HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 247 Telehealth Practice Standards
SPONSOR(S): Professions & Public Health Subcommittee, Fabricio and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 660

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Professions & Public Health Subcommittee	17 Y, 0 N, As CS	Grabowski	McElroy
2) Health & Human Services Committee	20 Y, 0 N	Grabowski	Calamas

SUMMARY ANALYSIS

Telehealth is the remote provision of health care services through the use of technology. Telehealth is not a type of health care service but rather is a mechanism for delivery of health care services. Health care professionals use telehealth as a platform to provide traditional health care services in a non-traditional manner. These services include, among others, preventative medicine and the treatment of chronic conditions.

Practitioners have the ability to prescribe drugs via telehealth, but state and federal law limits the ability of practitioners to dispense controlled substances using telehealth. Controlled substances are drugs with an increased potential for patient abuse. The Florida Comprehensive Drug Abuse Prevention and Control Act classifies controlled substances into five categories, called Schedules. Schedule I drugs have a high potential for abuse and no accepted medical use. Drugs classified in schedules II through V still have the potential for abuse, but also have well established medical uses.

At present, Florida law prohibits a telehealth provider from using telehealth services to prescribe a controlled substance except when treating:

- A psychiatric disorder;
- An inpatient at a hospital;
- A patient receiving hospice services; and
- A resident of a nursing home facility.

Federal law requires a practitioner to conduct at least one in-person medical evaluation prior to dispensing a controlled substance to a patient via telehealth.

CS/HB 247 allows practitioners to prescribe Schedule III, IV, and V controlled substances via telehealth.

The bill has no fiscal impact on state or local government.

The bill provides an effective date of July 1, 2021.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Telehealth

Telehealth is not a type of health care service but rather is a mechanism for delivery of health care services. Health care professionals use telehealth as a platform to provide traditional health care services in a non-traditional manner. These services include, among others, preventative medicine and the treatment of chronic conditions.[1]

Telehealth, in its modern form,[2] started in the 1960s in large part driven by the military and space technology sectors.[3] Specifically, telehealth was used to remotely monitor physiological measurements of certain military and space program personnel. As this technology became more readily available to the civilian market, telehealth began to be used for linking physicians with patients in remote, rural areas. As advancements were made in telecommunication technology, the use of telehealth became more widespread to include not only rural areas but also urban communities. Due to recent technology advancements and general accessibility, the use of telehealth has spread rapidly and is now becoming integrated into the ongoing operations of hospitals and healthcare systems around the country.[4] In fact, there are currently an estimated 200 telehealth networks, with 3,000 service sites in the U.S.[5]

Telehealth is used to address several problems in the current health care system. Inadequate access to care is one of the primary obstacles to obtaining quality health care.[6] This occurs in both rural areas and urban communities.[7] Telehealth reduces the impact of this issue by providing a mechanism to deliver quality health care, irrespective of the location of a patient or a health care professional. Cost is another barrier to obtaining quality health care.[8] This includes the cost of travel to and from the health care facility, as well as related loss of wages from work absences. Costs are reduced through telehealth by decreasing the time and distance required to travel to the health care professional. Two more issues addressed through telehealth are the reutilization of health care services and hospital readmission. These often occur due to a lack of proper follow-up care by the patient[9] or a chronic condition.[10] These issues however can potentially be avoided through the use of telehealth and telemonitoring.[11]

Regulation of Telehealth in Florida

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[1] U.S. Department of Health and Human Services, *Report to Congress: E-Health and Telemedicine*, (August 2016), available at https://aspe.hhs.gov/system/files/pdf/206751/TelemedicineE-HealthReport.pdf (last visited May 6, 2019).
[2] Historically, telehealth can be traced back to the mid to late 19th century with one of the first published accounts occurring in the early 20th century when electrocardiograph data were transmitted over telephone wires. See *supra* note **Error! Bookmark not defined.** at p. 9.
[3] *Id.*
[4] American Telemedicine Association, *Telehealth Basics*, available at https://www.americantelemed.org/resource/why-telemedicine/ (last visited May 6, 2019).
[5] *Id.*
[6] *Id.*
[7] *Id*.
[8] *Id.*
[9] Post-surgical examination subsequent to a patient's release from a hospital is a prime example. Specifically, infection can occur without proper follow-up and ultimately leads to a readmission to the hospital.
[10] For example, diabetes is a chronic condition which can benefit by treatment through telehealth.
[11] Telemonitoring is the process of using audio, video, and other telecommunications and electronic information processing technologies to monitor the health status of a patient from a distance.

