



MOVING TELEHEALTH FORWARD

The High Costs of Paying Later

AUGUST 2015



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Dear Fellow Taxpayers,

Telehealth continues to grow across the country, as more states adopt laws and policies to encourage its usage, and organizations such as the Federal Communications Commission explore its potential for business and health care. Telehealth has been shown to be clinically effective, and providers in Florida and nationally have demonstrated significant cost-savings and revenue generation.

While California, Texas, and New York have telehealth-friendly statutes and regulations, Florida does not. This Florida TaxWatch research report shows how Florida compares to other key states in Medicaid spending, hospital charges, and telehealth policy. It discusses telehealth reimbursement trends and misconceptions nationally, and how Florida can begin to move past barriers to telehealth payment.

During the 2015 Legislative Session, health care policy discussions significantly influenced the path of legislative decision-making and impacted all areas of the state budget. One of the best ways for Florida to impact health care spending and improve health outcomes is to expand the use of telehealth statewide. By incentivizing telehealth, Florida stands to realize significant cost-savings that can be reinvested into the state budget. Taxpayers save money when needed health services are provided in a timely fashion and reduce the later need for higher cost services.

In a health care environment where federal changes create uncertain funding streams, telehealth provides a way for states to increase self-sufficiency, contain costs, and improve access. As Florida's Medicaid enrollment and spending grows, and an aging population increasingly needs to access quality health care, the development of a statewide telehealth infrastructure is a critical step toward the physical and economic health of our state. It is our hope that this report will further telehealth policy development for the benefit of all Floridians, our visitors, businesses, and taxpayers.

Sincerely,

A handwritten signature in black ink that reads "Dominic M. Calabro".

Dominic M. Calabro
President & CEO

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Executive Summary

Among the four most populous U.S. states, Florida is the only one that does not legislatively mandate either private payer or Medicaid reimbursement for telehealth services. While Florida currently has no telehealth mandates, Florida Medicaid does reimburse physicians for certain telemedicine services, and an unspecified number of providers have successfully negotiated private payer reimbursement arrangements. Private payer coverage mandates in California, Texas, and New York, and Medicaid mandates in California and New York (Texas has proposed legislation) vary as to policy, but demonstrate a consistent movement toward the use of telehealth for a broad range of health services. In addition, these states specifically address selected areas of need such as school health, individuals with developmental disabilities, mental health, diabetes, and asthma. Florida's total hospital stays and total aggregate charges exceed those of Texas and New York, and Florida's rapidly increasing 65 and older population, projected to reach nearly 25% of the population by 2030, suggests the need for quick action to reduce hospitalizations, a goal that earlier and appropriate telehealth services could further.

In the 2015 Florida Legislative Session, the legislature avoided controversial telehealth coverage mandates and consensus-breaking details of more than 40 potential policy issues. Instead, both the Florida House of Representatives and the Florida Senate focused on a set of narrow telehealth policy issues that nearly led to consensus and bill passage. Areas of consensus or near-consensus included definitions of telehealth, a broad list of eligible telehealth providers, standards of care, recordkeeping, and most aspects of prescription drugs. Slight differences in bill language across patient location, the exclusion of consultations, prescription drugs, and eye care, in addition to exclusion of telehealth products from discount medical plans, may be issues for revisiting in 2016.

While the clinical effectiveness of telehealth has been reported in many peer-reviewed studies, conclusively demonstrating the cost-effectiveness and cost-savings of telehealth in larger studies has remained challenging due to inconsistencies in data and economic evaluation methodology. To project potential cost-savings, categorical and total Medicaid spending can be reviewed as an example. While Florida spends the least of the four most populous states on Medicaid, a one percent cost-savings in Medicaid alone would still yield more than \$200 million for Florida. In addition, if telehealth could reduce the need for hospitalizations alone by one percent in Florida, \$1.2 billion in charges could be saved. Individual providers and health systems reports suggest that a one percent telehealth cost-savings impact is both realistic and conservative, and Florida could realize even greater cost-savings if telehealth is adopted statewide.

Telehealth reimbursement struggles with many barriers, the first of which is lack of telehealth provider knowledge regarding billing and payment options. Florida providers need telehealth education, as some remain under the incorrect impression that Florida Medicaid provides no telehealth reimbursement. Across six clinical delivery models and nine business models for telehealth, standards of care and fraud and abuse concerns need to be addressed to provide assurances of comparative value for payers and quality of patient care for state actors. With a growing number of telehealth companies, certain companies have found ways to provide such assurances.

Surveys suggest that successfully engaging notable insurance thought leaders in key discussions may encourage additional private payers to follow suit with telehealth coverage. In addition, creative options such a statewide network for telehealth services, or market offerings/independent collaborations akin to a group purchasing organization for telehealth may create opportunities for provider entry and reimbursement. Several opportunities for statewide discussion of telehealth are available heading into the 2016 Florida Legislative Session, including a September TaxWatch Telehealth Conference focused on policy and taxpayer savings.

Telehealth legislation in the 2016 Florida Legislative Session should seek, at minimum, to promote the continuation of good current telehealth practices across a full range of healthcare providers, set standards of care and recordkeeping, and empower respective practice boards. Additional financial incentives and expanded availability for telehealth provision, especially in high-need, high-cost populations such as the aging and individuals with disabilities should be explored. Continued discussion of telehealth policy issues across all industries and stakeholders is encouraged and necessary as practices and needs evolve.

Florida excels at disaster preparation, having an established statewide emergency operations infrastructure that has successfully weathered hurricanes, flooding, and other unpredictable events. Before the silver tsunami strikes, and there is a state of emergency, Florida can prepare for a health care crisis by having in place an established telehealth infrastructure. In the midst of federal changes across the Affordable Care Act and Medicaid expansion, and with the stressful uncertainties of federal funding sources, such as Low Income Pool (LIP) funding, the state of Florida can act to increase financial self-sufficiency and timely access to health care through telehealth. Even by conservative estimates, telehealth can provide significant cost-savings to the state and payers that can be redirected into the state budget.

For every year that telehealth policy is not implemented and telehealth use is not expanded, significant cost-savings and patient health opportunities are lost, and Florida falls further behind other states in health policy while its health care needs continue to grow. Time wasted is money lost and, for Florida, the cost of waiting to act on telehealth is too high to ignore.

Introduction

This TaxWatch report, *Moving Telehealth Forward: The High Costs of Paying Later*, takes Florida's telehealth discussion to a new level of detail and insight. Having examined the basic practice and benefits of telehealth in previous reports, TaxWatch now takes an in-depth look at:

- o how Florida compares to other large states in hospital charges and Medicaid spending;
- o the cost-savings being lost to Florida each year that telehealth is not adopted statewide;
- o barriers to reimbursement and incentivization of telehealth;
- o Florida telehealth provider needs in education and collaboration; and
- o how telehealth can decrease reliance on federal funding while increasing the state's self-sufficiency in addressing Florida's health needs.

Previously, in the March 2014 report, *Critical Connections to Care*, Florida TaxWatch explored the critical and growing need for telehealth to meet the health needs of Florida's growing and diverse population. As an introduction to telehealth, *Critical Connections* discussed telehealth uses, Florida's experience with telehealth, high-level reimbursement, economic benefits, and a variety of challenging telehealth issues requiring discussion to move policy forward. More than \$1 billion savings in annual Florida health charges were estimated if telehealth were to be adopted statewide.

In the November 2014 report, *Time for Telehealth*, Florida TaxWatch examined how Florida compared to key states in telehealth policy adoption, discussed telehealth case studies evidencing a high return-on-investment, and studied policy decision points under consideration by the Florida legislature. Statewide adoption of telehealth provides opportunities for Florida to become more competitive in business and health care. In furtherance of the telehealth discussion, Florida TaxWatch hosted the inaugural Telehealth Cornerstone Conference in November 2014 and will be hosting the 2015 Telehealth Cornerstone Conference in September.

Telehealth benefits businesses, providers, and patients regardless of age or location. If adopted on a state level, the state budget would also benefit. Telehealth policy transcends political party lines and offers a healthcare and economic win across stakeholders. Each year that telehealth-friendly policy is not adopted statewide, Florida loses out on significant cost-savings and timely access to patient care. Given Florida's rising healthcare costs and increasing health needs, the state cannot afford to wait. Pay now and invest in a statewide telehealth infrastructure that could save billions of taxpayer dollars and lead to a healthier Florida, or pay significantly more later, without the benefits of cost-savings and improved health.

Background

Despite demonstrably significant cost-savings and increased access to care, and in the midst of unresolved crises surrounding state Medicaid expansion, LIP funding, population increase, and aging, Florida again failed to move a win-win telehealth solution forward beyond legislative and stakeholder discussion in the 2015 Legislative Session, and the price tag for inaction comes at a high cost to all Floridians.

Without a statutory foundation for health care delivery via telehealth in Florida, the state stands to fall further behind other states in the health status of its citizens and health care spending. Through 2013, geographic and status disparities in health as analyzed by America's Health Rankings placed Florida in the bottom quintile of all states for those metrics, with Florida ranked 48th out of 50 states in geographic disparity across its 67 counties.¹ Issues of access are particularly salient and will worsen quickly now that Florida has surpassed New York as the third most populous state during 2015.² In addition, individuals over the age of 65 will account for nearly 25 percent of Florida's population by 2030, up from 17 percent currently.³ This will present additional access-to-care challenges given complications of aging, such as reduced mobility. With the baby-boomer generation advancing in age, and the prevalence of dementia and other disabling conditions increasing, the need for long-term, sustainable solutions in health and aging has grown. The state must find ways to reduce the high costs of health care through increased use of evidence-based practices such as telehealth, which will improve access for individuals who live in rural or low-access areas, who are non-ambulatory and transportation-challenged, and who are likely to utilize costly services due to chronic disease. In addition, telehealth will improve access to needed specialty care, even in urban areas.

As demographic and health condition changes increasingly threaten to impact Florida's economy and taxpayers, it will be critical to assess need and to create health and aging policies that address service gaps, encourage cost-savings, and maximize return on investment to Florida's taxpayers. Telehealth is such a policy, and additional provider data and research are needed to assist policymakers in evaluating telehealth for Florida.

To that end, Florida TaxWatch recommended expanding the use of telehealth in Florida by creating a legislative framework in its March 2014 report, *Critical Connections to Care*,⁴ and advancing public policy to remain nationally competitive in its November 2014 report, *Time for Telehealth*.⁵ In addition, Florida TaxWatch hosted the inaugural Telehealth Cornerstone Conference in November 2014 and will be hosting the 2015 Telehealth Cornerstone Conference in September.⁶

In the widely-publicized research report *Critical Connections to Care*, Florida TaxWatch estimated that even a one percent reduction in hospital charges alone – not inclusive of emergency room care – could save the state of Florida more than \$1 billion annually through the avoidance of hospitalization resulting from increased access to timely and appropriate health care through telehealth. Other states have already acknowledged the benefits of telehealth, with Washington D.C. and 29 states legislatively mandating private coverage of telehealth, and several other states proposing legislation for private coverage.⁷ In addition, Washington D.C. and 13 states have mandated Medicaid coverage of telehealth.⁸

In the follow-up report *Time for Telehealth*, Florida TaxWatch explored how the state of Florida compared to other states with regard to telehealth policy advancement. The Sunshine State prides itself on being an ideal location to live, work, and play. While Florida remains competitive across areas such as economic development, business opportunities, and cutting-edge research, and arguably leads the nation in tourism, Florida lags behind a majority of states when it comes to addressing the health access needs of its large, rapidly growing, diversely-aged population through the adoption of telehealth-friendly legislation and policy. Projected health work force needs further support the need for long-term health planning solutions to ensure a healthy Florida going forward. Given the multitude of policy decision-making points for telehealth previously under consideration by the Florida Legislature, achieving consensus is highly challenging.⁹ Furthermore, despite stakeholder support and a favorable legislative climate with policymaking champions of telehealth, such a substantive solution can easily drown in a sea of federal health dollar debates and confusion.¹⁰

In the midst of health financing uncertainties, research suggests that telehealth could play a major role in sustainable health care delivery. However, the time to act is now. In the time that Florida considered telehealth legislation this past session, other states were continuing to advance policy, putting Florida even further behind in comparison. For example, in September 2014,¹¹ the American Telemedicine Association reported 28 states and Washington D.C. as receiving higher composite scores than Florida in coverage and reimbursement for telehealth. In its updated report released May 4, 2015,¹² that number has increased to 35 states and Washington D.C. receiving higher composite scores than Florida in coverage and reimbursement for telehealth.

SECTION 1

Comparing Key States: Telehealth Policy & Hospital Charges

As previously noted, Florida recently surpassed New York as the nation's third most populous state. How does Florida currently compare with the other large states in terms of telehealth policy? Specifically, how does Florida compare to California, Texas, and New York?

California¹³

California, the nation's largest state,¹⁴ also has the nation's greatest number of individuals over age 65,¹⁵ and has legislatively mandated parity for both private coverage and Medicaid coverage of telehealth. California distinguishes between telehealth and telemedicine. California's Medicaid program, Medi-Cal, reimburses for live video, but not telephone, e-mail, or facsimile. In addition, Medi-Cal reimburses for store-and-forward services for teledentistry, teledermatology, and teleophthamology. Patient consent is required for telehealth services. There is no limitation of service location, and both originating and distant sites receive some level of reimbursement. Additional telehealth coverage is available for certain state-approved services for children and individuals with developmental disabilities. Health plans cannot restrict location of service for telehealth or require in-person contact for payment beyond general contractual terms. Prior exam is required for online prescription of "dangerous" drugs. Furthermore, the California Board of Occupational Therapy has adopted standards of practice for telehealth.

Texas¹⁶

Texas, the nation's second largest state,¹⁷ has mandated private coverage parity for telemedicine, and has proposed legislation on Medicaid coverage.¹⁸ In 2015, a law was enacted to permit Medicaid coverage of school-based telehealth. Texas Medicaid reimburses live video for services that include consultation, outpatient services, medication management, and psychotherapy. Eligible providers include certain licensed professions for telemedicine, and certain other licensed telehealth providers such as dieticians and social workers. For both telehealth and telemedicine, a telepresenter is required to be with the patient. Texas Medicaid does not reimburse for email, telephone, facsimile, or chart review. Permissible originating sites, which are reimbursed facility fees, include mental health facilities, "established" medical locations, and state-supported living centers. Provider reimbursement is equivalent to face-to-face. In most situations, a previous in-person exam is required within the previous year before receiving telehealth services. Under certain conditions and patient criteria, home telemonitoring is covered. Private payers must cover telemedicine services, in accordance with their contractual terms. Telemedicine licenses may be issued for out-of-state providers. The Texas Children's Health Insurance Program permits reimbursement for live video telehealth services for children with special health needs. Patient consent is required for telehealth services. Furthermore, the Texas Medical Board and the Texas Board of Speech Pathology and Audiology have passed telehealth regulations.

New York¹⁹

New York, now the nation's fourth largest state,²⁰ has enacted laws effective in 2016 for both private payer and Medicaid coverage parity of telemedicine.²¹ As of February 2015, New York was updating Medicaid reimbursement policies for telehealth to expand permissible settings and provider types. While Medicaid managed care is still optional, major insurance providers have explicit policy statements for coverage of "telemedicine" including, among others, Amerigroup New York, BlueCross Blue Shield of Western New York, United Healthcare, and WellCare of New York. New York distinguishes between telehealth and telemedicine, allowing for differences in permissible forms of telecommunication (e.g., telephone as part of telehealth but not telemedicine). New York Medicaid reimburses for medically necessary services delivered via live video for patients located in specified settings such as hospitals, certain federally-qualified health centers (FQHCs), and school-based health centers. In addition, only certain Medicaid providers are currently covered for telehealth services including physician specialists, psychiatrists, certified diabetes and asthma educators. New York Medicaid does not reimburse store-and-forward and telephone transmissions. Responsibility for ensuring practitioner credentialing lies with originating sites such as hospitals. A new private pay mandate requires insurance plans to cover *telemedicine* if requested by the policy holder, with certain requirements (e.g., must be live video) and limitations. Coverage of *telehealth* services is optional.

Florida Revisited²²

Florida does not mandate either private payer or Medicaid reimbursement parity for telehealth. However, Florida Medicaid does reimburse physicians for certain telemedicine services in specified patient settings.²³ At the present time, it is used primarily for the provision of behavioral health services, rather than hospital diversion. Florida Medicaid recipients are usually enrolled in one or both of the State Medicaid Managed Care program: Managed Medical Assistance²⁴ (MMA) and Long-Term Care²⁵ (LTC), with a small number of recipients still in fee-for-service. Reimbursement for approved telemedicine is as if it were face-to-face, but fee schedules, which are negotiated with providers, may alter reimbursement amounts. Telemedicine markers were specifically build into recent Medicaid managed care contract rollouts targeting rural areas. Reimbursement is not restricted in terms of geographic area. For example, telemedicine is not limited to health professional shortage areas (HPSAs).

All this has led to a misconception by some providers that Florida Medicaid does not reimburse for telehealth. More than 3.8 million Floridians are eligible for Medicaid coverage each month,²⁶ and this number continues to increase with Florida's changing demographics. Across Florida's 67 counties, approximately 30 counties are considered to be rural with less than 100 people per square mile,²⁷ and are particularly targeted for telehealth services.

Florida's Changes Require Quick Action: State Hospital Charges Compared

Despite having the third highest number of hospital stays among these states, Florida has the second highest average and aggregate charges.

State Comparison of In-Patient Hospital Charges ²⁸				
	CA (2012) ²⁹	TX (2011) ³⁰	FL (2012) ³¹	NY (2011) ³²
Total Hospital Stays	3,794,261	2,937,579	2,659,767	2,583,090
Average/Mean Charges Per Stay	\$57,871	\$38,330	\$47,182	\$42,023
Total Aggregate Charges	\$219.6 B	\$112.6 B	\$121.2 B ³³	\$108.5 B

Notably, of these four states with significant hospitalizations and aggregate charges, Florida's need for cost-containment and cost-reduction options is particularly pressing in light of patient mix composition and changing demographics. According to the Florida Agency for Health Care Administration:

Patient discharges from Florida hospitals have increased from about 1.9 million in 1995 to almost 2.7 million in 2013. This reflects an increase of approximately 40.7%. The largest number of discharges continues to be among those 60 years and older, at 46.1% of the total discharges.³⁴

Florida's Changing Population & Demographics ³⁵		
	Total Florida Population	65 and up
2000 Census (Percent of Total Population)	15,982,824 (100%)	2,807,650 (17.6%)
2010 Census (Percent of Total Population)	18,801,310 (100%)	3,259,602 (17.3%)
2020 (Projected) (Percent of Total Population)	21,236,667 (100%)	4,465,169 (21.0%)
2030 (Projected) (Percent of Total Population)	23,872,566 (100%)	5,939,493 (24.9%)
2000-2010 (Numeric & Percentage Change)	2,818,486 (17.6%)	451,952 (16.1%)
2010-2020 (Numeric & Percentage Change)	2,435,357 (13.0%)	1,205,567 (37.0%)
2020-2030 (Numeric & Percentage Change)	2,635,899 (12.4%)	1,474,324 (33.0%)

The 46.1% increase in hospitalizations of Florida patients ages 60 years and older from 1995 to 2013, in the absence of a significant demographic shift increasing the aged populations (holding around 17% of the total population for both 2000 and 2010 Census counts), is particularly concerning. With the population of ages 65 and older expected to comprise nearly 25% of Florida's population by 2030, the corresponding increase in hospitalizations and associated costs across federal, state, and private payers is staggering.

To potentially reduce the need for hospitalizations, and for increased access to routine and non-emergent care, individuals ages 65 and older will need options beyond face-to-face visits due to transportation challenges and difficulty in ambulation. As a recent (2011) study published in the journal of the American Academy of Family Physicians reports:

At least 30 percent of persons 65 and older report difficulty walking three city blocks or climbing one flight of stairs, and approximately 20 percent require the use of a mobility aid to ambulate. In a sample of noninstitutionalized older adults, 35 percent were found to have an abnormal gait. The prevalence of abnormal gait increases with age and is higher in persons in the acute hospital setting and in those living in long-term care facilities. In one study, gait disorders were detected in approximately 25 percent of persons 70 to 74 years of age, and nearly 60 percent of those 80 to 84 years of age.

SECTION II

Telehealth in the 2015 Florida Legislative Session

Prior to legislative impasse primarily centered on issues that included Medicaid expansion and Low Income Pool (LIP) funding, Florida telehealth legislation stood a significant chance of finally being enacted into law during the 2015 Legislative Session. Historically, after several years of attempted legislation, the business and health industries pushed telehealth as a top priority issue heading into the 2014 Legislative Session, when four telemedicine bills were introduced: SB 70, HB 167, HB 751, and SB 1646. Although the issue ultimately failed to pass as part of a surviving omnibus health bill package, PCS for CS/HB 7113, it was championed heavily prior to the start of the 2015 Legislative Session. The bills introduced this session show a movement toward Senate and House consensus for a foundational telehealth law.

Following months of legislator and stakeholder discussions and media push in favor of telehealth legislation, the 2015 Legislative Session saw two telehealth bills actively move through committees of reference: CS/HB 545 and CS/SB 478. Unlike previous session bills, which contemplated a broad spectrum of issues that included reimbursement, mandates, and licensure, the 2015 bills were narrowly crafted to provide a foundational basis for telehealth. CS/HB 545 was not heard in its last committee of reference prior to cessation of House committee meetings, and no additional movement occurred after mid-March. CS/SB 478, while making it to the Senate Appropriations Committee, its last committee of reference, remained unheard and was not revived in the tumultuous last week of the 2015 Legislative Session. Below is a brief summary of where the final bill versions are the same and where they differ.

