and STD testing Immunization Outreach services Dental Wellness Case management Homeless outreach Discount pharmacy (340B)</td>
</tr>
<tr>
<td>Language/ Cultural Needs</td>
<td>Need for translators Most of the sites have bilingual staff and language line</td>
<td>Religious/spiritual competency Spanish and Creole</td>
<td>None</td>
<td>Creole, Spanish, and Mayan</td>
</tr>
<tr>
<td>Gaps Between Needs and Available Resources</td>
<td>Difficulty recruiting Primary Care Specialists Specialists in the area, restrict the number of Medicaid and Medicare recipients they see and are unwilling to provide sliding scale fees to the uninsured. Psychiatry is a major gap Dental Nephrology Urology Orthopedics Dietician</td>
<td>The gaps can be narrowed by authentically sharing resources. Often, the problem is the distance between providers that are willing to share, making it difficult for clients to go from one place to another. Dentists are scarce Mental health Substance abuse</td>
<td>All specialties Priorities are mental health, radiology, and lab</td>
<td>The result of a lack of specialty care for uninsured is resulting in repeated visits Mental health has a major gap Resources for pediatric optometry</td>
</tr>
<tr>
<td>Provider Shortages</td>
<td>Primary Care Pediatrics Dental</td>
<td>Psychiatry Dental Ophthalmology Mental health Health education</td>
<td>All services, especially Mental Health and Dental</td>
<td>Psychiatry Dental OB/Gyn</td>
</tr>
</tbody>
</table>

#### 3.1.4. Referral Patterns
A review of clinical referral patterns helps to identify the type of services where organizations are losing revenues from inability to provide the care at their own sites. For the uninsured and underinsured, opportunity costs extend beyond the clinics. When patients cannot access health services, they are more likely to be hospitalized, which presents a greater financial burden on the health care system as a whole. Our needs assessment surveys asked clinicians and administrators about their predominant referral patterns including the primary diagnoses and health care services they are unable to address; current referral relationships with distant sites and specialists; whether health care providers travel to their sites from another organization to provide care to their patients; and if providers from their sites travel to other organizations to supplement scarce resources; and the number of patient referrals per month. Table 7 lists our findings based on the stakeholder responses to these questions.

### Table 7

<table>
<thead>
<tr>
<th>Predominant Patterns</th>
<th>Site 1</th>
<th>Site 2</th>
<th>Site 3</th>
<th>Site 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider refers patients out for all specialty services. The only exceptions are for general dentistry, Mental Health Counseling, and Social Work. Referral clerks (located off site) process authorizations. Medical Assistants assist with non-auth referrals. Specialists All radiology services Psychiatry Orthopedics Dermatology Community Resource Centers, Hospitals, and other sites for overflow.</td>
<td>Insured patients are referred to specialists Cardiology Gastro Psychotherapy Ophthalmology Podiatry</td>
<td>Refer to local specialists if they are available. However, many patients, especially children must be referred far out of their local area</td>
<td>Within the organization, but to a site closer to patient’s home A referral coordinator and Project Access manager help with outside referrals Grant managers help arrange mammograms, they have info. on affordable radiologic services and are working with a hospital to collaborate on radiologic services Participating specialists for patients with insurance plans Hospitals Other local mental health providers</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Types of Services Referred</th>
<th>Site 1</th>
<th>Site 2</th>
<th>Site 3</th>
<th>Site 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatry</td>
<td>Dental Prenatal</td>
<td>Mental health</td>
<td>Mental Health</td>
<td></td>
</tr>
<tr>
<td>Pediatric Surgery</td>
<td>Psychotherapy</td>
<td>Radiology</td>
<td>Gastro-Intestinal</td>
<td></td>
</tr>
<tr>
<td>Pediatric Cardiology</td>
<td>Case management</td>
<td>Lab</td>
<td>Cardiology</td>
<td></td>
</tr>
<tr>
<td>Radiology</td>
<td>Cardiology</td>
<td>Orthopedics</td>
<td>Oncology</td>
<td></td>
</tr>
<tr>
<td>Cardiology</td>
<td>Preventive Care</td>
<td>Podiatry</td>
<td>Infectious disease</td>
<td></td>
</tr>
<tr>
<td>Endocrinology</td>
<td></td>
<td></td>
<td>Endocrinology</td>
<td></td>
</tr>
<tr>
<td>Ophthalmology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optometry</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastroenterology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Podiatry</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nephrology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dermatology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infectious Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopedics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrition</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Common Diagnoses and Health Services Referred**

<table>
<thead>
<tr>
<th>Diagnoses:</th>
<th>Pain Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abnormal EKGs</td>
<td>Substance Abuse</td>
</tr>
<tr>
<td>Chest pain</td>
<td>Psychiatry</td>
</tr>
<tr>
<td>Back pain</td>
<td>Cardiology</td>
</tr>
<tr>
<td>Fractures</td>
<td>Prenatal care</td>
</tr>
<tr>
<td>Cancer</td>
<td>Dental</td>
</tr>
<tr>
<td>STDs</td>
<td>GI</td>
</tr>
<tr>
<td>Services:</td>
<td>Podiatry</td>
</tr>
<tr>
<td>All diagnostic imaging (i.e. Mamography Ultrasound)</td>
<td>Ophthalmology</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>Radiology</td>
</tr>
<tr>
<td>Mental health</td>
<td>OB/Gyn</td>
</tr>
<tr>
<td>Colonoscopies</td>
<td>Endocrinology</td>
</tr>
<tr>
<td>Biopsies</td>
<td></td>
</tr>
<tr>
<td>Endocrinology</td>
<td></td>
</tr>
</tbody>
</table>

**Existing Referral Partners**

<table>
<thead>
<tr>
<th>Local imaging centers</th>
<th>Other FQHCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Access for uninsured specialty care</td>
<td>Center for Child Counseling</td>
</tr>
<tr>
<td>Referred to credentialed providers in the community</td>
<td>Family First</td>
</tr>
<tr>
<td>Referred from insurance panels, word of mouth, outside agencies</td>
<td>Boys Town</td>
</tr>
<tr>
<td>Dept. Of Children and Families</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Do Outside Providers Travel to Your Site?**

<table>
<thead>
<tr>
<th>Mixed responses</th>
<th>Yes</th>
<th>No</th>
<th>No</th>
</tr>
</thead>
</table>

**Do Your Providers Travel to Outside Orgs?**

| No | No | Yes | One OB-Gyn |

**Number of Referrals /Month**

| 5,789 | 30-40 | 1,800 | 300 |

---

**Table 7 - Referral Patterns among Palm Beach County FQHCs Based on Survey Results**

3.1.5. **Administrative and Educational Events**

Other uses for the videoconferencing equipment are conducting peer to peer consultations; administrative and clinical meetings among team members who work at different sites; and educational in-services for medical residents and nursing students. This increases utilization of the investment and saves time and travel expenses, while improving operational efficiency. In our survey, we assessed the stakeholders’ current way of conducting administrative and clinical educational events. We wanted to learn if there was any experience with virtual meetings, web-based continuing education programs, video grand rounds, or group patient sessions being
conducted at sites with existing videoconferencing capabilities. Finally, we discovered if there were meetings and events that any of the stakeholders are travelling to now, but they don’t necessarily require in-person attendance. Table 8 summarizes the responses. Most of the FQHC stakeholders we surveyed have experience with videoconferences and webinars.