Service Providers

In 2019, the Legislature passed and the Governor signed CS/CS/HB 23, which established a framework for telehealth services in Florida law.[12] The act broadly defines telehealth as the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services, including, but not limited to:

- Assessment, diagnosis, consultation, treatment, and monitoring of a patient;
- Transfer of medical data;
- Patient and professional health-related education;
- Public health services; and
- Health administration.

Telehealth does not include audio-only telephone calls, e-mail messages, or facsimile transmission under Florida law.[13] No express authority is needed to communicate using these methods.

Health care services may be provided via telehealth by a Florida-licensed health care practitioner, a practitioner licensed under a multistate health care licensure compact of which Florida is a member,[14] or a registered out-of-state-health care provider.[15]

Out-of-state telehealth providers must register biennially with DOH or the applicable board to provide telehealth services, within the relevant 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:

- Hold an active and unencumbered license, which is substantially similar to a license issued to a Florida practitioner in the same profession, in a U.S. state or jurisdiction and
- Not have been subject to licensure disciplinary action during the five years before submission of the registration application;[16]
- Not be subject to a pending licensure disciplinary investigation or action;
- Not have had license revoked in any state or jurisdiction;
- Designate a registered agent in this state for the service of process;
- Maintain professional liability coverage or financial responsibility, which covers services provided to patients not located in the provider's home state, in the same amount as required for Florida-licensed practitioners;[17] and
- Prominently display a link to the DOH website, described below, which provides public information on registered telehealth providers.[18]

Standards of Practice

Current law sets the standard of care for telehealth providers at the same level 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

[12] Ch. 2019-137, L.O.F.
[13] S. 456.47(1), F.S.
[14] Florida is a member of the Nurse Licensure Compact. *See* s. 464.0095, F.S.
[15] *Supra* note 13.
[16] The bill requires DOH to consult the National Practitioner Data Bank to verify whether adverse information is available for the registrant.
[17] Florida law requires physicians, acupuncturists, chiropractic physicians, dentists, anesthesiologist assistants, advanced practice registered nurses, and licensed midwives to demonstrate $100,000 per claim and an annual aggregate of $300,000 of professional responsibility (*see* ss. 458.320 and 459.0085, F.S.; r. 64B1-12.001. F.A.C; r. 64B2-17.009, F.A.C.; 64B5-17.0105, F.A.C.; rr. 64B8-31.006 and 64B15-7.006, F.A.C.; r. 64B9-4.002, F.A.C.; and r. 64B24-7.013, F.A.C.; respectively). Podiatric physicians must demonstrate professional responsibility in the amount of $100,000 (*see* r. 64B18-14.0072, F.A.C.).
[18] S. 456.47(4), F.S.

used by the health care professional to deliver the services. A patient receiving telehealth services may be in any location at the time services are rendered and a telehealth provider may be in any location when providing telehealth services to a patient.[19]

Practitioners may perform a patient evaluation using telehealth. A practitioner using telehealth is not required to research a patient's medical history or conduct a physical examination of the patient before providing telehealth services to the patient if the telehealth provider is capable of conducting a patient evaluation in a manner consistent with the applicable standard of care sufficient to diagnose and treat the patient when using telehealth.