CS/HB 545³⁶ & CS/SB 478³⁷:

Highlights of Where Final Bill Versions Were the Same

Florida legislators agreed on several telehealth policy points:

- The definition of “Telehealth” – Telehealth excludes audio-only, e-mail, and fax, but specifically includes public health and health care administration.
- Who can be “telehealth providers” – The following healthcare provider statutory chapters are specifically included as telehealth providers: acupuncture, allopathic and osteopathic medicine, chiropractic medicine, podiatric medicine, optometry, nursing, dentistry, midwifery, speech-language pathology and audiology, occupational therapy, radiology personnel, respiratory therapy, diet and nutrition, athletic trainers, orthotics/prosthetics, electrolysis, massage, clinical laboratory personnel, medical physicists, optical devices/hearing aids, physical therapy, psychology, clinical counseling and psychotherapy, and medical transportation services (emergency medical technicians and paramedics).
Note: The Senate version is more expansive and includes certified behavior analysts.
- Standard of care & recordkeeping – The standard of care and recordkeeping requirements for telehealth are the same as in-person care. A telehealth patient evaluation is deemed sufficient to diagnose and treat without an in-person exam or research of the patient’s medical history. *Note:* Bills differ in the arbiter of sufficiency, provider or standard of care.

- Unlicensed practice of medicine safeguards – A non-physician telehealth provider acting within his own scope of practice is not practicing medicine. *Note:* Bills vary in whether there is a cross-reference to respective practice acts.
- Prescription drugs³⁸ – At minimum, under both House and Senate bills, authorized prescribers can prescribe Schedules II-V and neither bill allows the prescribing of chronic non-malignant pain medication barring certain exceptions. Both bill versions provide an exception for a physician treating a hospital inpatient. *Note:* The Senate version is more expansive as it also provides an exception for advanced registered nurse practitioners and the treatment of hospice patients.
- Discount medical plans – Telehealth products are excluded from the definition of “discount medical plan” under Section 636.202, Florida Statutes.

CS/HB 545 & PCS to CS/SB 478: Highlights of Where Final Bill Versions Differed

Final Version of CS/HB 545	Final Version (PCS) of CS/SB 478
Creates 456.47	Creates 456.4501
Provider and patient may be “in any location”	Provider and patient may be “in separate locations”
Excludes all consultations	Excludes consultations between FL telehealth provider and licensed out-of-state providers when the FL provider maintains responsibility
Standard of care determines evaluation sufficiency	Provider determines evaluation sufficiency
Authorized prescribers can prescribe Schedules II-V; no chronic non-malignant pain except if hospital	Authorized prescribers can prescribe Schedules I-V; no chronic non-malignant pain except if physician or ARNP prescribing for hospital in-patient or hospice
No eye-specific prohibition.	Eye-specific prohibition: Cannot tele-prescribe optical devices (e.g., contacts, glasses) based only on refractive error shown by computer-controlled device

Legislative Trends toward Consensus & Areas for Further Discussion³⁹

The legislature reached near-consensus on the list of professionals included in the definition of “telehealth providers.” The inclusive list of telehealth providers was supportive of a full range of diverse patient access needs. Notably, the inclusion of medical transportation services (emergency medical technicians and paramedics) is important for timely emergency care. Also, the addition of certified behavior analysts in the final Senate bill version would allow needed supports and increased early intervention access for individuals with developmental disabilities and their families.

Consensus was achieved in setting the standard of care and recordkeeping requirements for telehealth to be the same as in-person care. These provisions were critical for both clinician clarity and patient safety. Allowing each respective telehealth provider board to govern and oversee its respective standard of care through rulemaking authority, as the expert in that area of health care, ensures that providers are held appropriately accountable for practice to the level of their skill and training within their own professions. It also allows best practices and innovation to evolve without constantly amending statute. Furthermore, clarifying that a non-physician

telehealth provider acting within her own scope of practice is not practicing medicine, with references to respective practice acts, provides additional public and clinician reassurances.

In the area of prescription drugs, the Senate bill was more permissive than the House bill. It allowed authorized prescribers to prescribe Schedules I-V medications via telehealth, rather than only Schedules II-V, allowed physician prescription of chronic non-malignant pain medication in the limited circumstances of both hospital in-patients and hospice patients, and allowed the same limited non-malignant pain prescription by advanced registered nurse practitioners. The more permissive position would allow greater access while still alleviating prescription drug abuse fears for patients in controlled acute and end-of-life settings. To reach consensus, the Legislature will need to carefully revisit permissions for advanced registered nurse practitioners for telehealth prescribing without unnecessarily conflating telehealth with scope of practice in discussions.

A new issue this legislative session was the exclusion of telehealth products from the definition of discount medical plans. This may be an issue that the Legislature may choose to revisit for potential unintended consequences. For example, many small businesses and those without insurance may seek discount medical plan options that offer limited providers who optionally participate. In addition, individuals with insurance sometimes use discount medical plans on items outside of traditional insurance coverage (e.g., dental, vision). Excluding telehealth products from discount medical plans may work against one of the main benefits of telehealth: access. Furthermore, upon initial review, such an exclusion would not appear to increase provider pay or allay any existing concerns of sham discount medical plans and, therefore, at such an early telehealth policy stage, may not be worthwhile.

Areas of non-consensus involving subtle bill language differences will need to be revisited going forward. This includes whether the sufficiency of a telehealth patient evaluation toward diagnosis and treatment is determined by the respective practice board's "standard of care" or by the provider's discretion. A "standard of care" benchmark would allow the standardization of expectations and quality. It would always remain within the provider's judgement to ascertain whether he is meeting the requirements of his respective area of practice. Such a position would also allow evolution of best practices, and certain practice areas may require more stringency. Other language considerations include whether the patient and provider can be "in any location," whether the definition of telehealth excludes "all consultations" or just those between Florida telehealth providers and licensed out-of-state providers when the Florida provider maintains responsibility. As Florida has a vested interest in protecting the health and safety of its residents and also regulating the quality of its licensed providers, these language differences should be examined for potential unexpected consequences including those altering current good telehealth practice. Finally, over multiple legislative sessions the Florida Senate has included eye-specific telehealth restrictions that the Florida House has not adopted in its bill versions.

SECTION III

The Loss of Potential Cost-Savings

Cost-Effectiveness & Cost-Savings: Challenges in Measuring Telehealth Success

The clinical effectiveness of telehealth has been evidenced across a broad spectrum of medical and health-related services and reported favorably in peer-reviewed literature.⁴⁰ In contrast, when it comes to evidencing cost-effectiveness in telehealth, researchers have come up against small sample sizes, research design and economic evaluation methodology challenges, lack of reliable or consistent data, short time-frame of data availability, and changes in technology.⁴¹ Many studies, even when some cost-effectiveness is demonstrated, remain inconclusive with study results that cannot be generalized.⁴² For example, in 2013, a United Kingdom-based research team conducted a critical appraisal study to examine published systematic reviews of the cost-effectiveness of general telehealth, not within specific health areas.⁴³ In studying the nine systematic reviews meeting the study's inclusion criteria out of more than 4,000 systematic reviews, the researchers concluded that additional assessment was needed to determine cost-effectiveness. Most studies did not comply with standard economic evaluation principles, data was inconsistent, varied with local nuances and research design, and were not generalizable.

In addition, economic evaluation methodology varied greatly across studies, and included cost-benefit analysis (CBA), cost-consequences analysis (CCA), cost-effectiveness analysis (CEA), cost minimization analysis (CMA), and cost-utility analysis (CUA).⁴⁴ Overall, telehealth research is a slowly-evolving arena in which, metaphorically, apples are compared to oranges and bananas, and it is difficult to ascertain which of apple slices, orange juice, or banana splits were the best result and worth the initial trip to the store. Where one person would select one outcome over another based on individualized goals, another might look at the whole and see any productive outcome to be beneficial and worthwhile. So it is with telehealth. While one telehealth provider may find the benefit of reduced emergency room usage, another reduced length of stay, and yet another compliance with chronic disease management medication, it is not a jump for policymakers to look at the now widespread practice - yet pocketed successes - of telehealth within Florida as a whole, and find any and all positive outcomes to beneficially advance a more sustainable health care system. Without clear comparative data and universal metrics, the determination of cost-effectiveness may be limited to specific examples, of which there are an increasing abundance across all areas of telehealth.⁴⁵

Medicaid Spending: Benchmarking & Forecasting

Similarly, examples of potential cost-savings may be viewed in limited pockets or extrapolated from available data. As billing and coding data vary across states and payers, looking at standardized, state-reported Medicaid expenditure data may provide a more "apples-to-apples" view of costs and, therefore, potential cost-savings.

At least 43 states, including Florida, provide some form of Medicaid reimbursement for telehealth regardless of the presence or absence of a mandate.⁴⁶ Nationally, Medicaid expenditures are projected to grow. A 2013 Medicaid actuarial report by the Centers for Medicare & Medicaid Services⁴⁷ projected an annual increase of

7.1 percent in Medicaid expenses and an annual increase of 3.3 percent in Medicaid enrollment, reaching \$853.6 billion and 80.9 million enrollees by 2022 (factoring in anticipated increases from Medicaid eligibility expansion under the Affordable Care Act). However, prior to expansion, the report noted a 5.9 percent increase in expenditures from 2012 to 2013, with “states taking fewer actions to reduce the rate of expenditure growth than in recent years.”⁴⁸

Even under the most conservative estimates of telehealth impact and, ignoring piecemeal stories of telehealth success rates for return on investment, it is plausible to argue that telehealth would, at bare minimum, reduce the rate of expenditure growth.

In 2013-2014, the nation’s four most populous states spent significant amounts of state dollars on Medicaid services, and the amounts continue to grow. For FY 2014-2015, Florida’s AHCA administered a Medicaid budget of \$23.6 billion,⁴⁹ compared to a \$20.4 billion spending in FY 2013-2014.⁵⁰ In comparison, other states reported higher Medicaid spending than Florida in FY 2013-2014.

Total Medicaid Spending (FY2013-14)				
FY 2013-2014	CA	TX	FL	NY
Total Medicaid Spending ⁵¹	\$63,941,985,764	\$32,202,713,428	\$20,425,755,781	\$54,204,075,597

Prior to implementation of the Affordable Care Act and attendant enrollment changes with Medicaid expansion, states still evidenced annual increases in Medicaid spending.

Average Annual Growth in Medicaid Spending (Select States & Years) ⁵²					
Location	2001-2004	2004-2007	2007-2010	2010-2013	Average of Annual Averages ⁵³
United States	9.40%	3.60%	6.80%	4.00%	5.95%
California	8.50%	5.10%	5.40%	13.70%	8.18%
Florida	14.10%	1.80%	8.60%	2.20%	6.68%
New York	9.10%	2.10%	5.50%	1.40%	4.53%
Texas	11.60%	8.10%	9.70%	1.40%	7.70%

Setting aside the larger noted Medicaid spending increases in the last couple of years,⁵⁴ Florida has seen an average annual increase of approximately 6.68 percent in Medicaid spending across fiscal years 2001-2013. If Florida’s state FY 2014-2015 Medicaid budget of \$23.6 billion is a current benchmark, it could suggest an annual increase of \$1.58 billion or more going forward.⁵⁵

Of note, since the last quarter of FY 2012-2013⁵⁶ until May 2015, California, a Medicaid expansion state, saw its Medicaid and state children's health insurance program (CHIP) enrollment increase by more than 37 percent.⁵⁷ Another Medicaid expansion state, New York, saw an increase of more than 13 percent during the same period.⁵⁸ However, even without Medicaid expansion, Texas⁵⁹ saw an increase of nearly four percent in enrollment, and Florida⁶⁰ saw an increase of more than 12.6 percent in enrollment during the identical time period spanning less than two years.

With demonstrated increases in both Medicaid enrollment and spending, even in the absence of optional Medicaid expansion, it would stand to reason that any small percentage of cost-savings gained through telehealth prevention of, or diversion from, more costly care will increase proportionally the absolute dollar amount saved. In other words, if telehealth can reduce one percent of Medicaid spending in a \$23.6 billion budget in a given fiscal year (a reduction of \$236 million), and spending the next year has increased by 6.68% to approximately \$25.2 billion, a 1% reduction would now equal \$252 million.

With more widespread telehealth penetration across the state, more cost-savings can be anticipated. By not investing early in telehealth, the time-value of money is lost. A comparison may be a college student or young adult putting money into a low to no interest bank account rather than taking a long-term investment strategy approach for retirement. There is still a return on investment closer to the time when the funds are needed, when higher-yield options are finally sought, but tremendous gains are foregone. Every economic and demographic indicator suggest that Florida will need its "funds" sooner, rather than later. Whether it is the silver tsunami,⁶¹ an increase in developmental disabilities,⁶² healthcare provider shortages, or a perfect storm of these and other factors combined, the time to invest in telehealth is now and, for each year that passes, potential gains are lost. For example, if an increase in telehealth use across the state can reduce Medicaid spend (represented by the \$23.6 billion FY 2014-15 budget) by 3% (\$708 million reduction), rather than 1% (\$236 million), cost savings can quickly add up. Any telehealth savings can be reinvested into Florida's economy.

Medicaid expenditures are higher in certain service categories than in others, and flexibility within a state's Medicaid program for telehealth, such as flexibility in reimbursable locations, may provide increased opportunities for cost-savings through timely access to care and less-costly interventions. The automated Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) allows states to electronically submit required forms directly to the CMS Data Center and the Medicaid data base. The resulting data summarizes state-by-state total expenditures by program for the Medicaid Program, Medicaid Administration and CHIP programs are available as well as summary state-specific data from financial management reports for a particular fiscal year. Selectively comparing reported Title XIX standard Medicaid expenditures for one year (federal FY 2012-2013), provides an idea of potential cost-savings across selective comparison states in specific service categories.

Medicaid Medical Assistance Program Expenditure Report FY2012-13⁶³
(Select Service Categories >\$100 million)

Service Category	CA - State Share	TX - State Share	FL - State Share	NY - State Share
Inpatient Hospital - Reg. Payments	3,382,048,803	931,596,281	1,189,940,140	2,444,354,251
Inpatient Hospital - Sup. Payments	2,320,331,996	812,734,546	416,635,960	(106,958,791)
Nursing Facility Services - Reg. Payments	2,206,432,398	960,528,308	1,183,739,808	3,432,860,171
Intermediate Care - Private	194,182,114	111,841,414	115,282,272	590,429,958
Physician & Surgical Services - Reg. Payments	375,231,232	425,078,991	412,537,041	154,688,510
Outpatient Hospital Services - Reg. Payments	748,757,931	207,466,467	430,933,158	957,553,740
Prescribed Drugs	1,208,615,644	291,348,781	559,773,556	367,486,528
Medicare - Part A	458,173,032	109,149,545	163,987,540	267,618,060
Medicare - Part B	662,444,803	277,452,245	303,070,992	357,180,330
Medicaid - MCO	8,011,595,861	5,266,862,144	1,617,728,135	10,246,181,143
Home & Community-Based Services - Reg. Pay. (Waiv)	1,323,673,325	508,562,680	516,201,520	2,879,610,935
Hospice Benefits	87,330,956	93,807,019	129,235,973	72,997,020
Other Care Services	2,468,038,560	512,060,242	168,836,211	1,054,066,837
Total Net Expenditures (Traditional Medicaid Medical Assistance Service Categories)	29,925,345,921	11,155,835,926	7,669,778,159	26,016,502,724

Despite being less populous than Texas, Florida Medicaid expenditures exceed those of Texas in several service categories (e.g., inpatient hospital, nursing facility services, outpatient hospital, and prescribed drugs). With Florida's state share of Medicaid medical assistance exceeding \$500 million in individual service categories such as inpatient hospital care (regular payments), nursing facility services (regular payments), Medicaid managed care, prescribed drugs, and home and community-based services (waiver/regular pay), and even hospital outpatient services (regular payments) exceeding \$400 million, even small percentage reductions in select service utilization areas can generate significant cost-savings.

Hospital Charges Revisited (Not Limited to Medicaid)

As discussed in *Critical Connections to Care*, if telehealth could reduce the need for costly hospitalizations by even one percent, \$1.2 billion in savings could be realized from in-patient hospital charges alone (from the more than \$120 billion in Florida hospital charges in FY 2012-2013).

The One Percent Argument: Realistic, Overestimate, or Conservative?

In *Time for Telehealth*, various provider experiences with telehealth across the country were highlighted. These providers demonstrated significant return-on-investment for both clinical impact and cost-savings well in excess of one percent for any particular metric chosen. For example, the CHRISTUS Health System in Texas used telehealth for heart failure patients and realized an overall return-on-investment of 246%, with a decrease in average admissions from 1.43 to 0.20, and a decreased cost of care from nearly \$13,000 to approximately \$1,200. In Florida, Baptist Health South Florida's eICU program realized in one year, a \$15 million cost savings, with 380+ more lives saved than anticipated, and length of ICU stay reduced by 29%, with a 33% reduction in hospital stay. A smaller University of Florida telehealth pediatric diabetes program increased access, decreased hospitalizations of children with diabetes from 13 to 3.5, and decreased emergency department visits from 8 to 2.5 per year.

These examples, and other examples across the United States,⁶⁴ suggest that a one percent cost-savings, within specific metrics, and potentially across entire programs, is both realistic and conservative in estimation.

SECTION IV

STATEWIDE INCENTIVIZING OF TELEHEALTH

Reimbursement as the Top Priority

Reimbursement remains the top priority issue for many telehealth providers.⁶⁵ While 29 states have adopted private payer mandates and 13 states have adopted Medicaid mandates,⁶⁶ Florida and other remaining states struggle with ways to incentivize telehealth and ensure payment.

What is really happening on the national and state levels with telehealth reimbursement? Progress in reimbursement policies has been made across the United States. However, it is slow moving, piecemeal, complex, and not well-publicized, creating a potential barrier to the utilization of telehealth. With multiple streams of potential payment and varying payment policies across public and private payers, across health systems, and across states, the “absence of consistent, comprehensive reimbursement policies” creates a challenging minefield for larger telehealth providers and a seemingly impossible barrier for smaller-scale providers.⁶⁷ In addition, without separate telehealth coding requirements, telehealth providers may not bill telehealth differently than in-person services, making telehealth reimbursement data difficult to cull out.⁶⁸

NATIONAL REIMBURSEMENT TRENDS & PRACTICES

In 2012, the American Telemedicine Association’s (ATA’s) Telemental Health Special Interest Group (SIG), Policy Group, and Business and Finance SIG, conducted an online survey of private payer reimbursement across the United States⁶⁹ as a follow-up to an earlier 2007 survey.⁷⁰ Respondents in 46 out of 50 states participated, the top eight of which included California, New York, Florida, and Texas. The majority of respondents were administrators, clinicians, or business managers involved with providing telehealth services. Forty-five percent of respondents, a number believed to be conservative, were in organizations that billed for telehealth services. Top reasons given among the 55 percent that did not bill for telehealth services were that Medicaid did not reimburse (33.0%), major payers do not pay (32.4%), the practice was in an urban area (19.3%), and telehealth services were bundled in contracts (17.4%). Less than five percent of non-billers indicated that either they could not get support from their organizations, or that fraud or abuse concerns were too great. Nearly 45 percent of non-billers cited other reasons that include lack of knowledge of billing practices and billing codes. In addition, some providers had little or no experience in billing private payers. However, for those providers that did bill, 81 percent received payment, and it was undetermined whether unsuccessful billing was due to a general denial of coverage or a telehealth-specific basis for denial. In addition, only nine percent found that it took longer for telehealth claim payments than in-person claims.

Survey results additionally showed that current procedural terminology (CPT) codes used to bill telehealth services varied in practical usage, and nearly half of all respondents did not know which telehealth modifiers to use. For both Medicare and Medicaid claims, approximately half of the survey respondents indicated that they provided services for which they were not reimbursed. In addition, 48 percent of respondents indicated that, at some point, they did not provide telehealth services due to lack of payment.

Interestingly, while more than two-thirds (67.8%) of respondents were generally aware of private insurers covering telehealth in their states, many did not know which private payers paid, with insurers such as Blue Cross Blue Shield, UnitedHealthcare, Cigna, and Humana identified by respondents by name as ***both*** the insurers that paid and the insurers that specifically did not pay for telehealth services.

Notably, the survey found that more than 40 percent of respondents were interested in learning more about Medicare, Medicaid, private payers, billing and coding, and how to approach payers. The study concluded that government payers set precedent for private payer coverage and that more consistent state and federal telehealth policies could incentivize private payers toward coverage, that variations between in-person and telehealth administrative rules present barriers, and that the telehealth provider community has significant gaps in knowledge of reimbursement opportunities, payer negotiation, and how to impact local policy change.

MYTH, MISUNDERSTANDING, & MISDIRECTION

Private payer reimbursement arrangements in Florida do exist, but they are few and far between, skillfully negotiated behind closed doors by larger providers that actively seek out such arrangements, and thereafter not publicized.⁷¹ As is often the case of physicians who provide Medicaid services but do not often want to be advertised as such for fear of gaining a higher Medicaid patient load, private insurers do not yet appear willing to publicize their limited telehealth reimbursement deals.

Barriers to Reimbursement⁷²

A CALL FOR TELEHEALTH EDUCATION

Bringing telehealth education to the next generation of health care providers while still in training was a top priority for Florida's late Senator Durell Peaden, a known telehealth champion, who wanted to see telehealth as part of the curriculum in Florida's medical and health professional schools.⁷³ Indeed, increasing provider understanding of telehealth delivery, including standards of care and reimbursement options, is paramount to expanding telehealth across the state.

Within the reimbursement arena, Florida telehealth providers can increase success by bridging these essential knowledge gaps in key areas that can be ameliorated by widespread education efforts in the provider community: 1) lack of known available Medicaid reimbursement, 2) lack of known private payers, and 3) leveraging negotiating/bargaining power.

Some Florida telehealth providers and those considering telehealth remain under the misconception that Florida Medicaid does not reimburse. The Agency for Health Care Administration (AHCA) recommends contacting the agency directly to avoid miscommunications that sometimes occur when provider fee schedules are being negotiated.⁷⁴ While private payer arrangements exist, private payers are not advertising telehealth coverage options. Prizing cooperative communication above competition among telehealth providers can reduce this knowledge gap to the benefit of all. Removing this barrier requires a concerted effort among telehealth providers at a time when providers insulate knowledge to protect hard-earned contracts in a highly competitive environment; however, increasing provider knowledge and provider-driven telehealth demand may lead to more insurers offering options and increased return, even for those providers with existing contracts. Finally, when it comes to negotiations, smaller telehealth providers may simply not know how to approach insurers about telehealth reimbursement and, even if they do, may not have enough patient flow to

leverage when engaging payers. Without state policy or collective provider action, such lone providers may not attempt private payer reimbursement.

THE BUSINESS OF TELEHEALTH

In the TaxWatch report *Critical Connections to Care*, six models of telehealth delivery were presented. From a medical clinician perspective, telehealth can be provided in these ways: 1) physician examines patient directly through an extender; 2) physician specialist assists the patient's primary care practitioner during a virtual bedside or office visit; 3) physician and patient discuss medical issues with minimal to no exam; 4) patient sends data to a central receiving center that is processed and forwarded to the physician; 5) medical assistant helps to obtain data, which is then sent to central office for processing; and 6) a call center triages calls and offers medical advice.⁷⁵

Another way to conceptualize telehealth provision is through business models and provider arrangements. Nine such models have been described: 1) direct-to-consumer; 2) institution-to-institution; 3) clinician-to-clinician; 4) oversight and processes (e.g., in-hospital eICU); 5) chronic care management; 6) online patient portal/access; 7) mHealth and medical applications; 8) hardware/software (e.g., kiosks at point of service); and 9) international.⁷⁶

Within these telehealth service delivery and business models are exciting new opportunities for job creation across various industries including, but not limited to, telecommunications (e.g., broadband), telehealth service companies (e.g., facilitating direct-to-consumer), medical tourism,⁷⁷ telehealth connectors (e.g., brokers, group purchasing organizations), and a broad range of health care providers. However, these models also raise questions as to patient safety, quality of care, comparative value to face-to-face, and likelihood of fraud and abuse.

COMPARATIVE VALUE FOR INSURANCE COMPANIES

Arguably, some of these models involve more "hands-on" patient interaction than others. Concerns regarding a differing level and quality of care, depending on telehealth delivery or business model, may be among potential reasons for the reluctance of insurance companies to cover telehealth at the same level (or any level in many cases) of reimbursement. Providing insurers assurances of equivalent value through equivalent standards of care as those of face-to-face exams, through carefully drafted statutes and regulations directing telehealth to be as true to an in-person encounter as possible, may allay such concerns. Regulatory boards can help to ensure that telehealth standards are appropriate for a particular health-related profession. A non-established patient providing financial information and accessing an unknown practitioner does not necessarily provide assurances that the practitioner is advising within the scope of his training and practice (e.g., a psychiatrist giving pediatric advice), that potentially life-threatening conditions would be caught (e.g., description of symptoms without a palpable physical exam leading to a missed blood clot), or that timely and appropriate care will be given. Without better assurances of standards of care, insurers may not feel they are getting the same value, either in immediate or long-term patient outcomes and, correspondingly, cost-savings. Additional patient outcome data from current telehealth providers may help with this concern, but without an accountable minimal standard across all providers and telehealth models, insurers may still retain concerns leading to reduced or non-existent reimbursement for telehealth.

At the national level, the emergence of newer, untested companies has created concerns regarding standards of care.⁷⁸ Within Florida, it is important to note that certain telehealth companies have evidenced a commitment to quality care. For example, MDLIVE providers have passed background checks, and are state-licensed and board-certified with an average of 15 years of experience.⁷⁹ The Lantana-based ClickAClinic.com voluntarily subjected itself to AHCA review, obtaining a Florida health care clinic license as the first telemedicine company approved as a Florida AHCA medical facility.⁸⁰

On the Horizon for Florida Telehealth

Interest in telehealth continues to grow across the nation and the state. With a rapid increase of interested stakeholders in Florida comes opportunities for more effective discussions with payers, exploration of creative state-tailored telehealth options, and raising the profile of telehealth among Florida's residents and providers, Florida's legislative and executive branches, and even national actors.

ENGAGING INSURANCE THOUGHT LEADERS

A 2003 survey by the ATA and AMD Global Telemedicine found indications that private payers, providing reimbursement in 25 states at the time, typically followed the lead of Blue Cross/Blue Shield, then reimbursing for telehealth in 21 states, rather than following federal leads of more limited reimbursement.⁸¹ Despite more than a decade passing, this insight may provide strategic guidance as to increasing private payer reimbursement at the state level. Whether done via large providers or health systems, special interest groups, legislative direction, or executive branch suggestion, bringing certain key payers to the discussion table may open the doors for more widespread private payer telehealth reimbursement.

CREATIVE OPTIONS

A market offering or independent collaboration akin to a group purchasing organization for telehealth providers and employers seeking telehealth coverage may create new business opportunities, create leverage for payer reimbursement negotiations, and allow smoother entry into telehealth for smaller providers and businesses.

In addition, the development of a state network for telehealth services, which would be a separate function from work for which AHCA is responsible, could allow for electronic verification and fraud reduction. Innovative programs and technology such as MAXIMUS's DecisionPoint, which coordinates data sources to increase Medicaid eligibility integrity, may provide early pathways toward that end.

ADDITIONAL TELEHEALTH DISCUSSION VENUES

In May 2015, Governor Rick Scott signed Executive Order 15-99 and created a Commission on Healthcare and Hospital Funding comprised of nine members and two co-executive directors. In its role of investigating taxpayer funding for various health entities in Florida and how the medical outcomes of Medicaid patients compare to other patients,⁸² the Commission may explore state telehealth efforts.⁸³

Then, in June 2015, Senator Aaron Bean, Chair of the Senate Health Policy Committee, called for the creation of a Joint Task Force on Health Care Policy Innovation that would allow the House and Senate to jointly hear public testimony and consider short-term and long-term solutions in health care for Florida.⁸⁴ If such a task force is convened, this would provide another venue for telehealth proponents to provide information to state policymakers.

As previously mentioned, Florida TaxWatch is hosting its second telehealth conference on September 9-10, 2015 in Orlando, Florida.⁸⁵ In addition, the Federal Communication Commission's (FCC's) task force, Connect2HealthFCC, which seeks to increase the adoption of advanced health care technologies such as telehealth and mHealth, has already hosted meetings in Virginia and Mississippi, and will be bringing the discussion to Florida at the end of September.⁸⁶ In addition, various Florida organizations are hosting meetings throughout the fall of 2015, including a December summit in Winter Park by the Southeastern Telehealth Resource Center, the Florida State University College of Medicine, and the Florida Partnership for TeleHealth.⁸⁷

TELEHEALTH OUTLOOK & SUGGESTED CONSIDERATIONS FOR THE 2016 FLORIDA LEGISLATIVE SESSION⁸⁸

With the increase in its aging population, the increase in individuals with disabilities, and skilled provider shortages, in addition to transportation challenges in rural areas and specialty care challenges in urban areas, Florida's access needs continue to rise and telehealth provides a viable, timely option. Among Florida telehealth proponents statewide,⁸⁹ many would prefer no legislation to poorly-drafted legislation that would create unnecessary restrictions or curtail good, current telehealth practice. However, at a minimum, telehealth legislation is worthwhile to provide standard of care and recordkeeping clarity to clinicians and protections to patients. Technology will always be ahead of legislative changes, so legislation should not specify or limit telehealth to specific telecommunications. In addition, legislation should set broad parameters and authorize more detailed rulemaking by those with greater technical knowledge.

Clarifying language would prevent non-physician telehealth providers who broadly use telecommunication for the provision of health-related services from being confused with medical practitioners. In policy discussions, issues of scope of practice should not be conflated with telehealth; they are separate issues. Leaving practice issues to the respective health-related boards would allow telehealth to follow current practice decisions without the need for constantly amending telehealth legislation.

As noted earlier, reimbursement remains a top priority for the majority of telehealth providers. However, having simple foundational legislation in place will facilitate reimbursement discussions with payers, even if the legislature does not seek a mandate. In the absence of a private payer mandate, state policies that incentivize telehealth and encourage provider-payer communications would help to expand telehealth. In the absence of a Medicaid mandate, policies that increase patient access locations and reimbursement across expanded Medicaid services would help Florida's neediest residents and reduce the utilization of higher cost services. For example, broader reimbursement of telehealth in nursing homes or for services for individuals with developmental disabilities may provide significant cost savings while increasing timely access to care.

Telehealth discussions across existing health-related commissions and task forces, or telehealth study within a joint legislative task force, may help to grow consensus. Financial incentives, including increased utilization of telehealth in state contracts, should be explored beyond mandates. Finally, as some states already do, Florida should consider the use of telehealth for state employee health, school-based health, inmate population services, rehabilitation, and other areas of notable state expenditures.

SECTION V

Toward A State of Self-Sufficiency

Reducing Reliance on Non-Secured Federal Health Care Funding

Telehealth has been discussed as a key puzzle piece in a long-term solution for health care. It can be viewed as a potential win-win situation regardless of partisan priorities, benefiting patients through access, practitioners through convenience, and providers through better patient outcomes and increased cost control. Clinical effectiveness has been demonstrated. Potential cost-savings suggest long-term benefits to state and private payers through prevention or reduction of more costly procedures. In the state of Florida, telehealth also has the potential to reduce costs while addressing the growing healthcare needs of the aging and of individuals with developmental disabilities. If telehealth is expanded to other state programs, additional cost-savings can be realized with an overall improvement to the health of Floridians.

While telehealth has received increasing amounts of attention in recent years, crises, confusion, and lengthy debate on federal funding of state healthcare needs has relegated telehealth to a secondary, or back-burner, issue. Indeed, in the 2015 Legislative Session, discussions and impasses regarding the Affordable Care Act, Medicaid expansion, low-income pool funding, and the availability of long-term federal healthcare funding contributed to an earlier session end date. How can Florida plan other allocations easily when Medicaid comprises a third of the state's budget, and federal issues remain unresolved? Moreover, in a state declining the acceptance of Medicaid expansion dollars due to federal funding uncertainties, and a desire to not rely upon unsecured dollars or become increasingly dependent on external funding sources, what can be done to develop a long-term sustainable health system to meet diverse health needs?

State prioritization of telehealth regardless of federal funding discussions is essential for one, little-discussed reason: statewide telehealth expansion can ultimately reduce reliance on non-secured federal health care funding and increase state self-sufficiency. Telehealth would allow Florida to reach its 19 million residents across its 67 counties regardless of location, age, infirmity, or transportation ability. Telehealth could generate cost-savings through reduced need for high cost health services that can be reinvested into Florida's economy, reducing the need for federal or external funding assistance. Telehealth may allow Florida's healthcare providers to continue practice in later life and encourage Florida-trained practitioners to remain in state. Telehealth can also generate new jobs and business opportunities across all telehealth points of service and marketing, including in international and in-country medical tourism.

Establishing a Statewide Telehealth Infrastructure

In light of these many telehealth benefits, establishing a statewide telehealth infrastructure would allow telehealth to effectively reach Floridians across the state. Whether as a state-backed statewide telehealth network, or as an independent collaborative body working closely with the state, having an established telehealth infrastructure would provide a ready-made foundation for addressing changing health delivery needs as state demographics shift.

