



# ANTICIPATING ECONOMIC RETURNS OF RURAL TELEHEALTH

March 2017

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## EXECUTIVE SUMMARY

- The United States spends more on health care than any other Organization for Economic Cooperation and Development (OECD) nation, both in absolute terms and as a percentage of gross domestic product (GDP).
- Within the United States, there is a distinct health disparity between rural and nonrural Americans, primarily as a result of demographics and limited access to health care.
  - Rural Americans tend to be older, less well off financially and subject to higher instances of chronic disease, and they have lower life expectancy than their nonrural counterparts.
  - The economics of rural America have led to a growing number of rural hospital closures.
- Telehealth/telemedicine—“the remote delivery of health care services and clinical information using telecommunications technology”—holds potential to improve the quality, cost and availability of health care in rural areas.
- According to the Center for Connected Health Policy, adoption of telehealth is driven by policy, technology, financing, health system transformation, evidence and consumer demand.
- Telemedicine is not viable without access to robust, reliable broadband service.
  - Rural areas currently lag in broadband deployment, but continue to make impressive gains due in large part to the efforts of small telecommunications providers.
  - Wireless applications require wireline infrastructure in order to be viable options.
- Among the nonquantifiable benefits of rural telehealth are access to specialists, timeliness, comfort, transportation, provider benefits and improved outcomes.
- Among the quantifiable benefits of rural telehealth are transportation cost savings, lost wages savings, hospital cost savings, and increased revenues to local labs and pharmacies.
- National average estimates of cost savings include:
  - Travel expense savings: \$5,718 per medical facility, annually;
  - Lost wages savings: \$3,431 per medical facility, annually;
  - Hospital cost savings: \$20,841 per medical facility, annually;
  - Increased local revenues for lab work: from \$9,204 to \$39,882 per type of procedure, per medical facility, annually; and
  - Increased local pharmacy revenues: from \$2,319 to \$6,239 per medical facility annually, depending on the specific drug prescribed.
- Realizing these benefits will first require overcoming the challenges to rural telehealth, which include reimbursement, cost, patient privacy and licensing.
- The decision to implement telemedicine is unique to each medical facility, and should take into account not only costs but also nonquantifiable benefits and quantifiable benefits accruing to parties other than the medical facility, such as the patient and local labs and pharmacies located in the communities where telemedicine takes place.
- Rural telemedicine’s ultimate role in addressing the significant health problems inherent to rural areas will depend in large part on the availability of an underlying future-proof, fiber-based broadband infrastructure. Further investment in, and expansion of, broadband infrastructure is a critical need for our nation.

## INTRODUCTION - TELEHEALTH

According to statistics from the Organization for Economic Cooperation and Development (OECD), the United States spends more on health care than any other OECD nation, both in absolute terms and as a percentage of gross domestic product (GDP). In 2015, the United States spent \$9,450 per capita on health care, representing 16.9% of GDP. That represents an inflation-adjusted increase of nearly 23% since 2005.<sup>1</sup> Forecasts show these expenditures continuing to grow. The Centers for Medicare & Medicaid Services, for example, forecasts total U.S. health expenditures to grow by 5.6% per year between 2016 and 2025, and to outpace GDP growth by 1.2% per year over that period.<sup>2</sup>

Slowing or even reversing this trend will require a multifaceted approach that will combine more efficient expenditure of health care dollars and reducing the need for health care through encouraging healthier lifestyles and giving consumers greater control over their own health. One possible piece of the eventual solution that will address both of these objectives is increased deployment and adoption of telemedicine technologies.

The American Telemedicine Association (ATA) defines telemedicine as “the remote delivery of health care services and clinical information using telecommunications technology. This includes a wide variety of clinical services using internet, wireless, satellite and telephone media.”<sup>3</sup>

There are subtle but distinct differences between the terms telehealth and telemedicine.

Telemedicine refers specifically to the use of technology to provide remote clinical services, while telehealth includes telemedicine, as well as remote nonclinical services, such as provider training, administrative meetings and continuing medical education. In practice, however, the two terms are frequently used interchangeably, and will be applied as such in future references in this paper.

Many different types of patient services fall under the umbrella of telemedicine. Perhaps the most intriguing is the use of telemedicine for *remote consultations*, which allow a physician—perhaps a specialist located many miles away—to speak with, examine and diagnose the patient in real time.

*Remote patient monitoring* allows a physician to monitor the patient outside the clinical environment, allowing for the identification of trends that might warrant further treatment. By allowing the health care provider access to more timely data, patients can receive treatment for medical issues faster and with greater precision.

*Health Information Technology (HIT)* refers to the use of technology to store, share and analyze health information, such as a patient’s electronic health records. Telemedicine intersects with HIT in many areas, such as interoperability, infrastructure, privacy and security.

Telemedicine also facilitates physician *teaching and education*. Medical professionals are able to view procedures that they would not otherwise have access to and ask questions of specialists. They are able to

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<sup>1</sup> Organization for Economic Cooperation and Development, “OECD.Stat,” <http://stats.oecd.org/Index.aspx?DataSetCode=SHA>. (Switzerland was a distant second, at 11.5% of GDP.)

<sup>2</sup> Centers for Medicare & Medicaid Services, “National Health Expenditure Projections, 2016–2025,” <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2016.pdf>.

<sup>3</sup> American Telemedicine Association (ATA), “Q&A About Telemedicine,” <http://www.americantelemed.org/main/about/telehealth-faqs->

participate in real-time patient examinations and thus increase the depth and breadth of their medical knowledge.

Telemedicine services take place in a wide variety of settings, including but not limited to hospitals, clinics, physicians' offices, and patients' homes and workplaces. In fact, with the increased ubiquity and capabilities of the smartphone, there are no geographic barriers at all to the practice of telemedicine. (It is important to emphasize, however, that a relatively small portion of any "wireless" telecommunication is actually wireless. In the absence of a viable wireline network, many of the most valuable applications that smartphones have to offer are simply not feasible—including telemedicine.<sup>4</sup>)

Currently, there are more than 200 telemedicine networks in the United States, with 3,500 service sites throughout the country. It is estimated that half of all U.S. hospitals currently employ telemedicine in one form or another.<sup>5</sup> As impressive as that may be, there still remains much work to be done. This report will detail the potential benefits of telemedicine; while much has been gained, much more work—and resultant gain—remains.

One thing is clear, however. The continuing advancement of telemedicine and the accrual of its potential benefits to patients, health care providers, health care facilities and the communities that house them will not be possible without high-quality, reliable broadband infrastructure. Moreover, this infrastructure must include both high-capacity fiber-based networks and a complementary layer of fixed and mobile wireless networks. Highly advanced, state of the art telemedicine applications—including some not even yet developed—can only be possible when accessed via a high-speed, reliable broadband network. This is particularly critical in rural America, where the highest potential benefits from telemedicine—and the greatest challenges to deploying broadband—can be found.

## **RURAL HEALTH CARE CHALLENGES**

As noted previously, health care expenditures in the United States are forecast to continue rising. Despite that, there is a distinct health disparity between rural and nonrural Americans, primarily as a result of demographics and limited access to health care.

A number of factors tend to work against rural Americans in terms of their overall health. First, the demographics of the rural population are such that rural Americans have a greater need for health care than their nonrural counterparts. Rural Americans tend to be older than those living in urban areas. The U.S. Census Bureau's 2011–2015 American Community Survey reports that the median adult age in rural America was 51, versus 45 in nonrural areas.<sup>6</sup> In addition, America as a whole is aging, as well—thanks to the aging of the baby boomers, the elderly population in the United States is forecast to nearly double

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<sup>4</sup> See, for example, "Wireless Needs Wires," The WK&T Connection, West Kentucky and Tennessee Telecommunications Cooperative, Jan. 15, 2014, <http://wkt.mytelcoconnection.com/wireless-needs-wires/>.

<sup>5</sup> ATA, "Q&A About Telemedicine."

<sup>6</sup> U.S. Census Bureau, "New Census Data Show Differences Between Urban and Rural Populations," December 8, 2016, <https://www.census.gov/newsroom/press-releases/2016/cb16-210.html>.

over the next several decades, from 43.1 million Americans age 65 and over in 2012 to an estimated 83.7 million in 2050.<sup>7</sup>

Rural Americans earn lower average incomes than nonrural Americans. According to the U.S. Census Bureau's 2011–2015 American Community Survey, the median household income in rural America was \$52,386, versus \$54,296 in urban America.<sup>8</sup> Lower income levels have repercussions for health, in terms of lower quality of diet, less health maintenance and fewer available expenditures for treatment of chronic illness. Lower-income households are less likely to have health insurance, meaning that many preventable illnesses are not detected early, but rather only after they become severe and possibly life threatening.

“Very often, by the time a patient shows up in our waiting room, it’s too late to reverse the long-term course of their illness,” says Jennifer Dittes, PA-C, founder and chief executive officer (CEO) of HOPE Family Health, a Federally Qualified Health Center in rural Macon County, Tenn. “Cancer, heart disease, diabetes, chronic kidney disease and substance abuse are all killers in our rural community, where the life expectancy is almost 20 years shorter than the national average due to poverty, other socioeconomic disparities, and lack of access to preventive, primary, behavioral and specialty care.”

Population density in rural areas is well below that of nonrural areas. The U.S. Census Bureau estimates population density within cities to be 46 times greater than that outside of cities: 1,593.5 residents per square mile versus 34.6 per square mile.<sup>9</sup> Population density directly affects the economics of health care facilities, and thus influences the placement of these vitally important resources. The result is that rural citizens have fewer options for health care treatment, and typically must travel much further than their urban counterparts to receive treatment.

In addition to—and to a certain extent, because of—these demographic challenges, the overall state of rural health is troubling. While living in rural America has numerous benefits, including lower cost of living, affordable housing and abundant green space, the Centers for Disease Control and Prevention (CDC) finds that rural residents are at higher risk of death from five leading causes than their urban counterparts.

According to a CDC study “Leading Causes of Death in Nonmetropolitan and Metropolitan Areas—United States, 1999–2014,” the five leading causes of death in the United States between 1999 and 2014 were heart disease, cancer, unintentional injury, chronic lower respiratory disease and stroke. Together, these accounted for more than 1.6 million deaths (approximately 62% of all deaths) in 2014.

CDC found that annual age-adjusted death rates for these five causes were higher in nonmetropolitan areas than in metropolitan areas between 1999 and 2014. Age-adjusted death rates for unintentional injury were approximately 50% higher in nonmetropolitan areas. While the overall rate of deaths from stroke, heart disease and cancer decreased in both metropolitan and nonmetropolitan areas over the period, the

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<sup>7</sup> U.S. Census Bureau, “An Aging Nation: The Older Population in the United States,” May 2014, <https://www.census.gov/prod/2014pubs/p25-1140.pdf>.

<sup>8</sup> Bishaw, Alemayehu and Kirby G. Posey, “A Comparison of Rural and Urban America: Household Income and Poverty,” Census Blogs, U.S. Census Bureau, ” December 8, 2016, [https://www.census.gov/newsroom/blogs/random-samplings/2016/12/a\\_comparison\\_of\\_rura.html](https://www.census.gov/newsroom/blogs/random-samplings/2016/12/a_comparison_of_rura.html).

<sup>9</sup> U.S. Census Bureau, “U.S. Cities are Home to 62.7 Percent of the U.S. Population, But Comprise Just 3.5 Percent of Land Area,” March 4, 2015, <https://www.census.gov/newsroom/press-releases/2015/cb15-33.html>.

rate of decrease in deaths due to heart disease and cancer was slower in nonmetropolitan areas, and the rate of deaths due to stroke was about the same.

Overall, chronic diseases affect rural residents disproportionately. Rural residents tend to be older and sicker than their urban counterparts, have higher rates of cigarette smoking, high blood pressure, and obesity.

According to 2010 U.S. Census Data, five of the ten most rural states in the United States also rank within the top 10 in adult obesity (Mississippi, Alabama, West Virginia, Kentucky and Arkansas), and all except for Arkansas also rank in the top 10 in the rate of diagnosed diabetes.<sup>10</sup>

Due in large part to increasing costs and the challenges noted previously, rural hospital closures continue to climb at an alarming rate. According to the National Rural Health Association (NRHA), more than 70 rural hospitals have closed since 2010. In addition, the rate of closures is accelerating—six times higher in 2015 than in 2010. Currently, more than 670 additional rural facilities, representing more than one-third of all rural hospitals in the United States, are considered “vulnerable” and in danger of closing.<sup>11</sup>

Put simply, the economics are stacked against rural hospitals. As one physician observes, “You don’t have the volumes. You still have to provide the same quality. You still have to buy the same equipment. You don’t have the economy of scale on the equipment, so your overhead is more and your reimbursements are less.”<sup>12</sup>

While approximately 46 million Americans, or 15% of the U.S. population, lives in rural areas, only 10% of the nation’s physicians practice in rural areas. And while there are 40 specialists per every 10,000 rural residents, there are 134 per every 10,000 urban residents.<sup>13</sup>

Taken together, the demographic challenges—leading to an increased demand for health care in rural America—coupled with the growing rate of closures among rural health care facilities—which results in a decreased supply of health care—poses very significant health challenges for rural Americans going forward.

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<sup>10</sup> 2010 U.S. Census Bureau, quoted in De Peña, Kristen and Kelly A. Sanders, “Bumps Along the Rural Road: Using Telemedicine to Treat Chronic Disease in Rural Communities,” Altarum Institute, March 22, 2016, <http://www.healthcareitnews.com/blog/bumps-along-rural-road-using-telemedicine-treat-chronic-disease-rural-communities>.

<sup>11</sup> National Rural Health Association, “Rural Health Closures Decimating Rural Health Care Delivery,” [https://www.ruralhealthweb.org/getattachment/Advocate/Save-Rural-Hospitals/PI-2016-SRH-Act-Talking-Points-economic-impact-\(1\).docx.aspx?lang=en-US](https://www.ruralhealthweb.org/getattachment/Advocate/Save-Rural-Hospitals/PI-2016-SRH-Act-Talking-Points-economic-impact-(1).docx.aspx?lang=en-US).

<sup>12</sup> Dr. Wendell Smith, Virginia Regional Medical Center, Duluth, MN, quoted in American Hospital Association, “The Opportunities and Challenges for Rural Hospitals in an Era of Health Reform,” <http://www.aha.org/research/reports/tw/11apr-tw-rural.pdf>, p.3.

<sup>13</sup> National Rural Health Association, “About Rural Health Care,” <https://www.ruralhealthweb.org/about-nrha/about-rural-health-care>.

## TELEHEALTH ADOPTION

As in most markets, consumer demand will be a primary driver of telehealth adoption. A recent poll of 4,017 adults conducted by American Well found that 20% would be willing to switch doctors if a different primary care physician offered telehealth services. Seventy-four percent of parents with young children would be willing to make the switch.<sup>14</sup>

The American Telemedicine Association conducted a consumer survey<sup>15</sup> in 2016 that found that 22% of the 429 respondents had used video conferencing to meet with a health provider. Of the 78% who had not used telehealth in the preceding year, a majority felt that telehealth would be more convenient: 72% indicated that telehealth appealed to them for time savings, and 59% noted the distance they need to travel to meet with their doctor. Seventy-three percent, however, noted that their doctor does not currently offer telemedicine service.

The Center for Connected Health Policy identifies six key drivers of telehealth adoption:<sup>16</sup> These include:

- Policy: national and state policies that support and promote telehealth;
- Technology: new advancements that improve usability and decrease costs;
- Financing: includes government and private payers/accountable care organizations (ACOs);
- Health System Transformation: incorporation of telehealth into standard of care practices;
- Evidence: increasing body of research; and
- Consumer Demand: consumer interest in telehealth.

Successful efforts to increase telehealth deployment will need to take place on a number of different fronts, and will require coordinated efforts on the part of several different parties.

According to a study conducted by researchers at the Center for Connected Health Policy, the University of Michigan, and Brigham and Women's Hospital, telehealth adoption at rural hospitals is outpacing that at urban areas.<sup>17</sup> They also found that population density was slightly inversely correlated with telehealth adoption, with the chances of telehealth availability increasing as population density decreased.

Estimates of the market for telemedicine vary greatly. A recent study conducted by Pharmaion estimated that the telemedicine market in the United States would surpass \$13 billion by 2021.<sup>18</sup> The study forecasts

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<sup>14</sup> PR Newswire, Jan. 23, 2017, <http://www.prnewswire.com/news-releases/one-in-five-consumers-would-switch-to-a-doctor-that-offers-telehealth-visits-300394562.html>.

<sup>15</sup> American Telehealth Association and WEGO Health Solutions, "Consumer Survey," <https://higherlogicdownload.s3.amazonaws.com/AMERICANTELEMED/3c09839a-fffd-46f7-916c-692c11d78933/UploadedImages/Policy/SURVEY%20RESULTS%20WEGO%20ATA%202016.pdf>.

<sup>16</sup> Center for Connected Health Policy, <http://www.cchpca.org/sites/default/files/uploader/Telehealth%20Adoption%20Graphic%201.pdf>.

<sup>17</sup> Adler-Milstein, Julia, Joseph Kvedar, and David W. Bates, "Telehealth Among US Hospitals: Several Factors, Including State Reimbursement and Licensure Policies, Influence Adoption," *Health Affairs* 33, no. 2 (2014), <http://content.healthaffairs.org/content/33/2/207.full.pdf+html>, p. 210.

<sup>18</sup> Press Release, "U.S. Telemedicine Market to Cross \$13 Billion by 2021: Pharmaion Consultants Report," Feb. 15, 2016, <http://www.prnewswire.com/news-releases/us-telemedicine-market-to-cross--13-billion-by-2021-pharmaion-consultants-report-568841771.html>.

that the technology sector of the industry will experience dramatic growth, and the service sector will remain strong. Another study, by Grand View Research, estimates a more modest U.S. market of \$2.8 billion, which still represents 400% overall growth from 2014.<sup>19</sup> Regardless of the exact numbers, dramatic growth seems inevitable. As ATA CEO Jonathan Linkous stated, “Telemedicine is an exploding field both in terms of the number of services delivered and the types of services being delivered using technology. It’s almost overwhelming.”<sup>20</sup>

Though it may seem obvious, there can be no telehealth without robust, reliable broadband service. Real-time consultations, in particular, require a high-speed, high-quality connection. According to the Federal Communications Commission (FCC), in 2016 10% percent of all Americans—34 million people—lacked access to 25 megabits per second (Mbps) downstream/3 Mbps upstream service, a speed that would make telemedicine viable. Broken down along rural/urban lines, 39% of rural Americans—23 million people—lacked access to 25 Mbps/3 Mbps service, as opposed to 4% of urban Americans lacking access to that same level of broadband service.<sup>21</sup> Rural areas are more difficult and more expensive to serve with broadband, due to higher costs resulting from lower population densities, rugged terrain and fewer customers over which to spread costs. Despite these obstacles, however, a number of small rural providers is making excellent progress in bringing high-quality broadband service to their customers. A recent survey conducted by NTCA–The Rural Broadband Association (NTCA) found that their member companies were offering service of 25 Mbps or better to 71% of their customers, on average.<sup>22</sup> This percentage has steadily grown over the years, as small rural providers continue to deploy their fiber networks and/or upgrade their services further out into rural America, despite the obstacles they face.

Once the underlying broadband infrastructure is in place, a number of end-user technologies can be used to maximize the benefits of telemedicine. On the physician’s end, use of technologies such as tablets and cellphones can allow them to keep in contact with their patients, as well as with other health care professionals. Patients can make use of apps to track their vital data and transmit the results to their physician. Smartphones can serve as the platform for video conferences between patients and health care providers. Given the ubiquity of smartphones, the devices represent a critical tool that can potentially play a significant role in giving individuals more control over their health care. This role will only grow, as new apps with expanded capabilities are developed and downloaded. It must be emphasized, however, that wireless telemedicine applications can only take place when supported by a robust wireline broadband network. Wireless telecommunications require wires in order to be viable.<sup>23</sup>

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<sup>19</sup> Grand View Research, “U.S. Telehealth Market Analysis, by Product (Hardware, Software, Services), by Delivery Mode (Web based, Cloud based, On Premise), by End-Use (Providers, Payers) and Segment Forecasts to 2022,” March 2016, <http://www.grandviewresearch.com/industry-analysis/us-telehealth-market>.

<sup>20</sup> Siwicki, Bill, “Telemedicine Is ‘An Exploding Field’ ATA CEO Says,” Healthcare IT News, Dec. 16, 2016, <http://www.healthcareitnews.com/news/telemedicine-exploding-field-ata-ceo-says>.

<sup>21</sup> FCC, “2016 Broadband Progress Report,” FCC 16-6, rel. Jan. 29, 2016, [https://apps.fcc.gov/edocs\\_public/attachmatch/FCC-16-6A1.pdf](https://apps.fcc.gov/edocs_public/attachmatch/FCC-16-6A1.pdf), p. 3.

<sup>22</sup> NTCA–The Rural Broadband Association, “NTCA 2015 Broadband/Internet Availability Survey,” July 2016, <http://www.ntca.org/images/stories/Documents/Advocacy/SurveyReports/2015ntcabroadbandsurveyreport.pdf>, pp. 6–7.

<sup>23</sup> See *supra* note 4.

## **POTENTIAL BENEFITS OF RURAL TELEHEALTH: NONQUANTIFIABLE**

Many of the benefits of telemedicine are qualitative, rather than quantitative. Simply put, it is not always possible to assign a dollar figure to a beneficial health care outcome. By offering patients access to a wide variety of medical specialists, oftentimes in situations where time is of the essence, telemedicine can greatly increase the overall quality of health care.

Among the nonquantifiable benefits of telemedicine:

Access to specialists. Gaining access to a specialist can be particularly challenging in rural areas. Telemedicine opens up the available universe of health care providers well beyond the patient's geographic location.

Timeliness. The availability of telemedicine allows for patients to be diagnosed and treated more quickly, at a time when immediate treatment will have a tremendous effect on the patient's ultimate outcome. In the case of heart attacks, strokes or severe physical trauma, a trip of hundreds of miles to the nearest medical facility may result in long-term disability, or, in the extreme, death.

Comfort. Telemedicine resources can allow patients to remain in their community with their family and friends, thus contributing to their overall comfort level and potentially shortening the length of their recovery. Often, the very ailment for which they seek treatment precludes them from being able to travel comfortably. The prospect of remaining within the comfort of one's home, rather than having to stay in an unfamiliar hospital or similar acute care environment, can be appealing.

Transportation. Some patients do not have the resources to be able to travel to a doctor. They may not have access to a car, and other forms of transportation may be prohibitively expensive. Patients may not have family or friends who have the available time and resources to take them to the treatment site.

Provider Benefits. Telemedicine can offer benefits to the provider as well as the patient. Engaging with health care experts in varying medical fields can help alleviate the sense of isolation that rural health providers may face. Working with specialists to help treat unusual cases, the rural provider can keep his or her skills sharp while gaining experience that will ultimately help him/her to become a more skilled practitioner. Broadband-enabled telemedicine also allows health care providers to avail themselves of the benefits of continuing education and training.

Improved Outcomes. Evidence suggests that the use of telemedicine results in a decreased need for follow-up visits to medical providers. One recent study found that 6% of patients using telemedicine required a follow up for a similar condition, compared to 13% of those visiting a physician's office and 20% of those visiting an emergency department.<sup>24</sup> Additionally, the study found that use of telehealth resources tends to rise on weekends and holidays, when patients otherwise have little recourse other than to visit the closest emergency room, since physicians'

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<sup>24</sup> Uscher-Pines, Lori and Ateev Mehrotra, "Analysis of Teledoc Use Seems to Indicate Access to Care for Patients Without Prior Connection to a Provider," *Health Affairs* 33:12 (2014), cited in American Hospital Association "Issue Brief—Telehealth: Helping Hospitals Deliver Cost-Effective Care," <http://www.aha.org/content/16/16telehealthissuebrief.pdf>, p. 3.

offices tend to be closed at those times. Collectively, these results point to an overall reduction in medical expenditures.

A recent study of almost 119,000 patients from 56 intensive care units (ICUs) in 32 hospitals found that mortality in the ICU telemedicine intervention group was significantly better than that of control subjects, and that the adjusted hospital length of stay was decreased by 0.5 days for those staying in the ICU for  $\geq 7$  days, by 1.0 days for those staying  $\geq 14$  days, and by 3.6 days for those staying in the ICU for  $\geq 30$  days.<sup>25</sup>

## **POTENTIAL BENEFITS OF RURAL TELEHEALTH: QUANTIFIABLE**

Some of the potential benefits of telemedicine can be quantified. These fall into two main categories: *opportunity costs*, or current costs that would not need to be incurred if telemedicine were implemented; and *direct benefits*, or real financial gains realized through the use of telemedicine.

There are three primary opportunity costs that could be eliminated or reduced: the costs incurred in procuring transportation to a distant treatment site, lost wages resulting from missed time at work by patients and their caregivers when in transit to treatment, and the need for local hospitals to spend precious resources employing specialists that may not make full use of their skills in rural facilities. The primary direct benefit is an increase in business for local labs and pharmacies, business that would otherwise be shipped out to establishments at distant treatment sites.

Among the quantifiable benefits of telemedicine:

Transportation costs. These costs include all travel costs incurred in visiting a distant health care provider, for the patient as well as for his or her caregiver. This includes, but may not be limited to, gas, tolls, parking, accommodations for the patient and/or caregiver and meals.

Lost wages. Traveling to distant health treatment often requires time away from the job. Many hourly workers are not compensated for the time they do not work. Salaried workers may be able to use accrued paid leave, but run the risk of not having sufficient leave or not having leave later in the year should another medical situation arise. The problem of lost wages confronts not only the patient, but also his or her accompanying caregiver.

Hospital costs. Retaining highly trained health care professionals on staff is challenging, particularly for rural hospitals. The realities of rural hospitals are such that these specialists may not see many cases in their areas of expertise. As noted previously, the economics of rural hospitals make it extremely difficult to justify such expenditures. Telemedicine can offer a cost-effective means of “sharing” personnel with other health care facilities.

Lab/pharmacy revenues. Hospitals have lab work done locally. Often, patients have their prescriptions filled close to the location where they were written. When local residents travel to distant locations for their treatment, these expenditures go with them. Telemedicine allows these expenditures to remain local, and those dollars to remain in the local economy.

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<sup>25</sup> Lilly, Craig M., MD, *et. al.*, “A Multicenter Study of ICU Telemedicine Reengineering of Adult Critical Care,” The American College of Chest Physicians, Chest Journal, March 2014, <http://journal.publications.chestnet.org/article.aspx?articleid=1788059>.

## ESTIMATING THE ECONOMIC BENEFITS OF RURAL TELEHEALTH

While identifying the quantifiable benefits of telemedicine may be relatively simple, the process of actually quantifying those benefits is far more difficult. Brian E. Whitacre, an associate professor and extension economist in the department of Agricultural Economics at Oklahoma State University took an interesting approach toward estimating the potential economic benefits of telemedicine adoption in four states: Arkansas, Kansas, Oklahoma and Texas.<sup>26</sup>

Whitacre examined 24 rural hospitals located in various communities within those four states. For each of the four categories detailed in the preceding section of this paper (transportation costs, lost wages, hospital costs, and lab/pharmacy revenues), he set out to quantify the potential economic benefit to be gained by the hospital, the patient, and/or the community from the implementation of telemedicine.

Patients who avail themselves of telemedicine services do not incur travel expenses that they otherwise would to visit a far-off treatment site. In quantifying this potential cost saving, Whitacre looked at the average distance traveled, the average cost per mile, and the number of encounters per year—taking into account the percentage of encounters that required immediate attention, as opposed to those who could wait until a specialist was available locally. The estimated annual cost savings ranged from \$2,303 to \$109,080, with a mean of \$32,671 and a median of \$24,210.

In calculating the value of lost wages, Whitacre used a similar methodology to that for travel expenses, but replaced the average cost per mile and distance with the average hourly wage rate and time spent traveling. The estimated annual cost savings ranged from \$4,188 to \$68,269, with a mean of \$19,761 and a median of \$16,769.

In looking at hospital cost savings, Whitacre operated under the assumption that “a group of physicians specializing in a particular modality (such as radiology or oncology) in a more urban area can [through the use of telemedicine] then market themselves to several rural hospitals and serve a larger number of hospitals and serve a larger number of patients, which supports the idea that telemedicine increases efficiency.”<sup>27</sup> Whitacre looked at two examples involving converting radiology and psychology consultations to telemedicine. In one example, the hospital reduced its use of a full-time radiologist from five days a week to one. Using rural specialists’ salaries from the Physician Compensation and Production Survey, the estimated annual cost savings was \$101,600. In another example, a hospital using a part-time radiologist and psychiatrist eliminated the need for these specialists altogether. In this case, the estimated annual cost savings was \$61,600.

Finally, in order to estimate the value of lab work and pharmacy revenues that would remain local as a result of telemedicine Whitacre spoke with medical professionals in the target facilities and gathered data on typical follow-up procedures and medications resulting from psychiatric and radiology visits. By using the number of yearly encounters along with the percentage of patients using each, the monthly cost per

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<sup>26</sup> Whitacre, Brian E., “Estimating the Economic Impact of Telemedicine in a Rural Community,” *Agricultural and Resource Economics Review* 40/2, August 2011, <http://ageconsearch.umn.edu/bitstream/117770/2/ARER%2040-2%20pp%20172-183%20Whitacre.pdf>.

<sup>27</sup> *Id.*, p. 176.

prescription or test costs, he was able to come up with his estimates. For telepsychiatry, the yearly cost of Adderall ranges from a low of \$10,710 annually to a high of \$44,100, and for Xanax, a low of \$3,024 annually to a high of \$15,120.<sup>28</sup> For teleradiology lab work, bloodwork ranges from a low of \$24,000 to a high of \$288,000; MRIs, low of \$19,200 and high of \$192,000; CT scan, low of \$48,000 and high of \$240,000; and biopsy, low of \$14,400 and high of \$57,600. For pain medication, yearly costs ranged from a low of \$36,000 to a high of \$216,000. Again, these are expenditures that, in the absence of telemedicine, likely would go outside of the local community. When telemedicine is available locally, these expenditures tend to remain in the local economy.

**Table 1. Summary of Anticipated Annual Cost Savings: AR, KS, OK, TX**  
(Annual savings, per facility, 2011 \$)

	<b>Low</b>	<b>High</b>	<b>Median</b>
<b>Travel Expenses</b>	\$2,303	\$109,080	\$24,210
<b>Lost Wages</b>	4,188	68,269	16,769
<b>Hospital Cost Savings</b>	61,600	101,600	81,300
<b>Lab Work</b>			
Bloodwork	24,000	288,000	156,000
MRI	19,200	192,000	105,600
CT Scan	48,000	240,000	144,000
Biopsy	14,400	57,600	36,000
Pain Meds.	36,000	216,000	126,000
<b>Pharmacy Revenues</b>			
Adderall	10,710	44,100	24,405
Xanax	3,024	15,120	9,072

Source: Whitacre, Brian E., “Estimating the Economic Impact of Telemedicine in a Rural Community.”

While these results give an idea of the cost savings that could be procured through the increased adoption of telemedicine in four states, what might the results look like in the rest of the country? Using these numbers as a baseline, state-specific indices were applied to customize the forecasts to other states. While sufficient uncertainty exists to preclude matching the level of precision of the above numbers, it is possible to determine in general terms what the potential cost savings would be relative to those for the above states.

The determining factors in estimating the travel expense savings per state are distance traveled and cost per mile. In calculating the distance traveled, the average number of hospitals per square mile for each individual state was applied to the Whitacre benchmark. The average cost per mile was the same as that used in the previous study—the official IRS mileage rate. (As this was a U.S. average, no per-state adjustment needed to be made.) A state population index was applied to account for the relative number of patient trips.

<sup>28</sup> Whitacre looks at revenues accruing to local pharmacies for prescriptions of Adderall and Xanax in examining the role of telepsychiatry, as these are commonly prescribed medications for certain psychiatric disorders. It must be noted, however, that abuse of these and other prescription medications is a serious problem in both rural and nonrural areas, and a substantial contributor to the rural health challenges detailed earlier in this paper. For more information about the problem of drug abuse in rural America see, for example, “Substance Abuse in Rural Areas,” RHHhub, <https://www.ruralhealthinfo.org/topics/substance-abuse>.

The determining factors in estimating lost wages are similar to those for travel expense savings. Distance traveled (as estimated by the hospitals per square mile calculation) served as a proxy for time spent traveling. The average hourly wage rate for each state was compared to that for the benchmark, and that index applied to the calculation. The state population index was also applied.

The determining factors in estimating hospital cost savings resulting from staffing reductions are the forecast reduction levels and the prevailing wage rate in each particular state. Here, Whitacre's assumptions about staffing level reductions were retained, and the average wage rates index was applied. The state population index was also applied to account for the varying number of patient visits. (See Table 2.)

**Table 2. State Breakdown of Expected Savings for Travel Expenses, Lost Wages, Hospital Costs  
(2016 \$)**

**(Annual savings, per facility)**

	<b>Travel Expense Savings*</b>	<b>Lost Wages Savings*</b>	<b>Hospital Cost Savings</b>
<b>Alabama</b>	\$2,600	\$1,019	\$10,263
<b>Alaska</b>	\$34,547	\$19,917	\$2,304
<b>Arizona</b>	\$10,289	\$4,430	\$16,073
<b>Arkansas</b>	\$3,049	\$1,114	\$5,878
<b>California</b>	\$17,384	\$8,599	\$104,564
<b>Colorado</b>	\$10,427	\$5,026	\$14,383
<b>Connecticut</b>	\$499	\$272	\$10,483
<b>Delaware</b>	\$228	\$107	\$2,404
<b>Florida</b>	\$5,025	\$1,985	\$43,844
<b>Georgia</b>	\$5,132	\$2,130	\$23,050
<b>Hawaii</b>	\$642	\$309	\$3,702
<b>Idaho</b>	\$8,027	\$3,176	\$3,587
<b>Illinois</b>	\$4,945	\$2,291	\$31,949
<b>Indiana</b>	\$2,379	\$972	\$14,598
<b>Iowa</b>	\$4,290	\$1,793	\$7,056
<b>Kansas</b>	\$4,018	\$1,681	\$6,552
<b>Kentucky</b>	\$2,272	\$913	\$9,598
<b>Louisiana</b>	\$1,903	\$756	\$10,017
<b>Maine</b>	\$1,917	\$827	\$3,091
<b>Maryland</b>	\$1,108	\$576	\$16,848
<b>Massachusetts</b>	\$671	\$380	\$20,762
<b>Michigan</b>	\$5,262	\$2,314	\$23,508
<b>Minnesota</b>	\$7,688	\$3,712	\$14,352
<b>Mississippi</b>	\$2,020	\$727	\$5,796
<b>Missouri</b>	\$4,673	\$1,938	\$13,604
<b>Montana</b>	\$9,291	\$3,689	\$2,229
<b>Nebraska</b>	\$4,953	\$2,082	\$4,317
<b>Nevada</b>	\$11,714	\$4,902	\$6,626
<b>New Hampshire</b>	\$838	\$388	\$3,328
<b>New Jersey</b>	\$879	\$600	\$32,875
<b>New Mexico</b>	\$6,687	\$2,684	\$4,499
<b>New York</b>	\$4,637	\$2,396	\$54,937
<b>North Carolina</b>	\$4,484	\$1,843	\$22,458
<b>North Dakota</b>	\$5,123	\$2,428	\$1,935
<b>Ohio</b>	\$3,127	\$1,360	\$27,209
<b>Oklahoma</b>	\$2,694	\$1,085	\$8,509
<b>Oregon</b>	\$10,132	\$4,666	\$10,153



**Table 3. State Breakdown of Increased Local Revenues for Lab Work (2016 \$)**  
**(Annual savings, per facility)**

	<b>Bloodwork</b>	<b>MRI</b>	<b>CT Scan</b>	<b>Biopsy</b>	<b>Pain Meds</b>
<b>Alabama</b>	\$26,407	\$17,875	\$24,376	\$6,094	\$21,329
<b>Alaska</b>	\$4,850	\$3,283	\$4,477	\$1,119	\$3,917
<b>Arizona</b>	\$41,321	\$27,971	\$38,142	\$9,536	\$33,374
<b>Arkansas</b>	\$16,170	\$10,946	\$14,926	\$3,732	\$13,061
<b>California</b>	\$272,833	\$184,687	\$251,846	\$62,961	\$220,365
<b>Colorado</b>	\$34,950	\$23,658	\$32,261	\$8,065	\$28,229
<b>Connecticut</b>	\$24,064	\$16,290	\$22,213	\$5,553	\$19,436
<b>Delaware</b>	\$6,000	\$4,061	\$5,538	\$1,385	\$4,846
<b>Florida</b>	\$126,326	\$85,513	\$116,609	\$29,152	\$102,033
<b>Georgia</b>	\$58,661	\$39,709	\$54,149	\$13,537	\$47,380
<b>Hawaii</b>	\$10,319	\$6,985	\$9,525	\$2,381	\$8,334
<b>Idaho</b>	\$9,722	\$6,581	\$8,974	\$2,244	\$7,852
<b>Illinois</b>	\$79,723	\$53,966	\$73,590	\$18,398	\$64,391
<b>Indiana</b>	\$37,493	\$25,380	\$34,609	\$8,652	\$30,283
<b>Iowa</b>	\$17,505	\$11,850	\$16,159	\$4,040	\$14,139
<b>Kansas</b>	\$16,307	\$11,039	\$15,053	\$3,763	\$13,171
<b>Kentucky</b>	\$24,339	\$16,476	\$22,467	\$5,617	\$19,658
<b>Louisiana</b>	\$26,463	\$17,913	\$24,427	\$6,107	\$21,374
<b>Maine</b>	\$7,995	\$5,412	\$7,380	\$1,845	\$6,458
<b>Maryland</b>	\$41,040	\$27,781	\$37,883	\$9,471	\$33,148
<b>Massachusetts</b>	\$45,117	\$30,541	\$41,646	\$10,412	\$36,441
<b>Michigan</b>	\$57,777	\$39,111	\$53,333	\$13,333	\$46,666
<b>Minnesota</b>	\$33,318	\$22,554	\$30,755	\$7,689	\$26,910
<b>Mississippi</b>	\$16,025	\$10,848	\$14,792	\$3,698	\$12,943
<b>Missouri</b>	\$33,687	\$22,803	\$31,095	\$7,774	\$27,209
<b>Montana</b>	\$6,073	\$4,111	\$5,606	\$1,402	\$4,905
<b>Nebraska</b>	\$10,686	\$7,233	\$9,864	\$2,466	\$8,631
<b>Nevada</b>	\$17,764	\$12,025	\$16,398	\$4,099	\$14,348
<b>New Hampshire</b>	\$8,568	\$5,800	\$7,909	\$1,977	\$6,921
<b>New Jersey</b>	\$63,336	\$42,874	\$58,464	\$14,616	\$51,156
<b>New Mexico</b>	\$12,226	\$8,276	\$11,286	\$2,821	\$9,875
<b>New York</b>	\$141,282	\$95,637	\$130,414	\$32,604	\$114,112
<b>North Carolina</b>	\$57,542	\$38,952	\$53,116	\$13,279	\$46,477
<b>North Dakota</b>	\$4,289	\$2,903	\$3,959	\$990	\$3,464
<b>Ohio</b>	\$64,141	\$43,419	\$59,207	\$14,802	\$51,806
<b>Oklahoma</b>	\$21,862	\$14,799	\$20,181	\$5,045	\$17,658
<b>Oregon</b>	\$25,062	\$16,965	\$23,134	\$5,784	\$20,242
<b>Pennsylvania</b>	\$77,638	\$52,555	\$71,666	\$17,917	\$62,708

	<b>Bloodwork</b>	<b>MRI</b>	<b>CT Scan</b>	<b>Biopsy</b>	<b>Pain Meds</b>
<b>Rhode Island</b>	\$6,448	\$4,365	\$5,952	\$1,488	\$5,208
<b>South Carolina</b>	\$27,766	\$18,796	\$25,630	\$6,408	\$22,427
<b>South Dakota</b>	\$4,710	\$3,188	\$4,348	\$1,087	\$3,804
<b>Tennessee</b>	\$37,102	\$25,115	\$34,248	\$8,562	\$29,967
<b>Texas</b>	\$166,452	\$112,675	\$153,648	\$38,412	\$134,442
<b>Utah</b>	\$18,304	\$12,390	\$16,896	\$4,224	\$14,784
<b>Vermont</b>	\$3,909	\$2,646	\$3,608	\$902	\$3,157
<b>Virginia</b>	\$53,374	\$36,130	\$49,268	\$12,317	\$43,109
<b>Washington</b>	\$46,784	\$31,669	\$43,185	\$10,796	\$37,787
<b>West Virginia</b>	\$10,067	\$6,815	\$9,293	\$2,323	\$8,131
<b>Wisconsin</b>	\$33,379	\$22,595	\$30,811	\$7,703	\$26,960
<b>Wyoming</b>	\$3,483	\$2,358	\$3,215	\$804	\$2,813

**U.S. AVERAGE            \$39,882            \$26,997            \$36,814            \$9,204            \$32,212**

The determining factors in estimating the cost savings from pharmacy revenues are the number of patient trips and the overall price level within the state. Thus the state population index and state RPP index were applied to the Adderall and Xanax benchmarks to obtain the state cost savings estimates. (See Table 4.)

**Table 4. State Breakdown of Increased Local Pharmacy Revenues (2016 \$)**  
**(Annual savings, per facility)**

	<b>Adderall</b>	<b>Xanax</b>
<b>Alabama</b>	\$4,131	\$1,536
<b>Alaska</b>	\$759	\$282
<b>Arizona</b>	\$6,464	\$2,403
<b>Arkansas</b>	\$2,530	\$940
<b>California</b>	\$42,683	\$15,866
<b>Colorado</b>	\$5,468	\$2,032
<b>Connecticut</b>	\$3,765	\$1,399
<b>Delaware</b>	\$939	\$349
<b>Florida</b>	\$19,763	\$7,346
<b>Georgia</b>	\$9,177	\$3,411
<b>Hawaii</b>	\$1,614	\$600
<b>Idaho</b>	\$1,521	\$565
<b>Illinois</b>	\$12,472	\$4,636
<b>Indiana</b>	\$5,865	\$2,180
<b>Iowa</b>	\$2,739	\$1,018
<b>Kansas</b>	\$2,551	\$948
<b>Kentucky</b>	\$3,808	\$1,415
<b>Louisiana</b>	\$4,140	\$1,539
<b>Maine</b>	\$1,251	\$465
<b>Maryland</b>	\$6,420	\$2,387
<b>Massachusetts</b>	\$7,058	\$2,624
<b>Michigan</b>	\$9,039	\$3,360
<b>Minnesota</b>	\$5,212	\$1,938
<b>Mississippi</b>	\$2,507	\$932
<b>Missouri</b>	\$5,270	\$1,959
<b>Montana</b>	\$950	\$353
<b>Nebraska</b>	\$1,672	\$621
<b>Nevada</b>	\$2,779	\$1,033
<b>New Hampshire</b>	\$1,340	\$498
<b>New Jersey</b>	\$9,908	\$3,683
<b>New Mexico</b>	\$1,913	\$711
<b>New York</b>	\$22,102	\$8,216
<b>North Carolina</b>	\$9,002	\$3,346
<b>North Dakota</b>	\$671	\$249
<b>Ohio</b>	\$10,034	\$3,730
<b>Oklahoma</b>	\$3,420	\$1,271
<b>Oregon</b>	\$3,921	\$1,457
<b>Pennsylvania</b>	\$12,146	\$4,515

	<b>Adderall</b>	<b>Xanax</b>
<b>Rhode Island</b>	\$1,009	\$375
<b>South Carolina</b>	\$4,344	\$1,615
<b>South Dakota</b>	\$737	\$274
<b>Tennessee</b>	\$5,804	\$2,158
<b>Texas</b>	\$26,040	\$9,680
<b>Utah</b>	\$2,863	\$1,064
<b>Vermont</b>	\$612	\$227
<b>Virginia</b>	\$8,350	\$3,104
<b>Washington</b>	\$7,319	\$2,721
<b>West Virginia</b>	\$1,575	\$585
<b>Wisconsin</b>	\$5,222	\$1,941
<b>Wyoming</b>	\$545	\$203

**U.S. AVERAGE                      \$6,239                      \$2,319**

Other real-world examples of the savings possible through telemedicine are equally impressive. The Veterans Health Administration (VHA) has long been a pioneer in the use of telemedicine. Between 2000 and 2003 the VHA conducted a pilot program in Florida, Puerto Rico and the Virgin Islands, which included seven hospitals, 10 multispecialty outpatient clinics and 28 community-based primary care clinics.<sup>29</sup> The 900 patients in the trial were able to utilize home telehealth devices, which allowed them to self-manage their health. The results were dramatic: a 40% reduction in emergency room visits, a 63% drop in hospital admissions and an 88% decrease in nursing home bed days of care. While the total cost savings resulting from the dramatic decrease in resource utilization was substantial, perhaps even more impressive was the 94% patient satisfaction rate.

The cost savings have been substantial: the VHA estimates the cost per patient participating in their Care Coordination/Home Telehealth (CCHT) program to be \$1,600 per year. By comparison, the direct cost of VHA’s home based primary care is \$13,121 per patient per year, while nursing home care rates average \$77,745 per year.<sup>30</sup> Couple this with the rapidly growing number of veterans who will require significant health assistance in the coming years, and the potential cost savings are nothing short of staggering.

The VHA has measured a significant decrease in days of hospital stay for those veterans participating in CCHT. Between 2004 and 2007, days of hospital stay for a patient suffering from depression decreased 56.4% among those utilizing telehealth; those suffering post-traumatic stress disorder saw a 45.1% decrease; other mental health issues were down 40.9%; hypertension, down 30.3%; congestive heart

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<sup>29</sup> Broderick, Andrew, “The Veterans Health Administration: Taking Home Telehealth Services to Scale Nationally,” The Commonwealth Fund Case Studies in Telehealth Adoption, Jan. 2013, [http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2013/Jan/1657\\_Broderick\\_telehealth\\_adoption\\_VHA\\_case\\_study.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2013/Jan/1657_Broderick_telehealth_adoption_VHA_case_study.pdf), p. 5.

<sup>30</sup> *Id.*, p. 6.

failure, down 25.9%; chronic obstructive pulmonary disease, down 20.7%; and diabetes down 20.4%.<sup>31</sup> Again, this decrease in hospital usage directly translates to cost savings.

More recently, the VA's telehealth efforts have taken off dramatically. In 2015, the VA did 2.1 million episodes of telehealth care, including home telehealth, site-to-site telehealth, and store and forward. Included in that total is 400,000 telemental health visits.<sup>32</sup> The VA's financial commitment is equally impressive: the 2017 VA budget provided \$1.2 billion for telehealth.<sup>33</sup>

While various estimates of the monetary gains to be realized from the increased adoption of telemedicine differ, they are all substantial. Taken together with the positive, nonquantifiable benefits of telemedicine, they present a compelling argument for pursuing policies to encourage adoption of these technologies.

### **CHALLENGES TO RURAL TELEHEALTH**

While the potential benefits to telemedicine are plentiful, there are also a number of impediments inhibiting the widespread implementation of telemedicine technology.

Reimbursement. Medicare has extremely strict requirements for reimbursing for telemedicine. Currently, Medicare does not provide reimbursement for “store-and-forward” delivered services, nor for remote patient monitoring services.<sup>34</sup> In order to be considered for reimbursement, the originating site must be located in a nonmetro county or in a designated Health Professional Shortage Area in a rural census tract of a metropolitan county.

Obtaining Medicaid reimbursement for telehealth can be a confusing process. Generally, it is up to each individual state to determine whether or not specific telehealth services are covered by Medicaid. As of August 2016, the Center for Connected Health Policy reported that Medicaid coverage for live video telehealth is available in 48 states. Twelve states offer some reimbursement for store-and-forward.<sup>35</sup> However, every state varies in its policies.

Medicare places strict limits on the professionals who may provide eligible telehealth services. These include physicians, nurse practitioners, physician assistants, nurse midwives, clinical nurse specialists, clinical psychologists and clinical social workers, and registered dietitians or nutrition professionals.<sup>36</sup>

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<sup>31</sup> *Id.*, p. 7.

<sup>32</sup> Comstock, Jonah, “How Telehealth is Helping the VA Address Its Access Crisis,” *MobiHealthNews*, May 17, 2016, <http://www.mobihealthnews.com/content/how-telemedicine-helping-va-address-its-access-crisis>.

<sup>33</sup> Department of Veterans Affairs, “Budget in Brief–2017,” <https://www.va.gov/budget/docs/summary/Fy2017-BudgetInBrief.pdf>, p. BiB-9.

<sup>34</sup> Center for Connected Health Policy, “Telehealth and Medicare,” <http://www.telehealthpolicy.us/telehealth-and-medicare>.

<sup>35</sup> Center for Connected Health Policy, “Telehealth Medicaid & State Policy,” <http://www.telehealthpolicy.us/telehealth-medicare-state-policy>.

<sup>36</sup> Center for Connected Health Policy, “Telehealth and Medicare.”

Medicare also imposes restrictions on the originating sites where reimbursed telemedicine services can take place. Currently, these include provider offices, hospitals, critical access hospitals, rural health clinics, federally qualified health centers, skilled nursing facilities, community mental health centers, and hospital-based or critical access hospital-based renal dialysis centers.<sup>37</sup> These reimbursement challenges are having an impact on the adoption of telemedicine. A survey of 1,557 physicians conducted by the Robert Graham Center, American Academy of Family Physicians, and Anthem, found that only 15% were utilizing telehealth in their practice. Nearly 90% indicated that they would use telehealth if they were reimbursed.<sup>38</sup>

According to the REACH Health 2016 U.S. Telemedicine Industry Benchmark Survey, 80% of the organizations surveyed classified managed care reimbursement as a “challenge” which is unaddressed or only partially addressed, 78% found Medicare reimbursement to be a challenge, and 78% Medicaid reimbursement.<sup>39</sup> Further, 35% said that Medicare reimbursement was a contributor to telemedicine return on investment (ROI), 34% said Medicaid reimbursement was a contributor to ROI, and 33% said managed care reimbursement contributed to ROI.<sup>40</sup>

Cost. Implementing telemedicine in a hospital can be an expensive proposition. Equipment costs can be substantial, ranging from \$7,000 to \$30,000 for a digital scanner, \$20,000 to \$250,000 for digital radiography equipment (for example, CT or MRI machines), and \$15,000 to \$20,000 for a video conferencing suite.<sup>41</sup> Upfront costs are only part of the overall picture—equipment must also be maintained and upgraded, as necessary. But the upfront costs are mostly one-time expenditures, and can be offset by ongoing cost savings over time.

In addition to equipment costs, there are also necessary expenditures for installation and training. Training is available through telemedicine associations, universities and colleges, vendors and peer-to-peer training through telemedicine programs. The cost for this training will vary according to the type of training provided.

Malpractice insurance is another significant cost. Currently, some malpractice insurance will cover services provided via telehealth, but not all do. As a result, additional coverage may be necessary. It is the responsibility of individual providers to ascertain whether they may need to seek out additional coverage.

As noted in the preceding section of this paper, not all of the potential quantifiable benefits of telemedicine accrue to the parties undertaking the requisite investments. In addition to the health care facility, tangible financial benefits may also accrue to patients and to businesses in the communities where telemedicine takes place. While this schism between costs and benefits may affect the investment decision to a certain degree, it is important to consider the complete picture to the extent possible.

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<sup>37</sup> *Ibid.*

<sup>38</sup> Men, Jessica, “Lack of Reimbursement Barrier to Telehealth Adoption,” AJMC Peer Exchange, Dec. 14, 2015, <http://www.ajmc.com/newsroom/lack-of-reimbursement-barrier-to-telehealth-adoption>.

<sup>39</sup> Saluke, Andrew, “Telemedicine Reimbursement a Challenge in 2016,” REACH Health, March 15, 2016, <http://reachhealth.com/telemedicine-reimbursement-2016/>.

<sup>40</sup> *Ibid.*

<sup>41</sup> Whitacre, p. 182.

where telemedicine takes place. While this schism between costs and benefits may affect the investment decision to a certain degree, it is important to consider the complete picture to the extent possible.

Patient Privacy. The Health Insurance Portability and Accountability Act of 1996, or HIPAA, is intended to protect individuals' personal health information (PHI). The use of telemedicine does not relieve medical facilities or health care providers of their obligation under HIPAA to protect PHI—the standards are exactly the same as they would be for a face-to-face encounter. It is vitally important that all reasonable steps be taken to insure that PHI remains protected including, but not limited to, the use of such security measures as data encryption and password protection. These are but a part of an overall data security strategy, however—each entity's strategy for HIPAA compliance must be flexible enough to encompass telemedicine, as well.

Licensing. Dealing with various state licensing regulations is a challenge for many telemedicine providers. While virtually all physicians must be licensed in the state in which they physically practice, a number of states require that physicians must also have a valid license in the state where the patient is located. While the concept of a national licensure compact has gained support over recent years, such a solution is still evolving. Eliminating the need for dealing with different regulations in different states will make practicing telemedicine considerably simpler.

## **CONCLUSIONS/NEXT STEPS**

Residents of rural areas face a number of health-related challenges. Demographics tend to work against rural Americans—on average, they are older than their urban counterparts, have fewer financial resources, and exhibit higher incidences of obesity, diabetes and heart disease. Studies have shown that rural Americans, on average, have a lower life expectancy than their urban counterparts.

In addition to these issues, rural Americans face a diminishing supply of health care options, as economic pressures are leading to the closing of an increasing number of rural hospitals. The result is that many rural residents must now travel longer distances to obtain access to the health care that they require.

Telemedicine holds tremendous potential for improving the overall quality of health care in rural America. By facilitating access to specialists located outside of the patient's community, telemedicine can reduce or eliminate costs related to traveling for treatment and lost time from work. It can offer patients access to experts in their particular field, while allowing them to remain in the comfort of their own town. By allowing physicians to remotely monitor their patients' health on an ongoing basis, illness can be identified and treated early on, before the situation becomes severe or even life-threatening.

Several efforts to quantify the cost-saving potential of telemedicine have been undertaken. These savings include reduced travel expenses, reduced time off from work, and hospital savings resulting from "sharing" specialists. In addition, telemedicine allows for lab and pharmaceutical work to be done locally, benefitting the local economy.

There are also costs associated with telemedicine, including equipment purchase, installation and maintenance; training of personnel, and possible increases in malpractice insurance.

The decision to implement telemedicine is unique to each medical facility. The quantitative savings and benefits must be calculated, and the nonquantitative quality of care benefits must also be considered. Like most investments, the long-term picture must be evaluated—while capital investment is higher in the early years, they will significantly decline over time, while costs savings will continue to accrue at a

steady rate. Quantifiable benefits will accrue over time not only to the medical facility, but also to patients and to businesses in the communities where telemedicine takes place.

One particularly critical, but often overlooked, piece of the equation is the need for high-quality, reliable broadband service. Particularly in rural areas, with lower population densities, rugged topography and greater distances between customers, this can be challenging due to the higher costs to serve.

But more and more, fiber-based broadband is being deployed throughout the country, which will enable the adoption of such life-changing technologies as telemedicine. And if the myriad challenges to rural health outlined in this paper are to be addressed in any substantial manner, then telemedicine solutions, built upon a foundation of reliable, future-proof, fiber-based broadband infrastructure, will be a significant part of the solution. Further involvement in, and expansion of, that infrastructure is a critical need for our nation.

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**About NTCA–The Rural Broadband Association:** *NTCA–The Rural Broadband Association is the premier association representing more than 800 independent, community-based telecommunications companies that are leading innovation in rural and small-town America. NTCA advocates on behalf of its members in the legislative and regulatory arenas, and it provides training and development; publications and industry events; and an array of employee benefit programs. In an era of exploding technology, deregulation and marketplace competition, NTCA’s members are leading the IP evolution for rural consumers, delivering technologies that make rural communities vibrant places in which to live and do business. Because of their efforts, rural America is fertile ground for innovation in economic development and commerce, education, health care, government services, security and smart energy use. Visit us at [www.ntca.org](http://www.ntca.org).*

**About Smart Rural Community:** *Smart Rural Community<sup>SM</sup> is an initiative of NTCA–The Rural Broadband Association. Smart Rural Community comprises programming related to and promoting rural broadband networks and their broadband-enabled applications that communities can leverage to foster innovative economic development, commerce, education, health care, government services, public safety and security and more efficient energy distribution and use. Smart Rural Community hosts educational events for communications and noncommunications professionals, including government policy-makers; administers an award program that invites and reviews applications of rural broadband providers for certification and recognition; and provides resources to rural broadband providers to assist their achievement of goals promoted by Smart Rural Community. Smart Rural Community also publishes original research and white papers that investigate issues relating to rural broadband deployment, adoption and use. For information please visit [www.ntca.org/smart](http://www.ntca.org/smart).*

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***Additional Smart Rural Community White Papers:***

Seidemann, Joshua, “Beyond Rural Walls: Identifying Impacts and Interdependencies Among Rural and Urban Spaces,” NTCA–The Rural Broadband Association ([http://www.ntca.org/images/stories/Documents/Advocacy/SmartCommunity/src\\_beyond\\_the\\_rural\\_walls\\_white\\_paper.pdf](http://www.ntca.org/images/stories/Documents/Advocacy/SmartCommunity/src_beyond_the_rural_walls_white_paper.pdf)) (2015).

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