<table>
<thead>
<tr>
<th>Current Administration/Educational Events Via Videoconference</th>
<th>Site 1</th>
<th>Site 2</th>
<th>Site 3</th>
<th>Site 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Educational Events Requiring Time/Travel</strong></td>
<td>Yes- Admin. team Management and Clinical</td>
<td>No</td>
<td>Yes</td>
<td>Yes- Clinical team members attend webinars</td>
</tr>
<tr>
<td><strong>Interest in Accessing Off-Site Educational Events or Meetings Virtually</strong></td>
<td>Mixed interest- Clinical and Admin./Management are more interested than IT</td>
<td>Yes, and clinicians also attend webinars</td>
<td>Yes</td>
<td>Yes, they already participate with the Southeast FL AETC in Miami</td>
</tr>
<tr>
<td><strong>Current Events and Meetings That Don’t Require In-Person Attendance</strong></td>
<td>Yes</td>
<td>Yes- Clinical No- Admin. and Management</td>
<td>Yes</td>
<td>Yes, many staff meetings do not require in-person attendance</td>
</tr>
</tbody>
</table>

Table 8 - Current Administration/Educational Events via Videoconference among the FQHCs

3.2. Current and Desired State

Current State
We learned that a high demand for health care services exists at the FQHCs, secondary to the socioeconomic indicators in the county. This demand results in patients waiting to be seen. Limited hours and lack of transport make it challenging for patients to coordinate public transportation to and from their local clinic. None of the clinics are open 24 hours, but mainly Monday through Friday from 8am to 5pm. Some sites have extended hours a few days a week.

In Palm Beach County, patients in Belle Glade and Pahokee may have to travel long distances to access any specialty services, because these are rural locations and therefore specialty providers are scarce. Even patients in less rural locales, like Palm Springs and North Palm Beach need to travel almost two hours to Miami-Dade to obtain specialty services such as ophthalmology, cardiology, nephrology, podiatry and gastroenterology. This is because those providers will accept uninsured patients, compared to specialists in Palm Beach County. Most of these specialties are in demand for the communities served by the Palm Beach County FQHCs, as listed in the section ‘Types of Services Referred’ from Table 7.

The good news is that all of those specialties are amenable to being delivered via telemedicine. Figure 9 lists all the medical specialties in which telehealth programs are being successfully implemented across the healthcare continuum.
Desired State

Based on our assessments, we believe there is a great opportunity for the FQHCs to leverage their facilities to increase access to specialty care for their patients with telehealth programs. The referral patterns data in Table 7 proves a strong business case exists and may incentivize more local specialists to provide video consults. Practitioners at the originating site (where the patient is located) and distant sites (where the provider is located) would share the costs and benefits of telehealth network access, leading to economies of scale. These initiatives align with value based care models, and allow each site to realize more reimbursement for improved quality scores. If patients can report to their local clinic and be telepresented to the remote specialist by the physician, nurse practitioner, physician assistant, or nurse, patients would be able to avoid long wait times, and transportation challenges.

Developing a telehealth network of specialty physicians who are affordable to access via appointment with patients at the clinic would increase turnaround time for patient diagnosis and treatment. It would also allow the FQHCs to offer more comprehensive services and enable them to have access to a larger network of specialists, while reducing distance as a barrier. Enabling patients to receive specialty services remotely at their local clinic will create new revenue generating opportunities for FQHCs and specialists, while providing better service for patients who are reliant on the community health system for access to health care.

The Payer Mix assessment in Table 9 shows that the majority of patients served are self-pay or uninsured. In many cases, telehealth visits cost less than an in-person visit. If an FQHC is the originating site, Medicare will cover the costs. It’s feasible to develop a cost structure that
mirrors the existing sliding scale fees for self-pay patients. There are select private insurers in Florida that reimburse for telehealth visits too.

3.3. Gap Analysis
The difference between the current state and the desired future state is significant. The excerpt from Table 6 below outlines the gaps between needed and available health services.

<table>
<thead>
<tr>
<th>Site 1</th>
<th>Site 2</th>
<th>Site 3</th>
<th>Site 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatry is a gap.</td>
<td>Dentists are scarce</td>
<td>All specialties</td>
<td>Mental health has a gap.</td>
</tr>
<tr>
<td>Dental</td>
<td>Mental health</td>
<td>Priorities are mental health,</td>
<td>Resources for pediatric optometry</td>
</tr>
<tr>
<td>Belle Glade: Nephrology</td>
<td>Substance abuse</td>
<td>radiology, and lab</td>
<td></td>
</tr>
<tr>
<td>Urology, Orthopedics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lake Worth: Dietician</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Excerpts from surveys are included below:

“The gaps can be narrowed by authentically sharing resources. Often, the problem is the distance between providers that are willing to share, making it difficult for clients to go from one place to another.”

“Specialists in the area restrict the number of Medicaid recipients they see and are not willing to provide slide fee scale to our uninsured patients.”

“It is difficult to find/replace providers, [there are] language barriers [and] space constraints, and a large demand for services. In addition, [we have a] lack of access to specialty services, especially Psychiatry.”

“The result of a lack of specialty care for uninsured is resulting in repeated visits; there is an infinite need but finite resources”

3.4. Identified Challenges to Implementation of Telehealth

Lack of Personnel
Many organizations do not have adequate staff to designate to program planning and development, and hiring more people for the task is a constraint. IMST Telehealth Consulting is willing and able to work on behalf of Quantum Foundation to plan, develop, and implement the program.

Lack of Knowledge of the Telehealth Implementation Process
It is also necessary to educate the clinical, administrative, and IT teams on the nuances of virtual visits and the implementation process. We recommend the end users obtain Telehealth
Certification as Clinical Presenters, Coordinators, or Liaisons with the National School of Applied Telehealth, in alignment with their current role. Telehealth Coordinator students will learn how to modify workflows to allow for smooth integration into the daily operations. Workflow development processes include scheduling, obtaining consent, and sharing the right clinical information with the distant provider prior to the specialty consult. Telehealth Clinical Presenter students will learn equipment specifications, and best practices for telepresenting. They will also learn room design considerations, like wall color, lighting, and noise levels. The technology selection criteria to consider during the planning and development phase include bandwidth, image resolution, interoperability, and security encryption.

**Lack of Adequate IT Infrastructure**

The need for widespread increase in bandwidth to ensure network connectivity, especially in the rural areas, will need to be addressed during program planning and development. All of the FQHCs stated they are using electronic medical records, and there is wireless and hard-wired internet access at all sites. High bandwidth connections or broadband are best suited to the data and live motion images used by live interactive telehealth encounters. Recommended minimum speeds for telehealth applications range between 384 kilobits and 512 kilobits at lower speeds. In order to conduct optimal virtual visits without delays in communication, higher bandwidth requirements are needed.

Lack of technology standards that support interoperability of equipment is seen as a barrier. While communication networks can take live interactive video and store and forward images anywhere in the world; not all equipment and software can communicate between manufacturers and models. Solutions to these barriers must be developed and implemented so telehealth can become a more widely accepted tool used to address the rapidly changing healthcare ecosystem.

**Legal Constraints**

For FQHC’s the Federal Tort Claims Act dictates relationships allowed among FQHCs. There are ways to overcome this barrier, through legal contractual relationships that comply with the law.

Another important legal consideration is interstate licensure for telehealth providers. While telehealth reduces geographical and physical barriers, clinical licensure is still on a state to state basis. This means a provider needs to have a license in each state where they want to provide services. Regarding physician licensing, there is currently little opportunity to avoid obtaining multiple licenses.

**Lack of Full Stakeholder Support**

We covered this barrier during the Organizational Readiness Assessment section. Buy-in from all stakeholders at the administrative, clinical, and technological level is crucial before beginning any telehealth endeavor.
4. Market Analysis

Market analysis is very important to successful telehealth program development. It provides information that helps to define the telehealth program model; determines what customer needs will be fulfilled; and assesses the demand for the service. In addition, market analysis identifies how the program will provide value to customers; whether the program will be competitive in the marketplace; sheds light on what target messages engage key customers; and assures a sustainable delivery model. This section of the report analyzes customer needs; identifies and analyzes competing programs and determines service charges.

4.1. Customer Needs Analysis

Internal Customers
Feedback from clinic staff and administrators in six domains is included below.

**Value:**

**Clinical Staff:** Increased access to care; reduction in emergency room visits and hospitalizations; enabling better collaboration among the medical team; optimization of scarce clinical resources; and advance patient-centered care.

**Administrators:** Reach new markets; keep health care dollars inside the organization; save money on hospitalizations; avoid readmission penalties; optimal use of resources; and generate new sources of revenue and reimbursement.

**Community Outreach:** Marketing telehealth services to the community served will enhance quality of relationships, because patients will know the organization has taken advantage of technologies that address their most critical needs and barriers to health care access.

**Needs:**

**Clinical Staff:** Learn the intricacies of delivering telehealth services, from scheduling and obtaining consent, to operating the equipment and telepresenting the patient for the provider at the distant site. Include all key providers in the program planning and development from the very beginning to ensure all insights are considered and integrated into the program.

**Administrators:** They will need to conduct a cost/benefit analysis, and budget for initial program development and future expansion. Collaboration among clinical, admin., and IT stakeholders is a major key to program success. Also, RFP development, vendor demonstrations and professional technology selection provides guidance in purchasing decisions for a minimal viable pilot program. Then, plan to scale the program development incrementally. Billing managers need to learn the coding intricacies to ensure maximum reimbursement, and pricing models for self-pay patients need to be determined.

**Community Outreach:** Education and training to effectively communicate the benefits of telehealth to the patients and community partner organizations; to generate maximum demand for the services. At sites already conducting telehealth, internal stakeholders are seeking to expand their outreach to increase the benefits they can offer and realize more revenues.
Responsiveness to Needs:
Internal customers have expressed transportation and financial barriers prevent patients from showing up to specialty care appointments. Telemedicine allows patients to maintain their sites as their medical home, while receiving specialty services remotely and obtaining supplementary guidance and follow-up care there, too.

Needs to Operate the Program:
At all the organizations, Practice Managers will need to take a brief Telehealth Coordinator course; clinicians will need to take a brief Telehealth Clinical Presenter Course. Community Outreach team members will need to take a Certified Telehealth Liaison course. The administration and IT team will need to work together to procure and install the solutions in the clinical facilities. Today, many live-video solutions are turn-key, and can be accessed with existing computer equipment, for minimal cash outlays. Usually, it’s just a monthly fee for the service and a fee per visit passed to the patient or the insurer.

Support for Program:
There is unanimous agreement within most sites that a need for a telehealth program exists due to patient barriers to access and lengthy wait times for specialty services. Early successes at a few sites have confirmed positive outcomes, but there is a great need to expand access and increase revenue streams.

Concerns and How to Mitigate Them:
At some sites, concerns exist due to limited knowledge and questions about reimbursement. Education, proven profitability, and demonstrations of lessons learned would be effective ways to overcome these uncertainties.

External Customers
Value:
Implementing telehealth reduces barriers to access, which can lead to improved health outcomes, and lower overall costs for health services.

External Customer Expectations:
Reduced wait times for mental health and other specialty services, improved health outcomes, lower overall costs for care, and reduced hospital admissions.

Needs:
Patients: Psychiatry patients have special needs and they need clinicians to facilitate that visit with a mental health professional that understands their unique needs and will provide a nurturing, private, environment of care. Many patients also need reduced transportation barriers and shorter wait times to be seen. This is especially important for medication management. Psychiatric medication therapies must be meticulously maintained in order for patients to maintain optimal mental health. Any lag in medication refills can produce adverse results in their
treatment. Access to the technology needed to participate in telehealth, training for the technology to be used and reassurance of patient privacy are also important.

**Sponsors/Supporters:** They need to ensure adequate time and resources are allocated to the program’s development. They need to be involved in facilitating cooperation among administration, clinical, and technology stakeholders and to stay informed of project planning, development, and implementation. In addition, they should remain informed on utilization, performance, and outcomes of the program for successful expansion and to gain support from partner organizations.

**Payers/Insurers:** Medicare pays for some telehealth services, especially in remote rural areas, but has several restrictions. Medicare needs evidence of the patient being in an eligible location, facility, and is being seen by an eligible provider. In addition, they require an eligible CPT billing code. Medicaid is the most common route states are taking is to cover telehealth services. They have almost the exact same requirements as Medicare, but are less stringent on rural location requirements. Like Medicaid, regulations for telehealth reimbursement by private payers are set by the state. Patients are also able to pay out-of-pocket for telepsychiatry visits. The costs may be able to match current sliding scale fees pending a detailed cost/benefit analysis.

**Governing/Oversight Agencies:** The Agency for HealthCare Administration’s (AHCA) Telehealth Advisory Council is currently conducting a statewide study to promote telehealth parity laws at the Florida legislative branch level. AHCA recognizes that telehealth reduces barriers to health care access and is an advocate for statewide adoption and reimbursement. The Florida Department of Health (FL-DOH) oversees licensing and practice eligibility of health professionals. The FL-DOH has designated prescribing laws via telehealth encounters. The only exception to prescribing controlled substances virtually is for psychiatric medications, otherwise it is not allowed. The FL-DOH also ensures appropriately licensed practitioners are working within their scope of practice.

**Psychiatry/LCSW/Specialist Network:** Patient consent, adequate patient history prior to visit, and patient accountability to attend their appointments. They also need compensation contracts, which may be established through a third-party or directly with the practitioner.

**IT Directors:** Active involvement in program planning, development and implementation. They need access to the technologies for troubleshooting, unless that service is provided by the chosen service vendor. Learn about and employ optimal connectivity and image quality to maximize patient/provider engagement, both at the originating and distant sites. Security of the connection is also a critical factor, as well as learning and implementing room requirements for maximum quality and outcomes.

**Responsiveness to Needs:**
Overall, the institution to institution model of delivering telemental health care is responsive to external stakeholder needs. Implementing telehealth reduces barriers to access, which can lead to improved health outcomes, and lower overall costs for health services. As long as stakeholders are willing to work together to learn, plan, develop, and implement the program using best practices and an incremental approach, the outcomes are expected to be highly successful.

**External Partner Opportunities:**

**Two sites** have expanded outreach to rural areas, but there are market opportunities for expansion to schools, homeless shelters, and prison inmates. **One site** has many partners in the community, including schools and homeless resource centers. Community outreach activities at all the organizations will identify them, and existing stakeholders can facilitate new partnerships.

### 4.4. Service Charges

In the Executive Summary of this report, we said there is effective demand for telehealth services among the FQHCs. We estimated the total number of monthly referrals from all the FQHCs to a wide range of specialists was 7,929. The excerpt from our Referral Patterns Assessment (Table 7, below) shows the number of estimated monthly off-site referrals per organization.

<table>
<thead>
<tr>
<th></th>
<th>Site 1</th>
<th>Site 2</th>
<th>Site 3</th>
<th>Site 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5,789</td>
<td>30-40</td>
<td>1,800</td>
<td>300</td>
</tr>
</tbody>
</table>

Given the number of referrals at each organization, there is an opportunity to significantly increase monthly and annual revenues.

### 5. Successful Models

Other states have developed successful telehealth programs for FQHCs, including Georgia, Mississippi and Arizona. A network of physicians for each organization to share access and connectivity costs, resulted in optimal revenues for the clinics, increased access to care for the critical populations, and reduced costs for the patients and organizations.

The American Telemedicine Association and Healthcare Information Management Systems Society telemedicine established critical success factors to abide by when implementing health technologies, based on Lessons learned from failed program development efforts.

<p>| Critical Success Factors |</p>
<table>
<thead>
<tr>
<th>Ensure Leadership Engagement</th>
<th>Educate Patients &amp; Community (External Marketing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish Governance</td>
<td>Assign Implementation Team</td>
</tr>
</tbody>
</table>
| Identify Program Champions   | Develop Detailed Project Plan Based On Phased Approach  
|                              | – Standardize Implementation And Support Processes  
|                              | – Integrate Telehealth Services Into Standard Of Care Workflow  
|                              | – Provide Effective Training                   |
| Build Consensus (Internal Marketing) | Monitor, Measure, And Communicate Success       |