Controlled Substances

Florida Law

Chapter 893, F.S., the Florida Comprehensive Drug Abuse Prevention and Control Act, classifies controlled substances into five categories, called schedules. These schedules regulate the manufacture, distribution, preparation, and dispensing of the substances listed therein. The distinguishing factors between the different drug schedules are the "potential for abuse"[20] of the substance and whether there is a currently accepted medical use for the substance.[21]

The controlled substance schedules are as follows:

- Schedule I substances have a high potential for abuse and currently have no accepted medical use in the United States, including substances such as cannabis and heroin.[22]
- Schedule II substances have a high potential for abuse and have a currently accepted but severely restricted medical use in the United States, including substances such as raw opium, fentanyl, and codeine.[23]
- Schedule III substances have a potential for abuse less than the substances contained in Schedules I and II and have a currently accepted medical use in the United States, including substances such as stimulants and anabolic steroids.[24]
- Schedule IV substances have a low potential for abuse relative to substances in Schedule III and have a currently accepted medical use in the United States, including substances such as benzodiazepines and barbiturates.[25]
- Schedule V substances have a low potential for abuse relative to the substances in Schedule IV and have a currently accepted medical use in the United States, including substances such as mixtures that contain small quantities of opiates, narcotics, or stimulants.[26]

Federal Law

The Federal Controlled Substances Act[27] also classifies controlled substances into schedules based on the potential for abuse and whether there is a currently accepted medical use for the substance. The

[19] S. 456.47(2), F.S.
[20] S. 893.035(3)(a), F.S., defines "potential for abuse" to mean that a substance has properties as a central nervous system stimulant or depressant or a hallucinogen that create a substantial likelihood of its being: 1) used in amounts that create a hazard to the user's health or safety of the community; 2) diverted from legal channels and distributed through illegal channels; or 3) taken on the user's own initiative rather than on the basis of professional medical advice.
[21] *See* s. 893.03, F.S.
[22] S. 893.03(1), F.S.
[23] S. 893.03(2), F.S.
[24] S. 893.03(3), F.S.
[25] S. 893.03(4), F.S.
[26] S. 893.03(5), F.S.
[27] 21 U.S.C. § 812.

Drug Enforcement Administration (DEA) is required to consider the following when determining where to schedule a substance:[28]

- The substance's actual or relative potential for abuse;
- Scientific evidence of the substance's pharmacological effect, if known;
- The state of current scientific knowledge regarding the substance;
- The substance's history and current pattern of abuse;
- The scope, duration, and significance of abuse;
- What, if any, risk there is to public health;
- The substance's psychic or physiological dependence liability; and
- Whether the substance is an immediate precursor of a substance already controlled.

Telehealth Prescribing of Controlled Substances

Federal law specifically prohibits prescribing controlled substances via the Internet without an in-person evaluation:[29]

> 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.[30]

The in-person medical evaluation requires that the patient be in the physical presence of the provider without regard to the presence or conduct of other professionals.[31] However, the Ryan Haight Online Pharmacy Consumer Protection Act,[32] signed into law in October 2008, created a pathway for telehealth practitioners to dispense controlled substances via telehealth. The practitioner is still subject to the requirement that all controlled substance prescriptions be issued for a legitimate purpose by a practitioner acting in the usual course of professional practice. But, once an in-person evaluation of the patient has occurred, the practitioner may provide future prescriptions for controlled substances for that patient using telehealth services.[33]

Florida law currently prohibits a telehealth provider from using telehealth services to prescribe a controlled substance except when treating:

- A psychiatric disorder;
- An inpatient at a hospital licensed under ch. 395, F.S.;
- A patient receiving hospice services as defined under s. 400.601, F.S.;
- A resident of a nursing home facility as defined under s. 400.021(12), F.S.

Effect of Proposed Changes

CS/HB 247 allows practitioners to prescribe Schedule III, IV, and V controlled substances using telehealth services and retains current law restrictions on prescribing Schedule II controlled substances through telehealth.

The bill provides an effective date of July 1, 2021.

B. SECTION DIRECTORY:

Section 1: Amends s. 456.47, F.S.; relating to use of telehealth to provide services.

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[28] 21 U.S.C. § 811(c).
[29] 21 CFR §829
[30] A valid prescription is defined as one issued by a practitioner who has conducted at least one in-person medical evaluation of the patient.
[31] 21 CFR § 829(e)(2).
[32] Ryan Haight Online Consumer Protection Act of 2008, Public Law 110-425 (H.R. 6353).
[33] *Id*.

Section 2: Provides an effective date of July 1, 2021.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

DOH has sufficient rule-making authority to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES