The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Appropriations

BILL:	CS/SB 1526
INTRODUCER:	Appropriations Committee and Senator Harrell
SUBJECT:	Telehealth
DATE:	April 19, 2019
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Brown	HP	**Favorable**
2.	McKnight	Kidd	AHS	**Recommend: Fav/1 amendment**
3.	McKnight	Kynoch	AP	**Fav/CS**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1526 establishes a statutory basis and definition for telehealth. Specifically, the bill:

- Creates section 456.47, Florida Statutes, to establish the use of telehealth to provide services.
- Provides definitions for telehealth and telehealth provider.
- Establishes standards of practice for telehealth providers to ensure the scope of practice is consistent with the standard of practice for in-person health care services.
- Authorizes any Florida-licensed health care practitioner, within the relative scope of practice established by Florida law and rule, to use telehealth to deliver health care services to Florida patients and authorizes out-of-state providers to deliver health care services if they register and meet certain eligibility requirements.
- Prohibits a telehealth provider, with limited exceptions, from using telehealth to prescribe a controlled substance.
- Requires the Department of Health (DOH) to use the National Practitioner Data Bank to verify out-of-state telehealth provider information and to publish on its website the name and specific background information of each registered out-of-state telehealth provider.
- Requires out-of-state telehealth providers to meet specific requirements related to license restrictions or disciplinary actions, medical malpractice insurance, and designating a duly appointed registered agent for service of process in Florida.
- Prohibits an out-of-state telehealth provider from opening an office in Florida and from providing in-person health care services to patients located in Florida.

- Authorizes the board, or the DOH if there is no board, to take disciplinary action against an out-of-state telehealth provider including suspension or revocation of the provider's registration or the issuance of a reprimand or letter of concern.
- Requires that the venue for any civil or administrative action initiated by the DOH or by a patient who receives telehealth services from an out-of-state provider is located in the patient's home county or Leon County.
- Provides exceptions to the registration requirement for emergencies or for consultations between health care practitioners.
- Authorizes the applicable board, or the DOH if there is no board, to adopt rules.
- Prohibits a health insurer or HMO, effective January 1, 2020, from reimbursing a telehealth provider for a covered service in an amount less than if the service were delivered in-person.
- Requires the DOH, effective July 1, 2020, to annually review the amount of fees collected for telehealth services in the prior fiscal year and determine whether the fees are sufficient to fully implement the use of telehealth services. If the DOH determines the fees are insufficient, they are required to recommend fee adjustments in its annual Legislative Budget Request.

The bill has a significant negative fiscal impact on the DOH, however, for Fiscal Year 2019-2020, $261,289 in recurring funds and $15,020 in nonrecurring funds are appropriated from the Medical Quality Assurance Trust Fund, and four full-time equivalent (FTE) positions with associated salary rate of 145,870 to the DOH to implement the bill's provisions. See Section V.

The bill has an effective date of July 1, 2019, except as otherwise provided.

II. Present Situation:

Telehealth and Telemedicine

The term, "telehealth," is sometimes used interchangeably with "telemedicine." Telehealth, however, generally refers to a wider range of health care services that may or may not include clinical services. The American Telemedicine Association refers to telemedicine as the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status.[1]

Telehealth often collectively defines the telecommunications equipment and technology that are used to collect and transmit the data for a telemedicine consultation or evaluation. Telemedicine is not a separate medical specialty and does not change what constitutes proper medical treatment and services.

The federal Health Resource Services Administration (HRSA) defines telehealth as the use of electronic information and telecommunications technologies to support and promote long-distance clinical-health care, patient, and professional health-related education, public health and health administration. Technologies include videoconferencing, the Internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.[2]

[1] Ron Hedges, *Telemedicine, Information Governance and Litigation: The Chicken and the Egg, IGIQ: A Journal of AHMIA Blog,* (Feb. 15, 2018) https://journal.ahima.org/2018/02/15/telemedicine-information-governance-and-litigation-the-chicken-and-the-egg/ (last visited Mar. 11, 2019).
[2] *Id.*

For another definition, the federal Centers for Medicare and Medicaid Services (CMS) defines telehealth as:

> The use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance. Telehealth includes technologies such as telephones, facsimile machines, electronic mail systems, and remote patient monitoring devises, which are used to collect and transmit data for monitoring and interpretation.[3]

Federal Medicaid law does not recognize telemedicine as a distinct service but as an alternative method for the delivery of services. Medicaid defines telemedicine and telehealth separately, using telemedicine to define the interactive communication between the provider and patient and telehealth to describe the technologies, such as telephones and information systems.[4]

The Florida Medicaid Managed Medical Assistance (MMA) contract defines telemedicine as the practice of health care delivery by a practitioner who is located at a site other than the site where the patient is located for the purposes of evaluation, diagnosis, or recommendation of treatment.[5]

Florida Telehealth and Telemedicine Issues

Florida Board of Medicine

The Florida Board of Medicine (board) regulates the practice of physicians licensed under ch. 458, F.S. In 2013, the board convened a Telemedicine Workgroup to review its rules on telemedicine, which had not been amended since 2003. The 2003 rules focused on standards for the prescribing of medicine via the Internet.

On March 12, 2014, the board's new Telemedicine Rule, 64B8-9.0141 of the Florida Administrative Code (F.A.C.), became effective. The rule defined telemedicine,[6] established standards of care, prohibited the prescription of controlled substances, permitted the establishment of a doctor-patient relationship via telemedicine, and exempted emergency medical services.[7]

Two months after the initial rule's implementation, the board proposed an amendment to address concerns that the rule prohibited a physician from ordering controlled substances via telemedicine for hospitalized patients. The board indicated such a prohibition was not intended.[8]

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[3] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services *Telemedicine*, available at https://www.medicaid.gov/medicaid/benefits/telemed/index.html (last viewed March 14, 2019).
[4] *Id.*
[5] Agency for Health Care Administration, Core Contract Provisions (Effective 02/01/2018), Attachment II, p. 30, http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2018-02-01/Attachment_II_Core_Contract_Provisions_Feb_1_2018.pdf (last visited March 18, 2019).
[6] The term, "telemedicine," is defined to mean the practice of medicine by a licensed Florida physician or physician assistant where patient care, treatment, or services are provided through the use of medical information exchanged from one site to another via electronic communications. Telemedicine shall not include the provision of health care services only through an audio only telephone, email messages, text messages, facsimile transmission, U.S. Mail or other parcel service, or any combination thereof.
[7] Telemedicine, Rule 64B15-14.0081, F.A.C., also went into effect March 12, 2014, for osteopathic physicians.
[8] Florida Board of Medicine, *Latest News - Emergency Rule Related to Telemedicine*, http://flboardofmedicine.gov/latest-news/emergency-rule-related-to-telemedicine/ (last visited March 15, 2019).

Additional changes followed to clarify medical record requirements and the relationship between consulting or cross-coverage physicians.

On December 18, 2015, the board published another proposed rule to allow controlled substances to be prescribed through telemedicine for the limited treatment of psychiatric disorders.[9] The change relating to psychiatric disorders under Rule 64B8-9.0141-Standards for Telemedicine Practice, F.A.C., became effective March 7, 2016.[10]

On February 3, 2017, the board held a public hearing on a proposed amendment to Rule 64B8-9.0141, F.A.C., to prohibit the ordering of low-THC (Tetrahydrocannabinol) cannabis or medical cannabis through telemedicine. Additional public hearings were noticed for April and August of that year on the amended rule; however, the rule was eventually withdrawn in August 2017 without being amended.

On March 7, 2019, a variance request was filed with the board seeking a waiver to the provision that prohibits a physician or physician assistant from providing treatment or treatment recommendations and issuing a prescription based solely on responses to an electronic medical questionnaire. The petitioners argue that the medical questionnaire is used only for certain low acuity medical conditions and a physician reviews the patient's responses which includes the patient's demographics, current medication list and allergies, and when necessary the patient's medical record where the provider has access to it, and the patient is provided a response to his or her request within an hour if the request is made within the hours of 8 a.m. to 7 p.m. Central Time, seven days a week, 365 days a year.[11] The petition lists 14 medical conditions that would be included in the service for patients 18 months of age through 75 years of age.[12] The clinics are currently offered by the Mayo Clinic in Minnesota, Iowa, and Wisconsin. The conditions currently covered are:

- Allergies
- Cold (upper respiratory illness)
- Cold sores
- Conjunctivitis (pink eye)
- Influenza
- Lice
- Oral contraceptives (females ages 18-34)
- Sinusitis (sinus symptoms)
- Smoking cessation (age 18 plus)
- Sore throat
- Sunburn
- Tick exposure
- Urinary tract infections (females ages 12-75)
- Vaginal yeast infections (females ages 18-65).[13]

[9] Vol. 41/244, Fla. Admin. Weekly, Dec. 18, 2015, available at https://www.flrules.org/BigDoc/View_Section.asp?Issue=2011&Section=1 (last visited March 15, 2019).
[10] Florida Board of Medicine, Latest News, Feb. 23, 2016, available at http://flboardofmedicine.gov/latest-news/board-revises-floridas-telemedicine-practice-rule/ (last visited March 15, 2019).
[11] State of Florida, Department of Health, Board of Medicine, Petition for Waiver or Variance, Floyd B. Willis, M.D., et al, Mayo Clinic; Rule No. 64B8-9.0141, F.A.C. (March 8, 2019, Florida Admin. Register, Vol. 45, No. 47 p. 954) (on file with the Senate Committee on Health Policy).
[12] State of Florida, Department of Health, Board of Medicine, Petition for Waiver or Variance, *Id* at 10.
[13] *Id.*

In June 2019, the program, will add six new conditions:

- Acne
- Athlete's foot
- Impetigo
- Poison ivy
- Shingles
- Pertussis exposure without cough.

After a health care professional, a physician assistant, or nurse practitioner has reviewed the responses, the patient may be contacted if there are discrepancies between the form and an existing medical record with Mayo Health, discrepancies between the responses, or to clarify any information that was submitted electronically. Some patients may be prescribed a legend drug, other patients whose responses suggest a more serious illness or the provider would like to see the patient in person in order to meet the standard of care, may be advised that an in-person visit is necessary.[14] The patient receives an email message letting them know that a clinical note is in his or her patient portal, and if a drug has been prescribed, prescriptions are transmitted electronically to the patient's designated pharmacy via SureScripts service. No controlled substances are prescribed.[15]

Florida Medicaid Program's Use of Telehealth[16]

Medicaid managed care plans may elect to use telemedicine for any service as long as the managed care plan includes a fraud and abuse procedure to detect potential or suspected fraud or abuse in the use of telemedicine services.[17] The Agency for Health Care Administration's (AHCA) Medicaid managed care contracts for the MMA component of Statewide Medicaid Managed Care include specific contractual provisions for managed care plans that elect to use telehealth to deliver services, including, but not limited to:

- Must be licensed practitioners acting within the scope of their licensure.
- Telephone conversations, chart review, electronic mail message, or facsimile transmission are not considered telemedicine.
- Equipment and operations must meet technical safeguards required by 45 CFR 164.312.
- Providers must meet federal and state laws pertaining to patient privacy.
- Patient's record must be documented when telemedicine services are used.
- No reimbursement for equipment costs to provide telemedicine services.
- Must ensure the patient has a choice whether to access services through telemedicine or a face to face encounter.[18]

The MMA contracts also allow an MMA plan to assure access to specialists by providing telemedicine consultations with specialists not listed in the MMA plan's network at a location or via the patient's PCP office within 60 minutes travel time or 45 miles from the patient's zip

[14] *Id* at *12.*
[15] *Id.*
[16] *See* Agency for Health Care Administration, *Analysis of SB 280* (Oct. 9, 2017) (on file with the Senate Banking and Insurance Committee).
[17] *Id.*
[18] Agency for Health Care Administration, MMA Contract, Attachment II, Exhibit II-A (Effective 02/01/2018), p. 37, *available at* http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2018-02-01/EXHIBIT_II-A_MMA_Managed_Medical_Assistance_(MMA)_Program_Feb_1_2018.pdf (last visited March 18, 2019).

code.[19] MMA plans must also have policies and procedures specific to telemedicine, if they elect to provide services through this delivery system, relating to fraud and abuse, record-keeping, consent for services, and privacy.

Florida Medicaid statutes and the federal Medicaid laws and regulations consider telemedicine to be a delivery system rather than a distinct service; as such, Florida Medicaid does not have reimbursement rates specific to the telemedicine mode of service. In the fee-for-service system, Florida Medicaid reimburses services delivered via telemedicine at the same rate and in the same manner as if the service were delivered face-to-face.

Medicaid health plans can negotiate rates with providers, so they have the flexibility to pay different rates for services delivered via telemedicine. The managed care plans are required to submit their telemedicine policies and procedures to the AHCA for approval, but are not required to do so prior to use.[20]

Florida Telehealth Advisory Council

In 2016, legislation[21] was enacted that required the AHCA, with assistance from the DOH and the Office of Insurance Regulation (OIR), to survey health care practitioners, facilities, and insurers on telehealth utilization and coverage, and submit a report on the survey findings to the Governor, President of the Senate, and Speaker of the House of Representatives by December 31, 2016. The law also created a 15-member Telehealth Advisory Council and tasked the Council with developing recommendations and submitting a report on the survey findings to the Governor, President of the Senate, and Speaker of the House of Representatives by October 31, 2017.

Of the 11,900 health care facilities surveyed by the AHCA, 49 percent responded to the survey; all of the 54 health plans surveyed by the OIR responded to the survey; and the DOH received 26,579 responses to the survey. Among health care facilities surveyed by the AHCA, approximately 45 percent of hospitals responding to the survey offer telehealth services through their facilities.[22]

The facilities indicated that the benefits of providing services using telehealth included patient convenience, better care coordination, better patient outcomes, and better access to specialists. Health care facilities use telehealth most often to diagnose and treat patients, provide emergency care, or to provide or obtain a second opinion. The health care facilities also identified the greatest barriers to services using telehealth. The ongoing challenges for offering telehealth include, among other things, lack of health insurance reimbursement for services provided using telehealth, lack of funding for telehealth equipment, and an inability to determine the return on investment.

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[19] *Id* at *57*.
[20] Agency for Health Care Administration, *Statewide Medicaid Managed Care (SMMC) Policy Transmittal* (March 11, 2016), http://ahca.myflorida.com/medicaid/statewide_mc/pdf/plan_comm/PT_16-06_Telemedicine_03-11-2016.pdf (last visited March 18, 2019).
[21] Chapter 2016-240, Laws of Fla. The law designated the Secretary of the Agency for Health Care Administration (AHCA) as the council Chair, and designated the State Surgeon General and Secretary of the Department of Health as a member. The AHCA's Secretary and the State Surgeon General appointed 13 council members representing specific stakeholder groups.
[22] Agency for Health Care Administration, *Florida Report on Telehealth Utilization and Accessibility*, (December 2016), available at http://www.ahca.myflorida.com/SCHS/telehealth/docs/Telehealth_Report_Final.pdf (last visited April 15, 2019).

Although a national survey of health care executives in 2016 reported 63 percent of health care practitioners provide some services via telehealth, the survey conducted by DOH found that only six percent of the responding health care practitioners in Florida use telehealth to provide health care services.[23] The health care practitioners indicated that the major factors in adopting the use of telehealth in their private practice include the lack of insurance reimbursement for services provided using telehealth, lack of funding for telehealth equipment, and inability to determine return on investment.[24]

OIR found that 43 percent of Florida health insurers cover some form of telehealth services.[25] However, that coverage is usually very limited. Unlike the majority other states, Florida does not have any statutory requirements that coverage and reimbursement for telehealth services be covered the same as face-to-face services. The surveyed health plans indicated that the greatest barriers to covering and reimbursing for services provided using telehealth include government regulation,[26] concerns with liability, costs of the still evolving technology, and a need to significantly change payment and reimbursement guidelines.

The Telehealth Advisory Council's final report contained the following recommendations:[27]

- Establish a clear and consistent definition for telehealth, including the following elements:
  - Telehealth can be used for providing health care and public health services;
  - Telehealth includes both synchronous and asynchronous transmission modalities;
  - Health care practitioners treating Florida patients must be licensed in Florida or supervised by a Florida-licensed health care practitioner;
  - Health care practitioners must practice act within the scope of their practice;
  - Telehealth may occur between health care practitioners or a health care practitioner and a patient; and
  - There must be no limitations on geographic location or place of service;
- Require Florida-licensed health insurance plans to provide coverage for health services provided via telehealth, if coverage is available for the same service if provided in-person;
- Require Florida-licensed health insurance plans to provide reimbursement parity[28] for covered services provided via telehealth;
- Amend the Medicaid fee-for-service rule for telehealth to include coverage of store-and-forward and remote patient monitoring in addition to the currently-reimbursed synchronous or live transmission modality;
- Authorize Medicaid managed care plans to incorporate telehealth for the purpose of meeting network adequacy;
- Enact laws to authorize participation in multistate health care practitioner licensure compacts, if the eligibility requirements for licensure are equal to or more stringent than existing Florida requirements; and
- Authorize the establishment of a patient-practitioner relationship through telehealth, including for the purposes of prescribing and care coordination.

[23] *Id*.
[24] *Id*.
[25] *Id*.
[26] *Id*. This includes issues of interstate practice since each state is responsible for licensing the health care practitioners that provide services in its state.
[27] *Id*.
[28] Reimbursement parity is the requirement that health plans pay health care practitioners and facilities for covered health care services at a rate that is equivalent to reimbursement rate for the same service if performed face-to-face.

Other Statutory References to Telehealth or Telemedicine

Sprinkled throughout the Florida Statutes are numerous other references to the use of telehealth, telemedicine, or teleconference services to deliver health care services, including the following references:

- The Department of Management Services, to facilitate the development of applications, programs, and services, including, but not limited to telework and telemedicine.[29]
- Legislative intent for the Department of Children and Families (DCF) to use telemedicine for the delivery of health care services to children and adults with mental health and substance abuse disorders diagnoses for patient evaluation, case management, and ongoing patient care.[30]
- Recommendations by the DCF for voluntary and involuntary outpatient and inpatient services under ch. 394, F.S., with authorizations or second opinions provided by a physician assistant, a psychiatrist, a clinical social worker, or a psychiatric nurse.[31]
- Opinions provided under s. 394.467, F.S., relating to admission to a treatment facility to be provided through face-to-face examination, in person, or by electronic means.[32]

Jurisdiction and Venue

A Florida court has jurisdiction over a resident health care practitioner due to his or her presence in the state. For a nonresident health care profession, a Florida patient must establish in court that:

- The health care practitioner subjected himself or herself to jurisdiction through Florida's long-arm statute; and
- The health care practitioner had sufficient minimum contacts with the state so that he or she could reasonably anticipate being hauled into court in Florida.[33]

Under the long-arm statute, any health care practitioner (irrespective of whether he or she is a resident of the state) who commits certain enumerated acts is subject to the jurisdiction of the courts of Florida.[34] Such acts include:

- Operating, conducting, engaging in, or carrying on a business or business venture in this state or having an office or agency in this state;
- Committing a tortious act within this state;
- Causing injury to persons or property within this state arising out of an act or omission by the defendant outside this state, if, at or about the time of the injury, the health care practitioner was engaged in solicitation or service activities in this state; and

[29] Section 365.0135(2)(d)4, F.S.
[30] Section 394.453(3), F.S. The provision states, in part: The Legislature further finds the need for additional psychiatrists to be of critical state concern and recommends the establishment of an additional psychiatry program to be offered by one of Florida's schools of medicine currently not offering psychiatry. The program shall seek to integrate primary care and psychiatry and other evolving models of care for persons with mental health and substance use disorders. Additionally, the Legislature finds that the use of telemedicine for patient evaluation, case management, and ongoing care will improve management of patient care and reduce costs of transportation.
[31] Sections 394.4655(3)(a)1, and 349.4655(3)(b), F.S.
[32] Section 394.467(2), F.S. The examination under this section may be performed by a psychiatrist, a clinical psychologist, or if neither one of those is available, the second opinion may be provided by a physician who has the postgraduate training and experience in diagnosis and treatment of mental illness or by a psychiatric nurse.
[33] *Venetian Salami Co. v. Parthenais*, 554 So.2d 499, 501 (Fla. 1989).
[34] Section 48.193(1), F.S.

- Breaching a contract in this state by failing to perform act required by the contract to be performed in this state.[35]

"Venue" refers to the geographical area, that is the county or district, where a cause may be heard or tried.[36] For Florida residents, actions may be brought in the county where the defendant resides, where the cause of action accrued, or where the property in litigation is located.[37] An action against a nonresident may be brought in any county of the state.[38]

Service of process on a person outside of the state may be made by any officer authorized to serve process in the state where the person is served.[39]

National Practitioner Data Bank

The National Practitioner Data Bank (NPDB) is a federal databank that serves as a repository of information related to the professional competence and conduct of health care practitioners in the U.S.[40] Due to the perceived increase in medical malpractice litigation, the Congress created the NPDB to improve the quality of medical care and restrict the ability of an incompetent physician or dentist to move from state to state without the disclosure or discovery of the physician's or dentist's previous damaging or incompetent performance.[41]

The information collected in the NPDB includes:[42]
- Medical malpractice payments;
- Adverse licensure actions;
- Adverse clinical privileges actions related to professional competence or conduct;
- Adverse actions taken by the Drug Enforcement Administration (DEA) against a practitioners controlled substance registration;
- Exclusions from participation in Medicare, Medicaid, and other federal health care programs;
- Negative actions or findings by peer review and private accreditation organizations;
- Actions taken by certain state agencies, such as law enforcement, Medicaid Fraud Control Units, or state agencies administering state health care programs; and
- Health-care related criminal convictions and civil judgments.

Certain entities are required to submit the above-referenced actions to the NDPB. These include medical malpractice payers, hospitals and other health care entities, state licensing agencies, health plans, peer review and private accreditation organizations, federal government agencies, federal and state law enforcement agencies, state Medicaid Fraud Control Units, and state agencies administering state health care programs.[43]

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[35] *Id*.
[36] *Metnick & Levy, P.A. v. Seuling*, 123 So.3d 639 (Fla. 4th DCA 2013).
[37] Section 47.011, F.S.
[38] *Supra* note 36. This is subject to the doctrine of forum non conveniens.
[39] Section 48.194, F.S.
[40] U.S. Department of Health and Human Services, National Practitioner Data Bank, About Us, available at https://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp (last visited April 15, 2019).
[41] U.S. Department of Health and Human Services, NPDB Guidebook, (Oct. 2018), available at https://www.npdb.hrsa.gov/resources/NPDBGuidebook.pdf (last visited April 15, 2019).
[42] *Id* at pp. C-7 – C-8.
[43] *Id* at p. E-1.

The information in the NPDB is not available to the general public and is limited to certain entities. The information released may vary by the entity performing the query, including state practitioner regulatory agencies and boards.[44]

Although, the database initially only contained information related to physicians and dentists, it now includes many other types of health care practitioners.[45]

For physicians, the DOH is required to verify the information submitted by the applicant using the NPDB for disciplinary history and medical malpractice claim history at the time of initial licensure and each licensure renewal thereafter.[46]

Federal Telemedicine Provisions

Federal laws and regulations address telemedicine from several perspectives, including prescriptions for controlled substances, Medicare reimbursement requirements and privacy and security standards.

Special Registration Process – Drug Enforcement Agency

In Section 3232 of the federal Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act signed by President Trump on October 24, 2018,[47] Section 311(h)(2) requires the U.S. Attorney General (Attorney General), no later than one year after enactment, in consultation with the U.S. Department of Health and Human Services (HHS) Secretary, to promulgate regulations specifying the limited circumstances under which a special registration for telemedicine may be issued and the procedure for obtaining the registration. Previously, the federal Controlled Substances Act (CSA) contained language directing the Attorney General to promulgate rules for a special registration process for telemedicine; however, to date, no rule has been issued from the U.S. Department of Justice (DOJ) or the DEA. The Fall 2018 Unified Agenda of Office of Management and Budget had indicated that the DEA planned to publish a proposed rule in the *Federal Register*.[48] A registration process would allow a practitioner[49] to deliver, distribute, dispense, or prescribe via telemedicine a controlled substance to a patient that has not been medically examined in-person by a prescribing practitioner.[50]

Federal law further requires that practitioners meet three general requirements for the special registration:

- Must demonstrate a legitimate need for the special registration.
- Must be registered to deliver, distribute, dispense, or prescribe controlled substances in the state where the patient is located.

[44] *Id* at pp. D-1 – D-13.
[45] *Id*.
[46] Section 456.041(1)(b).
[47] Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, Pub. Law 115-271, 56-57 (2019).
[48] Victoria Elliot, Congressional Research Service, *The Special Registration for Telemedicine: In Brief* (December 7, 2018), p. 1, *available at* https://fas.org/sgp/crs/misc/R45240.pdf (last visited March 18, 2019).
[49] A practitioner is defined under Section 802(21) of Title 21, U.S.C., as a physician, dentist, veterinarian, scientific investigator, pharmacy, hospital, or other person licensed, registered, or otherwise permitted by the United States or the jurisdiction in which he practices or does research, to distribute, dispense, conduct research with respect to, administer, or use in teaching or chemical analysis, a controlled substance in the course of professional practice or research.
[50] *Supra* note 48 at 2.

- Must maintain compliance with federal and state laws when delivering, distributing, dispensing, and prescribing a controlled substance, unless the prescriber is:
  - Exempt from such registration in all states,[51] or
  - Is an employee or a contractor of the VA who is acting within the scope of his or her contract or is utilizing the registration of a hospital or clinic operated by the VA as permitted under these regulations.[52]

Protection of Personal Health Information

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects personal health information (PHI). Initial privacy rules were issued in 2000 by the HHS and later modified in 2002. These rules address the use and disclosure of an individual's health information and create standards for privacy rights. Additional privacy and security measures were adopted in 2009, with the Health Information Technology for Economic Clinical Health (HITECH) Act as part of the American Recovery and Reinvestment Act (ARRA).[53] The Office of the National Coordinator (ONC) under the HITECH Act was given the responsibility of implementing provisions relating to interoperability, accessibility, privacy, and security of health information technology.[54]

Only certain entities are subject to HIPAA's provisions. These "covered entities" include:
- Health plans;
- Health care providers;
- Health care clearinghouses; and
- Business associates of the entities listed above.

While not a covered entity as an individual, the patient still maintains his or her privacy and confidentiality rights regardless of the method in which a medical service is delivered. The HITECH Act specifically identified telemedicine as an area for review and consideration, and funding was provided to, in part, strengthen infrastructure and tools to promote telemedicine.[55]

Under the provisions of HIPAA and the HITECH Act, a health care provider or other covered entity participating in telemedicine is required to meet the same technical and physical HIPAA and HITECH requirements as would be required for a physical office visit. These requirements include ensuring that the equipment and technology are HIPAA compliant, reduce travel requirements for patients in remote areas, and facilitate home health care and remote patient monitoring.[56]

The HITECH and ARRA legislation also expanded who was considered a "business associate" under the updated security and privacy rules. The final rule in January 2013 modified the definition to include patient safety organizations, health information organization, e-prescribing gateways, and other persons that facilitate data transmissions and vendors of personal health

[51] The Act exempts certain manufacturers, distributers, and dispensers of controlled substances.
[52] *Supra* note 48 at 5 and 21 U.S.C. ss. 823 and 831(h)(1) (January 2019).
[53] American Recovery and Reinvestment Act (ARRA); Public Law 111-5 (2009).
[54] Office of the National Coordinator for Health Information Technology, HealthIT.gov, *Health IT Legislation* (February 10, 2019), *available at* https://www.healthit.gov/topic/laws-regulation-and-policy/health-it-legislation (last visited March 18, 2019).
[55] ARRA; Public Law 111-5 (2009), s. 3002(b)(2)(C) and s. 3011.
[56] *Supra* note 53.

records to one or more persons. These organizations and businesses would be required to enter into business associate agreements under the revised definition.[57]

The final rule also includes two new e-prescribing measures relating to opioids (Schedule II controlled substances) in the performance based scoring methodology for the Medicare's Electronic Health Records Incentive Program. Beginning in Calendar Year (CY) 2019, a query of a state's prescription drug monitoring program (PDMP) is optional; however, this query becomes required in CY 2020.[58] The second measure added is verification of an Opioid Treatment Agreement.[59] As with the PDMP query, the verification of the agreement is also optional for CY 2019 and mandatory in CY 2020.

Prescribing Via the Internet

Federal law has specifically prohibited the prescribing of controlled substances via the Internet without an in-person evaluation. A valid prescription is one that is issued for a legitimate medical purpose in the usual course of professional practice by a practitioner who has conducted at least one in-person medical evaluation of the patient or a covering practitioner.[60] The in-person evaluation requires that the patient be in the physical presence of the provider without regard to the presence or conduct of other professionals.[61]

Federal law at 21 U.S.C. s. 829 provides:

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

Telemedicine Exception

The DEA and the DOJ issued their own definition of telemedicine in April 2009, as required under the Ryan Haight Online Pharmacy Consumer Protection Act (Haight Act).[62] The federal regulatory definition of telemedicine under the DEA includes, but is not limited to, the following elements:

- The patient and practitioner are located in separate locations;
- The patient and practitioner communicate via a telecommunications system;
- The practitioner must meet other registration requirements for the dispensing of controlled substances via the Internet; and
- Certain practitioners (VA employees, for example) or practitioners in certain situations (public health emergencies) may be exempted from registration requirements.[63]

However, the Haight Act[64] created an exception for the delivery, distribution, or dispensing of a controlled substance by a practitioner engaged in the practice of telemedicine or for a covering

[57] 78 Fed. Reg. 5687, (Jan. 25, 2013) (to be codified at 45 CFR 160.103, Definition of Business associate).
[58] Centers for Medicare and Medicaid Services, *Fiscal Year (FY) 2019 Medicare Hospital Inpatient Prospect Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Final Rule Fact Sheet)* (August 2, 2018), *available at* https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2019-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-acute-0 (last visited Mar. 19, 2019).
[59] *Id.*
[60] Ryan Haight Online Pharmacy Consumer Protection Act of 2008; Public Law 110-425 (H.R. 6353); 21 U.S.C. sec. 829(e)(2)(A)(2006 Ed., Supplement 4).
[61] *Id.*
[62] *Id.*
[63] Drug Abuse and Prevention, Definitions, 21 U.S.C. s. 802 (54).
[64] *Supra* note 60.

practitioner where the practitioner has conducted the required one, in-person medical evaluation through the practice of telemedicine within the previous 24 months.[65] The practitioner is still subject to the requirement that all controlled substances be issued for a legitimate purpose by a practitioner acting in the usual course of professional practice. The definition of the "practice of telemedicine" includes seven distinct categories or exceptions. Those seven distinct categories require the practice of telemedicine be delivered or conducted:

- To a patient that is located in a hospital or a clinic.
- During an in-person examination with another practitioner.
- Through the Indian Health Service.
- During a public health emergency.
- By a practitioner that has obtained a special registration for telemedicine.
- During a medical emergency situation.
- At the discretion of the DEA.[66]

The DEA regulations require practitioners to meet certain requirements before issuing prescriptions for controlled substances electronically. All controlled substance prescriptions must be issued through an application that can meet standards that include, but is not limited to, user controls and locks, prescriber signature verification, final prescription review and approval by the prescriber, two factor authentication, and record archival and audit functionality.[67]

Medicare Provisions

In a proposed rule issued on November 30, 2018, prescription drug plan sponsors and Medicare Advantage organizations will be required to establish electronic prescription drug programs that comply with e-prescribing standards under the Medicare Prescription Drug, Improvement, and Modernization Act.[68] The law and regulation does not require that prescribers or dispensers comply with the requirement; however, any prescribers and dispensers who electronically transmit and receive prescriptions and certain other pieces of information for covered drugs on behalf of Medicare Part D eligible beneficiaries, directly or through an intermediary, are required to comply with any standards.[69]

U.S. Department of Veterans Affairs Telehealth

The VA has been using telehealth to increase access to health care for veterans through a variety of programs including real-time telehealth, the Polytrauma Rehabilitation Network, TeleMental Health, TeleRehabilitation, and Telesurgery. The VA's telehealth services use real-time technologies to provide health care access through Clinical Video Telehealth (CVT). Examples of services that might be provided include access to a specialty care physician with the patient located at a local clinic closest to the veteran's home and a specialty physician who may not be available at the clinic closest to the veteran's home. Not all of the clinics have the specialty care available and it may be difficult for some of the veterans to travel distances to receive care, so

[65] *Id*.
[66] Information from the Congressional Research Service, *The Special Registration for Telemedicine: In Brief* (December 7, 2018), *available at* https://www.everycrsreport.com/files/20181207_R45240_d2f8e1a6693c4181f2c46db32a29f0595dfb5d03.pdf. (last visited March 19, 2019). Based on 21 U.S.C. s. 802(54) and s. 831(h).
[67] Requirements for Electronic Orders and Prescriptions, 21 C.F.R., pt. 1311, sub. C.
[68] Fed. Reg. Vol. 83, No. 231 (Nov. 30, 2018), p. 62164, 423.160.
[69] *Id.*

CVT is used to make diagnoses, manage care, perform check-ups, and actually provide care for these veterans.[70]

A VA telehealth report in 2013, on home health services showed that home telehealth services had reduced bed days care 59 percent and hospital admissions by 35 percent, while clinical video telehealth services reduced bed days of care for mental health patients by 38 percent.[71] Clinical video telehealth saved approximately $34.45 per consult and store-and-forward telehealth saved approximately $38.81 per consult in travel costs for the patient.[72]

For the VA, a health care provider who is licensed to practice a health care specialty listed and qualified under 38 U.S.C. 7402(b),[73] is appointed to an occupation within the Veterans Health Administration that is listed as authorized, maintains his or her health credentials as required, and is not a contractor for the VA. The health care provider is authorized to provide telehealth services within the scope of their practice and in accordance with the privileges granted by the VA, irrespective of the state or location within the state where the health care provider or the beneficiary is located.[74] The health care provider must practice within the limitations imposed by the Controlled Substances Act, 21 U.S.C. 801, et seq, as well as any other provisions set forth by the VA. This federal regulation preempts state law to achieve an important federal interest to care for veterans.[75]

Federal Trade Commission

In recent years the Federal Trade Commission (FTC) has sent comments or intervened in state and federal actions relating to telehealth and telemedicine rulemaking and litigation and how it relates to competition. In one of its more recent letters on the topic, to the VA, the FTC commented on a proposed telemedicine rule allowing VA telehealth providers to provide services to or from non-federal sites, regardless of whether the provider was licensed in the state where the provider was located.[76] The FTC writes in support of the proposed rules with the following:

> Our findings reinforce the view that the Proposed Rule would enable the use of telehealth to reach underserved areas and VA beneficiaries who are unable to travel, improving the ability of the VA to utilize its health care resources. Accordingly, we believe that the Proposed Rule would likely increase access to telehealth services, increase the supply of telehealth providers, increase the range of choices available to patients, improve health care outcomes, and reduce the VA's health care costs, thereby benefitting veterans.

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[70] U.S. Department of Veterans Affairs, *VA Telehealth Services: Real-Time Clinic Based Video Telehealth, https://www.telehealth.va.gov/real-time/index.asp* (last visited March 11, 2019).
[71] Center for Connected Health Policy, *Telehealth Private Payer Laws: Impact and Issues,* Millbank Memorial Fund (August 2017), p. 4, https://www.milbank.org/wp-content/uploads/2017/08/MMF-Telehealth-Report-FINAL.pdf (last viewed March 14, 2019).
[72] *Id.*
[73] To be eligible for appointment in the Administration, a health care provider must meet the federal qualifications as listed in this statute for a physician, dentist, nurse, director of hospital, domiciliary, center, or outpatient clinic, podiatrist, optometrist, pharmacist, psychologist, social worker, marriage and family therapist, licensed professional mental health counselor, chiropractor, peer specialist, or other health care position as designated by the Secretary.
[74] 38 CFR section 17.417, Health care providers practicing via telehealth.
[75] 38 CFR section 17.417(c), Health care providers practicing via telehealth.
[76] U.S. Federal Trade Commission, Letter to Director of Regulation Policy and Management (November 1, 2017), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-department-veterans-affairs-regarding-its-proposed-telehealth-rule/v180001vatelehealth.pdf (last visited March 18, 2019).

…

> The VA's Proposed Rule involves the intersection of two important and current FTC advocacy areas that directly affect many consumers: occupational licensing and telehealth. Since the late 1970s, the Commission and its staff have conducted economic and policy studies relating to licensing requirements for various occupations and professions[77], and submitted numerous advocacy comments to state and self-regulatory entities on competition policy and anti-trust law issues relating to occupational regulation, including the regulation of health professions.[78]

The FTC also commented on telemedicine legislation in Alaska, occupational board rules in Delaware, investigated the Texas Board of Medicine, and filed a joint brief with the DOJ over restrictions relating to dentistry in Texas.[79, 80, 81]

Interstate Medical Licensure Compact

The Interstate Medical Licensure Compact (IMLC) provides an expedited pathway for medical and osteopathic physicians to qualify to practice medicine across state lines within a Licensure Compact. Currently, 24 states and one territory, which cover 31 medical and osteopathic boards, participate in the IMLC and as of February 2019, six other states have active legislative to join the IMLC.[82, 83]

Approximately 80 percent of physicians meet the eligibility guidelines for licensure through the IMLC.[84] The providers' applications are expedited by using the information previously submitted in their State of Principal Licensure (SPL). Once the SPL has been established and a Letter of Qualification has been awarded, the physician can select which states to practice in under his or her compact license. However, to qualify for consideration for that compact license, the physician must hold a full, unrestricted medical license from a compact member state and meet one of the following additional qualifications:

- The physician's primary residency is the SPL.
- The physician's practice of medicine occurs in the SPL for at least 25 percent of the time.

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[77] *See* Carolyn Cox & Susan Foster, BUREAU OF ECON., FED. TRADE COMM'N, The Costs and Benefits of Occupational Regulation (1990), http://www.ramblemuse.com/articles/cox_foster.pdf (last visited March 18, 2019).
[78] *Supra* note 76.
[79] The Alaskan legislation would allow licensed Alaskan physicians located out of state to provide telehealth services in the same manner as in-state providers. *See* https://www.ftc.gov/news-events/press-releases/2016/03/ftc-staff-comment-alaska-legislature-should-consider-potential (last visited March 18, 2019).
[80] In Delaware, there were three situations, one involving whether telepractice was appropriate for Speech/Language Pathologists, another for the occupational board that regulates occupational therapists, and a third for the board that regulates the dietitians and nutritionists. https://www.ftc.gov/policy/advocacy/advocacy-filings/2016/08/ftc-staff-comment-delaware-board-occupational-therapy, https://www.ftc.gov/policy/advocacy/advocacy-filings/2016/11/ftc-staff-comment-delaware-board-speechlanguage , and https://www.ftc.gov/news-events/press-releases/2016/08/ftc-staff-comment-delaware-dieteticsnutrition-board-proposal (last visited March 18, 2019).
[81] In Texas, the FTC began an investigation of whether the Texas Medical Board violated federal antitrust law by adopting rules restricting the practice of telemedicine. *See* https://www.ftc.gov/news-events/press-releases/2017/06/federal-trade-commission-closes-investigation-texas-medical-board (last visited March 18, 2019).
[82] Interstate Medical Licensure Compact, *The IMLC*, https://imlcc.org/ (last visited Mar. 8, 2019).
[83] Interstate Medical Licensure Compact, Draft Executive Committee Meeting Minutes (February 5, 2019), https://imlcc.org/wp-content/uploads/2019/02/2019-IMLC-Executive-Committee-Minutes-February-5-2019-DRAFT.pdf (last visited Mar. 8, 2019).
[84] *Supra* note 82.

- The physician's employer is located in the SPL.
- The physician uses the SPL as his or her state of residence for U.S. federal income tax purposes.

Additionally, the physician must maintain his or her licensure from the SPL at all times. The SPL may be changed after the original qualification. The application cost is $700 plus the cost of the license for the state in which the applicant wishes to practice. The individual state fees vary from a low of $75 in Alabama to a high of $700 in Maine.[85]

III. Effect of Proposed Changes:

This bill creates s. 456.47, F.S., and establishes statutory provisions for the use of telehealth to provide services.

Telehealth Providers

The bill:

- Defines telehealth as the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services. It does not include audio-only telephone calls, e-mail messages, or facsimile transmission.
- Authorizes any Florida-licensed health care practitioner or registered out-of-state health care providers to provide health care-related services using telehealth.
- Requires Florida-licensed telehealth providers to be one of the following licensed health care practitioners listed below[86], licensed under a multi-state health care licensure compact of which Florida is a member state, or registered as an out-of-state telehealth provider:

Behavioral Analyst	Pedorthist
Acupuncturist	Prosthetist
Allopathic physician	Medical Physicist
Osteopathic physician	Emergency Medical Technician
Chiropractor	Paramedic
Podiatrist	Massage Therapist
Optometrist	Optician
Nurse	Hearing Aid Specialist
Pharmacist	Clinical Laboratory Personnel
Dentist	Respiratory Therapist
Dental Hygienist	Psychologist
Midwife	Psychotherapist
Speech Therapist	Dietician/Nutritionist
Occupational Therapist	Athletic Trainer
Radiology Technician	Clinical Social Worker
Electrologist	Marriage and Family Therapist
Orthotist	Mental Health Counselor

[85] Interstate Medical Licensure Compact, *What Does It Cost?* https://imlcc.org/what-does-it-cost/ (last visited Mar. 8, 2019).
[86] These are professionals licensed under s. 393.17; part III, ch. 401; ch. 457; ch. 458; ch. 459; ch. 460; ch. 461; ch. 463; ch. 464; ch. 465; ch. 466; ch. 467; part I, part III, part IV, part V, part X, part XIII, and part XIV, ch. 468; ch. 478; ch. 480; part II and part III, ch. 483; ch. 484; ch. 486; ch. 490; or ch. 491.

Telehealth Standards of Practice

The bill:

- Establishes that the standard of care for telehealth providers is the same as the standard of care for health care practitioners or health care providers providing in-person health care services to patients in this state. This ensures that a patient receives the same standard of care irrespective of the modality used by the health care professional to deliver the services.
- Authorizes a telehealth provider to use telehealth to perform a patient evaluation if an in-person physical examination is not required and if a patient evaluation is sufficient to diagnose and treat the patient.
- Prohibits a telehealth provider from prescribing a controlled substance unless prescribed for the treatment of a psychiatric disorder; inpatient treatment at a facility licensed under ch. 395, F.S.; treatment of a patient receiving hospice services as defined under s. 400.601, F.S.; or treatment of a nursing home facility resident as defined under s. 400.021(12), F.S.
- Provides that a nonphysician telehealth provider using telehealth and acting within the applicable scope of practice, as established under Florida law, may not be interpreted as practicing medicine without a license.
- Requires a telehealth provider to document in a patient's medical record the health care services rendered using telehealth according to the same standard as used for in-person services. Medical records, including video, audio, electronic, or other records generated as a result of providing such services, are confidential pursuant to ss. 395.3025(4) and 456.057, F.S.

Out-of-State Telehealth Providers

The bill:

- Authorizes an out-of-state telehealth provider to provide health care services to a patient located in Florida if the health care professional registers with the applicable board, or the DOH if there is no board, to provide telehealth services, and provides health care services within the scope of practice established by Florida law and rule, to patients in this state. To register or renew registration as an out-of-state telehealth provider, the health care professional must:
  - Complete an application;
  - Possess an active, unencumbered license, consistent with the definition of "telehealth provider" listed above, in a U.S. state or jurisdiction and against whom no disciplinary action has been taken during the five years before submission of the application;[87]
  - Designate a duly appointed registered agent for service of process in Florida.
  - Maintain professional liability coverage or financial responsibility (medical malpractice insurance), including for telehealth services provided to patient's not located in the provider's home state, to the same degree that Florida-licensed practitioners must be covered under Florida law; and
- Requires the DOH to use the National Practitioner Data Bank to verify information submitted by an out-of-state telehealth provider.
- Requires out-of-state telehealth providers to notify the applicable board, or the DOH if there is no board, of restrictions placed on the health care professional's license to practice or

[87] The bill requires the DOH to consult the National Practitioner Data Bank to verify whether adverse information is available for the registrant.

disciplinary actions taken against the health care practitioner within five days after such occurrence.

- Prohibits an out-of-state telehealth provider from opening an office in Florida and from providing in-person health care services to patients located in Florida.
- Requires an out-of-state telehealth provider, who is a pharmacist, to use a pharmacy holding a Florida permit, a nonresident pharmacy registered in Florida, or a nonresident pharmacy or outsourcing facility holding a nonresident sterile compounding permit to dispense medicinal drugs to Florida patients.
- Requires the DOH to publish on its website the name of each registered out-of-state telehealth provider. It must also include the following background information, to the extent applicable, for each registrant:
  - Name;
  - Health care occupation;
  - Completed health care training and education, including completion dates and any certificates or degrees obtained;
  - Out-of-state health care license with license number;
  - Florida telehealth provider registration number;
  - Specialty;
  - Board certification;
  - Five-year disciplinary history, including sanctions and board actions;
  - Medical malpractice insurance provider and policy limits, including whether the policy covers claims which arise in this state; and
  - The name and address of the registered agent designated for the service of process in this state.
- Authorizes the board, or the DOH if there is no board, to take disciplinary action against an out-of-state telehealth provider if the registrant:
  - Fails to notify the board or the DOH of any adverse actions taken against his or her license within five days after such adverse action;
  - Has restrictions placed on or disciplinary action taken against his or her license in any state or jurisdiction; or
  - Violates any of the requirements for the registration of out-of-state telehealth providers.
  - Commits any act that constitutes grounds for disciplinary action
  - Clarifies that disciplinary action may include suspension or revocation of the provider's registration or the issuance of a reprimand or letter of concern.

In addition, the bill:

- Requires that the venue for any civil or administrative action initiated by the DOH or by a patient who receives telehealth services from an out-of-state provider is located in the patient's home county or Leon County.
- Provides exceptions to the registration requirement for emergencies or for consultations between health care practitioners.
- Provides the applicable board, or the DOH if there is no board, with rulemaking authority.
- Prohibits a health insurer or HMO, effective January 1, 2020, from reimbursing a telehealth provider for a covered service in an amount less than if the service were delivered in-person.
- Requires the DOH, effective July 1, 2020, to annually review the amount of fees collected for telehealth services in the prior fiscal year and determine whether the fees are sufficient fully

implement the use of telehealth services. If the DOH determines the fees are insufficient, they are required to recommend fee adjustment in its annual Legislative Budget Request.

- Provides for Fiscal Year 2019-2020, an appropriation of $261,389 in recurring funds and $15,020 in nonrecurring funds from the Medical Quality Assurance Trust Fund, and four full-time equivalent (FTE) positions to the DOH to offset the workload increase anticipated from the telehealth provider registration requirement.

The bill has an effective date of July 1, 2019, except as otherwise provided.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Providing a statutory definition for telehealth will add clarity to an area that has lacked a standard in state law and clarify the use of technological modalities as an acceptable way to treat patients within their scope of practice. Further, health plans noted the need for clarity in the allowable modes for telehealth for coverage and reimbursement purposes.

These changes may encourage the use of telehealth options, which may result in reduced health care costs; increased patient access to providers, especially in medically underserved areas; improved quality and continuity of care; and faster and more convenient treatment resulting in reduction of lost work time and travel costs for patients.

Preventing the unnecessary use of intensive services, such as emergency department visits, can reduce overall health care costs and improve health outcomes.

C. Government Sector Impact:

The DOH will experience a recurring increase in cost and workload associated with the registration, enforcement, and communication of out-of-state telehealth providers that are licensed in another jurisdiction. The number of out-of-state healthcare providers who will apply for telehealth registration is currently indeterminate.[88]

In Fiscal Year 2019-2020, the bill provides the DOH with $261,389 in recurring funds and $15,020 in nonrecurring funds from the Medical Quality Assurance Trust Fund, in addition to four full-time equivalent (FTE) positions with the associated rate salary of 145,870, to address the workload associated with the registration, enforcement, and communication of out-of-state telehealth providers.

The DOH also anticipates additional recurring and nonrecurring costs, however, the DOH anticipates being able to absorb the following associated costs within existing budget authority:[89]

- Recurring cost associated with queries to the National Practitioner Data Bank to verify information submitted by an out-of-state telehealth provider. The estimated cost is $3.00 per query. The impact is indeterminate at this time.
- Nonrecurring costs for rulemaking.
- Nonrecurring increase in costs and workload associated with the application development to implement provisions of the bill.
- Increase in workload associated with updating the Licensing and Enforcement Database System (LEIDS), the Medical Quality Assurance websites, and online services for each profession to implement provisions of the bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. None. Statutes Affected:

This bill amends the following sections of the Florida Statutes: 627.42396 and 641.31.

This bill creates section 456.47 of the Florida Statutes.

[88] *See* Department of Health, Analysis of HB 23 (March 22, 2019) (on file with the Senate Appropriations Subcommittee on Health and Human Services).
[89] *Id*.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Appropriations on April 18, 2019:
The committee substitute:

- Creates s. 456.47, F.S., to establish the use of telehealth to provide services and replaces the provision that created s. 456.4501, F.S. to establish Florida's telehealth statute.
- Revises the standard of practice for telehealth providers.
- Authorizes any Florida-licensed health care practitioner to use telehealth to deliver health care services to Florida patients; and authorizes an out-of-state telehealth provider to deliver health care services to Florida patients if they registered and meet certain eligibility requirements. The bill was previously limited only to providers who held a Florida license under chs. 458 (medical doctors) or 459 (osteopathic physicians), F.S.
- Requires the DOH to use the National Practitioner Data Bank to verify information submitted by an out-of-state telehealth provider and to publish on its website the name and specific background information of each registered out-of-state telehealth provider.
- Requires out-of-state telehealth providers to notify the applicable board, or the DOH if there is no board, of restrictions placed on the health care professional's license to practice or disciplinary actions taken against the health care practitioner within five days after such occurrence.
- Requires a provider to maintain medical malpractice insurance to the same degree that Florida-licensed practitioners must be covered under Florida law.
- Prohibits an out-of-state telehealth provider from opening an office in Florida and from providing in-person health care services to patients located in Florida.
- Authorizes the board, or the DOH if there is no board, to take disciplinary action against an out-of-state telehealth provider including suspension or revocation of the provider's registration or the issuance of a reprimand or letter of concern.
- Requires that the venue for any civil or administrative action initiated by the DOH or by a patient who receives telehealth services from an out-of-state provider is located in the patient's home county or Leon County.
- Revises exceptions to the registration requirement, providing exceptions for emergencies or for consultations between health care practitioners. Exemptions were previously limited to only emergency physicians, emergency medical technicians, paramedics, or emergency dispatchers.
- Prohibits a health insurer or HMO, effective January 1, 2020, from reimbursing a telehealth provider for a covered service in an amount less than if the service were delivered in-person.
- Requires the DOH, effective July 1, 2020, to annually review the amount of fees collected for telehealth services in the prior fiscal year and determine whether the fees are sufficient fully implement the use of telehealth services. If the DOH determines the fees are insufficient, they are required to recommend fee adjustment in its annual Legislative Budget Request.

- Removes requirements in the bill that would have impacted the Florida Medicaid program, related to:
  - Amending s. 409.967, F.S., to prohibit Medicaid managed care plans from using providers who exclusively provide services through telehealth to achieve network adequacy;
  - Creating s. 627.42393, F.S., to provide reimbursement requirements for health insurers relating to telehealth services;
  - Amending s. 641.31, F.S., to prohibit a health maintenance organization from requiring a subscriber to receive services via telehealth; and
  - Creating s. 641.31093, F.S., to provide reimbursement requirements for health maintenance organizations relating to telehealth services.
- Appropriates $261,389 in recurring funds and $15,020 in nonrecurring funds from the Medical Quality Assurance Trust Fund, and four full-time equivalent (FTE) positions with associated salary rate of 145,870 to the DOH to offset the workload increase anticipated from the telehealth provider registration requirement.
- Provides an effective date of July 1, 2019, except as otherwise provided.

B. Amendments:

None.