Florida's political climate is one that encourages the natural balancing of free market forces. While consumer demand and provider demand for telehealth can play a significant role in driving the market toward encouraging payer participation and offerings, they cannot provide statewide provider clarity of standards or ensure patient safety. In addition, to the extent that insurers are not readily volunteering to cover telehealth services as they do in-person services, financial and other incentives should be considered by the state. To that end, Florida's legislative and executive branches should consider acting now to provide assurances and shape a statewide telehealth infrastructure.

Expanding Telehealth Offerings

Even in the absence of Medicaid mandates, states have wide and creative latitude in structuring Medicaid coverage of telehealth. Noting that other large states have implemented policies that facilitate telehealth use in high-cost populations, Florida should consider telehealth possibilities for all health-related services across Florida's aging and disabilities populations, school health, chronic conditions, and state employee health offerings. In addition, telehealth may provide safer options for the provision of mental health and inmate health services. Telehealth may also provide needed access to care for Florida's families facing developmental disabilities, whether or not receiving state or Medicaid waiver assistance. The state can support expanded telehealth offerings with corresponding Medicaid/state contract offerings and private payer incentives.

SECTION VI

In Conclusion: TaxWatch Recommendations

Florida TaxWatch continues to recommend the statewide expansion of telehealth. The clinical effectiveness of telehealth has been evidenced, and while the cost-effectiveness and cost-savings of telehealth remains challenging to prove, mounting provider experience of significant cost-savings are influential.

As the third most populous state, behind in health rankings and telehealth policy adoption in comparison to similarly populated states, Florida should consider having an established telehealth infrastructure in place in time to meet the needs of its rapidly increasing aging population. Within this infrastructure, providers should receive education on telehealth regulations, billing, and payment options.⁹⁰

In the event that federal funding ever declines or ceases, and even if it continues, having an established telehealth infrastructure in place will allow the state of Florida to care for its residents across rural and urban counties while reducing the need for more costly healthcare services.

As reimbursement discussions continue, the state and interested stakeholders should explore monetary and non-monetary telehealth incentives for businesses and providers as alternative policies for Medicaid and private payer mandates. Opportunities should be explored for payer-provider collaborations, accountable care structuring, increased medical tourism, and the creation of new, telehealth-related jobs. Telehealth expansion and infrastructure discussions should engage all sectors and industries, bringing patients, practitioners, institutional providers, and payers to the table.

In summary, Florida should work collectively to develop and refine an established telehealth infrastructure to provide increased access for its diverse residents, to realize cost-savings to reinvest in Florida's economy or health programs, and to increase state financial and health provision self-sufficiency at a time of changing and uncertain federal funding options. As discussions progress, current telehealth providers can improve the case for reimbursement through better tracking of telehealth-specific return-on-investment and other notable patient/institutional metrics. The time value of cost-savings and health prevention potentially achieved by telehealth is lost each year that statewide telehealth policies are not implemented and telehealth is not expanded. With changing demographic needs and uncertain healthcare funding, Florida cannot afford to wait in making telehealth the pivotal piece in a long-term healthcare solution.

ENDNOTES

- 1 See America's Health Rankings (2012). Florida: Geographic disparity, at 67. Retrieved from <http://cdnfiles.americashealthrankings.org/SiteFiles/Reports/Americas-Health-Rankings-2012-v1.pdf>. This former metric was a measure of age-adjusted mortality rates at the county level. See also America's Health Rankings (2013). Florida: Disparity in health status, at 81. Retrieved from <http://cdnfiles.americashealthrankings.org/SiteFiles/Reports/AHR-AnnualReport2013.pdf>. In the 2014 report, Florida's ranking for disparity in health status (health status based on educational attainment) had improved to 27th from 41st, but was 44th in income disparity and 48th in health insurance. See America's Health Rankings (2014): Florida, at 93. Retrieved from <http://cdnfiles.americashealthrankings.org/SiteFiles/Reports/Americas Health Rankings 2014 Edition.pdf> and <http://www.americashealthrankings.org/FL/gini>
- 2 See, e.g., U.S. Census Bureau (December 23, 2014). Florida passes New York to become the Nation's third most populous state, Census Bureau report. Release Number CB14-232. Retrieved from www.census.gov/newsroom/press-releases/2014/cb14-232.html. See also U.S. Census Bureau (December 2014). Annual estimates of the resident population: April 1, 2010 to July 1, 2014: 2014 population estimates. Retrieved from <http://factfinder.census.gov>. Florida has an estimated population of 19.9 million.
- 3 See Florida Legislature Office of Economic & Demographic Research (March 17, 2014). Florida's economic future and the impact of aging [PowerPoint presentation]. Retrieved from http://edr.state.fl.us/Content/presentations/economic/FIEconomicFuture&theImpactofAging_3-17-14.pdf; and Florida Legislature, Office of Economic and Demographic Research (2015). *Florida Census Day Population: 1970-2040*. Data source: Florida Demographic Estimating Conference, Feb. 2015 and the University of Florida, Bureau of Economic and Business Research, Florida Population Studies, Bulletin 172, June 2015. Retrieved from http://edr.state.fl.us/Content/population-demographics/data/Pop_Census_Day.pdf
- 4 Florida TaxWatch (March 2014). Critical connections to care: Expanding the use of telemedicine in Florida will improve health outcomes and generate savings. Retrieved from <http://www.floridataxwatch.org/resources/pdf/CriticalConnectionsFINAL.pdf>
- 5 Florida TaxWatch (November 2014). Time for telehealth: Florida lags behind much of the country in telehealth, but thoughtful action can be the remedy. Retrieved from <http://floridataxwatch.org/resources/pdf/telehealthreportnov14.pdf>
- 6 For more information, please visit <http://www.floridataxwatch.org/events/telehealth.aspx>
- 7 American Telemedicine Association (2015). 2015 State Telemedicine Legislation Tracking (as of 08/04/2015). Retrieved from <http://www.americantelemed.org/docs/default-source/annual-meeting-2013/2015-state-legislation-matrix.pdf>. Washington D.C. and 29 states have legislatively mandated parity for private coverage of telemedicine: Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Hawaii, Indiana, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, New York, Oklahoma, Oregon, Tennessee, Texas, Vermont, Virginia, and Washington. This is an increase of nine states since March 2014. Eight additional states have proposed private payer mandates: Illinois, Iowa, Massachusetts, New Jersey, North Carolina, Ohio, Pennsylvania, and Rhode Island. For a discussion on the most recent state to mandate private payer reimbursement, Delaware, see Lacktman, N. (2015). Delaware enacts telehealth commercial insurance parity law. Foley & Lardner, Health Care Law Today. Retrieved from <http://www.healthcarelawtoday.com/2015/07/08/delaware-enacts-telehealth-commercial-insurance-parity-law/>
- 8 American Telemedicine Association (2015). 2015 State Telemedicine Legislation Tracking (as of 08/04/2015). Retrieved from <http://www.americantelemed.org/docs/default-source/annual-meeting-2013/2015-state-legislation-matrix.pdf>. Washington D.C. and 13 states have legislatively mandated Medicaid coverage of telemedicine, generally in the form of interactive video: Arkansas, California, Colorado, Indiana, Kentucky, Maryland, Minnesota, Mississippi, Nebraska, Nevada, New York, Tennessee, and Vermont. This is an increase of three states since March 2014. Ten additional states have proposed Medicaid mandates: Iowa, Kansas, Maine, Massachusetts, Missouri, New Jersey, Ohio, Rhode Island, Texas, and Washington.
- 9 See, e.g., Florida TaxWatch (November 2014). Policy decision points, at 18. Time for telehealth: Florida lags behind much of the country in telehealth, but thoughtful action can be the remedy. Retrieved from <http://floridataxwatch.org/resources/pdf/telehealthreportnov14.pdf> (original compilation of legislative issues considered during the 2014 Florida Legislative

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- Session and factors gathered from national research); Florida TaxWatch (March 2014). Critical connections to care: Expanding the use of telemedicine in Florida will improve health outcomes and generate savings, at 20-25. Retrieved from <http://www.floridataxwatch.org/resources/pdf/CriticalConnectionsFINAL.pdf> (in-depth discussion of policy considerations for telehealth).
- 10 See, e.g., Webber, D., & Hatter, L. (April 29, 2015). Florida's House quits early, at impasse over Medicaid expansion. NPR. Retrieved from www.npr.org/sections/health-shots/2015/04/29/402875028/floridas-legislature-quits-early-at-impasse-over-medicaid-expansion
- 11 Thomas, L. & Capistrant, G. (Sept. 2014). State telemedicine gaps analysis: Coverage & reimbursement. American Telemedicine Association. Retrieved from <http://www.americantelemed.org/policy/state-policy-resource-center>
- 12 Thomas, L. & Capistrant, G. (May 2015). State telemedicine gaps analysis: Coverage & reimbursement. American Telemedicine Association. Retrieved from <http://www.americantelemed.org/docs/default-source/policy/50-state-telemedicine-gaps-analysis---coverage-and-reimbursement.pdf>
- 13 Center for Connected Health Policy (July 2015). State telehealth laws and Medicaid program policies: A comprehensive scan of the 50 states and District of Columbia. California, at pp. 32-34. Retrieved from <http://cchpca.org/sites/default/files/resources/STATE TELEHEALTH POLICIES AND REIMBURSEMENT REPORT FINAL JULY 2015.pdf>
- 14 U.S. Census Bureau (December 2014). Annual estimates of the resident population: April 1, 2010 to July 1, 2014: 2014 population estimates. Retrieved from <http://factfinder.census.gov>. California has an estimated population of 38.8 million.
- 15 U.S. Census Bureau (June 2015). Annual estimates of the resident population for selected age groups by sex for the United States, states, counties, and Puerto Rico commonwealth and municipios: April 1, 2010 to July 1, 2014: 2014 population estimates. Retrieved from <http://factfinder.census.gov>. For both sexes in 2013, California has an estimated 65 and older population of 4.8 million.
- 16 Center for Connected Health Policy (July 2015). State telehealth laws and Medicaid program policies: A comprehensive scan of the 50 states and District of Columbia. Texas, at pp. 189-196. Retrieved from <http://cchpca.org/sites/default/files/resources/STATE TELEHEALTH POLICIES AND REIMBURSEMENT REPORT FINAL JULY 2015.pdf>
- 17 U.S. Census Bureau (December 2014). Annual estimates of the resident population: April 1, 2010 to July 1, 2014: 2014 population estimates. Retrieved from <http://factfinder.census.gov>. Texas has an estimated population of 27 million.
- 18 See, e.g., American Telemedicine Association (2015). 2015 State Telemedicine Legislation Tracking (as of 08/04/2015). Retrieved from <http://www.americantelemed.org/docs/default-source/annual-meeting-2013/2015-state-legislation-matrix.pdf>.
- 19 Center for Connected Health Policy (July 2015). State telehealth laws and Medicaid program policies: A comprehensive scan of the 50 states and District of Columbia. New York, at pp. 147-152. Retrieved from <http://cchpca.org/sites/default/files/resources/STATE TELEHEALTH POLICIES AND REIMBURSEMENT REPORT FINAL JULY 2015.pdf>
- 20 U.S. Census Bureau (December 2014). Annual estimates of the resident population: April 1, 2010 to July 1, 2014: 2014 population estimates. Retrieved from <http://factfinder.census.gov>. New York has an estimated population of 19.7 million.
- 21 Center for Connected Health Policy (July 2015). State telehealth laws and Medicaid program policies: A comprehensive scan of the 50 states and District of Columbia. New York, at 147.
- 22 See Florida TaxWatch (March 2014). Critical connections to care: Expanding the use of telemedicine in Florida will improve health outcomes and generate savings, at 15-16. Retrieved from <http://www.floridataxwatch.org/resources/pdf/CriticalConnectionsFINAL.pdf>; Senior, J. (November 2014). "Florida Medicaid and Telemedicine Services." Presentation by the Florida Deputy Secretary for Medicaid at the 2014 Florida TaxWatch Telehealth Cornerstone Conference. Summary retrieved from <http://old.floridataxwatch.org/resources/pdf/ConferenceSummaryFINAL.pdf>; Center for Connected Health Policy (July 2015). State telehealth laws and Medicaid program policies: A comprehensive scan of the 50 states and District of Columbia. Florida, at pp. 51-54. Retrieved from <http://cchpca.org/sites/default/files/resources/STATE TELEHEALTH POLICIES AND REIMBURSEMENT REPORT FINAL JULY 2015.pdf>

- 23 Locations include hospitals, physician offices, and certain community health centers. If state oversight or fraud is a barrier to broadly expanding telehealth service locations, one intermediate option between limited locations and any location is to allow telehealth coverage at any state-licensed/state-regulated facility. Note that Children's Medical Services, within the Florida Department of Health also provides telemedicine services. For more information, please visit http://www.floridahealth.gov/AlternateSites/CMS-Kids/families/health_services/telemedicine.html.
- 24 The Managed Medical Assistance (MMA) Waiver program is made possible under an extension of Florida's 1115 Research and Demonstration Waiver. For a history of the program, see Agency for Health Care Administration (2015). Federal Authorities: Managed Medical Assistance. Retrieved from http://ahca.myflorida.com/medicaid/statewide_mc/mma_fed_auth_amend_waiver_2015-03.shtml
- 25 The Long-Term Care (LTC) Waiver program is made possible under Florida's concurrent sections 1915(b) and 1915(c) waivers. The program provides long-term care services and supports to eligible disabled individuals age 18-59, and age 65 or older. Services are provided through competitively selected managed care organizations. For an overview of Florida's various Medicaid waivers, see Agency for Health Care Administration (2015). Federal Waivers. Retrieved from http://ahca.myflorida.com/Medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/index.shtml
- 26 See, e.g., Agency for Health Care Administration (2015). Medicaid eligibles report (Webpage)(Noting that Florida's average monthly eligible is now around 3.8 million Medicaid recipients.) Retrieved from http://www.fdhc.state.fl.us/medicaid/Finance/data_analytics/eligibles_report/index.shtml
- 27 Florida Department of Health (2015). Florida's rural counties: Rural per 2010 Census (100 persons or less per square mile) (Map). Retrieved from http://www.floridahealth.gov/programs-and-services/community-health/rural-health/_documents/ruralcountiespdf.12.pdf
- 28 Note that data reflect the amounts charged, not the amounts paid. Derived from self-reported hospital data at state level from all reporting hospitals regardless of payer. See notes 28-31 for original source citations.
- 29 California Office of Statewide Health Planning and Development (2015). Inpatient Summary Reports for California Hospitals: Inpatient Discharge Summary by Year – 2012. Retrieved from <http://gis.oshpd.ca.gov/atlas/topics/use/inpatient#charts>
- 30 Texas Department of State Health Services (July 2013). Statistical Brief: Overview of Hospital Stays in Texas, 2011, at Table 1. Retrieved from <http://www.dshs.state.tx.us/thcic/publications/hospitals/Statisticalreports.shtm>
- 31 See Agency for Health Care Administration (2014). Hospital Inpatient Data Search: 2012-2013. Retrieved from <http://www.floridahealthfinder.gov/researchers/researchers.aspx>. For discussion and additional data, see also Florida TaxWatch (March 2014). Critical connections to care: Expanding the use of telemedicine in Florida will improve health outcomes and generate savings. Retrieved from <http://www.floridatxwatch.org/resources/pdf/CriticalConectionsFINAL.pdf>
- 32 New York State Department of Health (2015). Hospital Inpatient Discharges (SPARCS De-Identified): 2012. Derived from data retrieved from <https://health.data.ny.gov/Health/Hospital-Inpatient-Discharges-SPARCS-De-Identified/u4ud-w55t#revert>
- 33 Unlike the three other states, this conservative number was calculated by data division into counties and AHCA service areas. A direct multiplication of average charges (average of averages) across all counties per stay (\$47,182) and the total number of hospitalizations (2,659,767) yields higher total aggregate charges of \$125.5 billion.
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- 35 Florida Legislature, Office of Economic and Demographic Research (2015). Florida Census Day Population: 1970-2040. Data source: Florida Demographic Estimating Conference, Feb. 2015 and the University of Florida, Bureau of Economic and Business Research, Florida Population Studies, *Bulletin 172*, June 2015. Retrieved from http://edr.state.fl.us/Content/population-demographics/data/Pop_Census_Day.pdf

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- 36 For the complete legislative history and bill text for House Bill 545 of the 2015 Regular Session of the Florida Legislature, please visit the Florida House of Representatives at <http://www.myfloridahouse.gov/Sections/Bills/billsdetail.aspx?BillId=53572>
- 37 For the complete legislative history and bill text for Senate Bill 478 of the 2015 Regular Session of the Florida Legislature, please visit the Florida Senate at <http://www.flsenate.gov/Session/Bill/2015/0478/>
- 38 Note that effective in 2014, Florida physicians may not prescribe controlled substances via telemedicine except for hospitalized patients. Prescription of legend drugs is permissible in the course of a physician's professional practice under specified standards of care (same as in-person) and recordkeeping, See Rule 64B8-9.0141, Florida Administrative Code. Standards for Telemedicine Practice. Waivers and variances may be sought by petition from the Florida Board of Medicine, which continues to review exemption possibilities for the teleprescribing of non-narcotic controlled substances in medical specialties such as psychiatry. See *Critical Connections to Care and Time for Telehealth* for background on the Board of Medicine's previous telehealth discussions. For additional information and upcoming Board of Medicine meeting dates, please visit <http://flboardofmedicine.gov/>
- 39 Based on Health Policy Advisors, LLC document prepared for the Florida TeleHealth Workgroup (personal communication, August 2015).
- 40 See Florida TaxWatch (March 2014). Critical connections to care: Expanding the use of telemedicine in Florida will improve health outcomes and generate savings, at 5-6. Retrieved from <http://www.floridataxwatch.org/resources/pdf/CriticalConectionsFINAL.pdf> (noting various studies that found clinical effectiveness across many health fields such as mental health, neurology, dermatology, otolaryngology, and developmental disabilities).
- 41 See, e.g., Mistry H., Garnvwa H., and Oppong R. (2014). Critical Appraisal of Published Systematic Reviews Assessing the Cost-Effectiveness of Telemedicine Studies. *Telemedicine and e-Health*, 20(7): 609-618 (discussing challenges observed across a systematic review of cost-effectiveness literature).
- 42 However, particular telehealth services and service delivery models, such as "hub-and-spoke" telestroke networks, have been noted as cost-effectiveness across various studies and viewed, in practice, as generalizable. See, e.g., Mayo Clinic – Center for the Science of Health Care Delivery (Dec. 2013). *Telestroke Networks for Management of Acute Ischemic Stroke* (PowerPoint slides). Retrieved from <http://www.mayoclinic.org/tradition-heritage/telemedicine.html>; Slide 4 [citing Nelson, R.E., Saltzman, G.M., Skalbris, E.J., Demaerschalk, B.M., & Majersik, J.J. (2011). The cost-effectiveness of telestroke in the treatment of acute ischemic stroke. *Neurology*, 77, 1590-1598].
- 43 Mistry H., Garnvwa H., and Oppong R. (2014). Critical Appraisal of Published Systematic Reviews Assessing the Cost-Effectiveness of Telemedicine Studies. *Telemedicine and e-Health*, 20(7): 609-618.
- 44 See also Dávalos, M.E. French, M.T., Burdick, A.E., & Simmons, S.C. (2009). Economic evaluation of telemedicine: Review of the literature and research guidelines for benefit-cost-analysis. *Telemedicine and e-Health*, 15(10), 933-948; Health Resources and Services Administration (2014). What return on investment (ROI) models can I use? Retrieved from <http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Financing/roi.html>. For additional discussion of economic considerations, see Florida TaxWatch (March 2014). Critical connections to care: Expanding the use of telemedicine in Florida will improve health outcomes and generate savings, at 16-17. Retrieved from <http://www.floridataxwatch.org/resources/pdf/CriticalConectionsFINAL.pdf>
- 45 See, e.g., Florida TaxWatch (November 2014). Time for telehealth: Florida lags behind much of the country in telehealth, but thoughtful action can be the remedy. Retrieved from <http://floridataxwatch.org/resources/pdf/telehealthreportnov14.pdf>
- 46 National Conference of State Legislatures (2014). State coverage for telehealth services. Retrieved from <http://www.ncsl.org/research/health/state-coverage-for-telehealth-services.aspx>. This references both states with and without legislatively-mandated Medicaid coverage.
- 47 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services (2013). *Report to Congress: 2013 Actuarial report on the financial outlook for Medicaid*. Retrieved from <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2013.pdf>.

- 48 Id. at page iii.
- 49 See, e.g., http://ahca.myflorida.com/Medicaid/Finance/finance/budget_fiscal_planning/index.shtml. State fiscal year.
- 50 Kaiser Family Foundation (2015). *Total Medicaid Spending: FY2014*. Original source: Urban Institute estimates based on data from CMS (Form 64) as of June 2015. Reflects Federal Fiscal Year 2013-2014. Retrieved from <http://kff.org/medicaid/state-indicator/total-medicaid-spending/>
- 51 Id.
- 52 Kaiser Family Foundation (2015). Average annual growth in Medicaid spending. Retrieved from <http://kff.org/medicaid/state-indicator/growth-in-medicaid-spending/>. Originally sourced from KCMU analysis of CMS Form 64 data, FY1990 – 2013, and based on the federal fiscal year. “All spending includes state and federal expenditures. Growth figures reflect increases in benefit payments and disproportionate share hospital payments; growth figures do not include administrative costs, accounting adjustments, or costs for the U.S. territories.”
- 53 Average across the pre-grouped three federal fiscal year averages.
- 54 A Medicaid budget of \$23.6 billion in State Fiscal Year 2014-2015 versus an estimated Medicaid spend of \$20.4 billion in Federal Fiscal Year 2013-2014.
- 55 Even more conservative estimates of Medicaid spending increases are significant. See, e.g., McGrory, K. (Aug. 11, 2015) Ready for another Medicaid debate? Program could cost Florida another \$500 million next year. Tampa Bay Times. Retrieved from <http://www.tampabay.com/news/health/ready-for-another-medicaid-debate-program-could-cost-florida-another-500/2240873>
- 56 Fourth quarter in Federal Fiscal Year 2012-2013.
- 57 Preliminary May 2015 enrollment was at 12,549,540, an increase of approximately 3.93 million enrollees or 37.05% above July-September 2013 enrollment. California is a Medicaid expansion state. See <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/california.html>.
- 58 Preliminary May 2015 enrollment was at 6,434,993, an increase of approximately 756,600 enrollees or 13.32% above July-September 2013 enrollment. New York is a Medicaid expansion state. See <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/new-york.html>
- 59 Preliminary May 2015 enrollment was at 4,618,527, an increase of approximately 176,900 enrollees or 3.98% above July-September 2013 enrollment. Texas is not a Medicaid expansion state. See <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/texas.html>.
- 60 Preliminary May 2015 enrollment was at 3,496,934, an increase of approximately 391,900 enrollees or 12.62% above July-September 2013 enrollment. Florida is not a Medicaid expansion state. See <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/florida.html>.
- 61 For example, the prevalence rate of Alzheimer’s disease is 1 in 9 in individuals 65 years and older, at a projected national annual cost of \$214 in health-related care across Alzheimer’s and other dementias (Alzheimer’s accounts for between 60 and 80 percent of all dementias). Alzheimer’s Association (2014). 2014 Alzheimer’s disease facts and figures. Retrieved from http://www.alz.org/downloads/facts_figures_2014.pdf. For additional discussion on Alzheimer’s disease and economic impact, see Florida TaxWatch (April 2014). Florida’s looming Alzheimer’s crisis. Retrieved from <http://floridatxwatch.org/resources/pdf/Alzheimers2014FINAL.pdf>
- 62 For example, the prevalence rate of autism spectrum disorder (ASD) is now 1 in 68. See generally, Centers for Disease Control & Prevention (2015). Autism Spectrum Disorder. Retrieved from <http://www.cdc.gov/ncbddd/autism/data.html>
- 63 Medicaid.gov (2015). Medicaid Financial Management Report FY 2012-2013. Retrieved from <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/expenditure-reports-mbes-cbes.html>

- 64 See, e.g., Kumar, S., Merchant, S., & Reynolds, R. (2013). Tele-ICU: Efficacy and cost-effectiveness of remotely managing critical care. *Perspectives in Health Information Management / AHIMA*, American Health Information Management Association, 10, 1f. (a review of 25 studies on the clinical and cost effectiveness of eICUs and noting studies showing a 10% reduction in ICU length of stay, a 25-31% ICU cost reduction, and a decrease in hospital costs between 12-19%).
- 65 See, e.g., Adler-Milstein, J., Kvedar, J., & Bates, D. (2014). Telehealth among US hospitals: Several factors, including state reimbursement and licensure policies, influence adoption. *Health Affairs*, 33(2), 207-215 (while 42 percent of U.S. hospitals have telehealth capabilities, hospital telehealth adoption varies across state policy with private payer reimbursement associated with higher adoption, and out-of-state telehealth licensure requirements associated with reduced adoption).
- 66 American Telemedicine Association (2015). 2015 State Telemedicine Legislation Tracking (as of 08/04/2015). Retrieved from <http://www.americantelemed.org/docs/default-source/annual-meeting-2013/2015-state-legislation-matrix.pdf>.
- 67 Baker, D. C., & Bufka, L. F. (2011). Preparing for the telehealth world: Navigating legal, regulatory, reimbursement, and ethical issues in an electronic age. *Professional Psychology: Research and Practice*, 42(6), 405-411.
- 68 *Id.*
- 69 Antoniotti, N.M., Drude, K.P., and Rowe, N. (2014). Private payer telehealth reimbursement in the United States. *Telemedicine Journal and e-Health*, 20(6): 539-543.
- 70 Whiteen, P., and Buis, L. (2007). Private payer reimbursement of telemedicine services in the United States. *Telemedicine Journal and e-Health*, 13(1):15-23. As a follow-up to a 2003 survey conducted by the American Telemedicine Association (ATA) and AMD Telemedicine, 116 telemedicine programs were surveyed in 2005. Of the 64 organizations responding, 58% received private reimbursement, an increase of 5% in 2003. The study concluded that slow progress in telehealth reimbursement was being made, but was sub-optimal and greatly outpaced by telehealth growth. For additional historical context on telehealth reimbursement, see Brown, N. (2006). State Medicaid and private payer reimbursement for telemedicine: An overview. *Journal of Telemedicine and Telecare*, 12(6), 32-39 (discussing various reports and development of telehealth reimbursement).
- 71 In addition, providers focusing exclusively on reimbursement, rather than a larger picture that includes multiple potential revenue streams and business arrangements, and clinical and cost returns-on-investment, may be reluctant to adopt telehealth services. See, e.g., Gruessner, V. (June 30, 2015). Reimbursement misconceptions trending in telehealth services. mHealth Intelligence. Retrieved from <http://mhealthintelligence.com/news/reimbursement-misconceptions-trending-in-telehealth-services> (discussion with N. Lacktman regarding results of a telehealth provider survey); Lacktman, N. (2015). *Telehealth Compensation Methodologies [PowerPoint slide]*. Foley & Lardner LLP. Available by request. (Showing sample compensation arrangements such as institutional, with a combination of recurring services and fee-for-service, and patient self-pay, with a combination of subscription services and fee-for-service).
- 72 For a broad, multi-area discussion of telehealth barriers, see, e.g., LeRouge, C., & Garfield, M. (2013). Crossing the telemedicine chasm: Have the US barriers to widespread adoption of telemedicine been significantly reduced? *International Journal of Environmental Research and Public Health*, 10(12), 6472-6484.
- 73 Information from Senator Durell Peaden (personal communication, 2013-2015).
- 74 Senior, J. (November 2014). "Florida Medicaid and Telemedicine Services." Presentation by the Florida Deputy Secretary for Medicaid at the 2014 Florida TaxWatch Telehealth Cornerstone Conference. Summary retrieved from <http://old.floridataxwatch.org/resources/pdf/ConferenceSummaryFINAL.pdf>
- 75 Landry, K. (Nov. 14, 2013). Telemedicine 101. Presentation at the Joint Meeting of the Florida Boards of Medicine & Osteopathic Medicine Telemedicine Subcommittee Meeting in Tampa, Florida. Retrieved from http://w10.doh.state.fl.us/pub/medicine/Agenda_Info/Public_Information/Public_Books/November2013/1142013_TelemedicineSubcommittee_AgendaBook.pdf. Original classification by Dr. Kim Landry. For discussion, see also Florida TaxWatch (March 2014). Critical connections to care: Expanding the use of telemedicine in Florida will improve health outcomes and generate savings. Retrieved from <http://www.floridataxwatch.org/resources/pdf/CriticalConnectionsFINAL.pdf>

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- 76 Lacktman, N. (2015). *Sample Business Models and Provider Arrangements*. Foley & Lardner LLP. Available by request.
- 77 See, e.g., Florida TaxWatch (Oct. 2014). Medical Tourism in Florida. Retrieved from <http://floridataxwatch.org/resources/pdf/MedicalTourismFINAL.pdf>
- 78 World Congress (July 2015). "Consider Medicaid Telemedicine Programs to Reduce Costs and Improve Access." Panel Discussion at the 5th Annual Medicaid Summit, 2015 Government Health Care Congress. Conference information retrieved from www.worldcongress.com
- 79 Mulligan, D. (November 2014). Business and Innovation presentation by MDLIVE's Chief Medical Officer at 2014 Telehealth Cornerstone Conference. Presentation at the 2014 Florida TaxWatch Telehealth Cornerstone Conference. Summary retrieved from <http://old.floridataxwatch.org/resources/pdf/ConferenceSummaryFINAL.pdf>
- 80 ClickAClinic.com, Inc. (2015). Homepage (noting state approval as a licensed medical facility). Retrieved from <https://clickaclinic.com/index.php/>
- 81 American Telemedicine Association & AMD Global Telemedicine (2004). Private payer reimbursement information directory. Summary retrieved from http://www.amdtelemedicine.com/telemedicine-resources/private_payerabout_survey.html. At the time, Medicaid reimbursed only in 18 states, whereas now it does with or without mandate in 43 states. See also discussion at Baker, D. C., & Bufka, L. F. (2011). Preparing for the telehealth world: Navigating legal, regulatory, reimbursement, and ethical issues in an electronic age. *Professional Psychology: Research and Practice*, 42(6), 405-411, at 409-410.
- 82 Executive Office of Governor Rick Scott (May 5, 2015). Executive Order 15-99: Creation of Commission on Healthcare and Hospital Funding. Retrieved from http://www.flgov.com/wp-content/uploads/orders/2015/EO_15-99.pdf
- 83 Information provided by the Florida TeleHealth Workgroup (personal communication, July 2015).
- 84 Florida Senate Press Release (June 15, 2015). Senator Bean Calls for the Creation of a Joint Legislative Task Force on Health Care Policy Innovation: Committee to Thoroughly Examine Health Care Policy Proposals during the Legislative Interim. Retrieved from <http://www.flsenate.gov/Media/PressReleases>Show/2272>
- 85 For more information, and to register, please visit <http://www.floridataxwatch.org/events/telehealth.aspx>.
- 86 Federal Communications Commission (2015). Connect2HealthFCC Beyond the Beltway Series: Florida. Retrieved from <https://www.fcc.gov/events/connect2healthfcc-beyond-the-beltway-series-florida>. Discussions will be held September 30 and October 1, 2015 in Miami and Jacksonville, respectively. While discussions vary across states, Florida discussions at this time will focus on broadband solutions for the state, with special attention to the aging population and individuals with disabilities (personal communication, July 2015).
- 87 For more information on the December 3-4, 2015, 2nd Annual Florida TeleHealth Summit, please visit <http://www.fltelehealth.org/florida/conference/fpt-conference-2014/>.
- 88 Based on Health Policy Advisors, LLC document prepared for the Florida TeleHealth Workgroup (personal communication, August 2015).
- 89 See, e.g., discussion of the Florida TeleHealth Workgroup in Florida TaxWatch (March 2014). Critical connections to care: Expanding the use of telemedicine in Florida will improve health outcomes and generate savings, at 19. Retrieved from <http://www.floridataxwatch.org/resources/pdf/CriticalConnectionsFINAL.pdf>
- 90 The California Telehealth Resource Center published an updated Telehealth Reimbursement Guide in January 2015. It is available at <http://www.caltrc.org/wp-content/uploads/2015/06/Reimbursement-Guide-January-2015.pdf>

ABOUT FLORIDA TAXWATCH

As an independent, nonpartisan, nonprofit taxpayer research institute and government watchdog, it is the mission of Florida TaxWatch to provide the citizens of Florida and public officials with high quality, independent research and analysis of issues related to state and local government taxation, expenditures, policies, and programs. Florida TaxWatch works to improve the productivity and accountability of Florida government. Its research recommends productivity enhancements and explains the statewide impact of fiscal and economic policies and practices on citizens and businesses.

Florida TaxWatch is supported by voluntary, tax-deductible donations and private grants, and does not accept government funding. Donations provide a solid, lasting foundation that has enabled Florida TaxWatch to bring about a more effective, responsive government that is accountable to the citizens it serves since 1979.

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All Florida TaxWatch research done under the direction of Dominic M. Calabro, President, CEO, Publisher & Editor.

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