Texas Health and Human Services e-Health Advisory Committee

As Required by
Title 1, Part 15, Texas Administrative Code,
Section 351.823(d)

e-Health Advisory Committee
December 2024

Contents

Disclaimer

This report is not authored by and does not necessarily reflect the views and opinions of the Texas Health and Human Services system, its component agencies, or staff. For a full roster of representatives who contributed to this report, see Appendix A.

Executive Summary

The Texas Health and Human Services Commission's (HHSC's) e-Health Advisory Committee (eHAC) was established under Texas Government Code, Section 531.012 to advise the Executive Commissioner and Health and Human Services (HHS) system agencies on strategic planning, policy, rules, and services related to the use of health information technology (HIT), health information exchange (HIE) systems, telemedicine, telehealth, and home telemonitoring services.[1]

As directed by Title 1, Part 15, Texas Administrative Code (TAC), Section 351.823(d), the eHAC is making several recommendations, which fall into three categories:

Task 1 (Section 351.823. eHAC): Advises HHS agencies on the development, implementation, and long-range plans for health care information technology (IT) and HIE, including use of:

1. Electronic health records (EHRs), computerized clinical support systems, HIE systems for exchanging clinical and other types of health information, and

2. Other methods of incorporating HIT in pursuit of greater cost-effectiveness and better patient outcomes in health care and population health.

Task 2 (Section 351.823. eHAC): Advises HHS agencies on incentives for increasing health care provider adoption and usage of EHR and HIE systems.

Task 3 (Section 351.823. eHAC): Advises HHS agencies on the development, use, and long-range plans for telemedicine, telehealth, and home telemonitoring services, including consultations, reimbursements, and new benefits for inclusion in Medicaid telemedicine, telehealth, and home telemonitoring programs.

The eHAC includes HHS stakeholders concerned with the use of HIT, HIE, telemedicine, telehealth, and home telemonitoring services. eHAC membership includes representation from the Texas Medical Board, the Texas Board of Nursing, the Texas State Board of Pharmacy, the Statewide Health Coordinating Council, managed care organizations (MCOs), representatives from the pharmaceutical industry, academic health science centers, an expert on telemedicine, an expert on home telemonitoring services, a representative of

[1] See TAC Section 351.823(a) and (b).

consumers of health services through telemedicine, a Medicaid provider, a representative from the Texas Health Services Authority (THSA), a representative from a local or regional HIE, and representatives with expertise in implementation of EHRs, computerized clinical support systems, and HIE systems for exchanging clinical and other types of health information. The committee also includes two ex-officio representatives from HHSC and one ex-officio representative from the Department of State Health Services (DSHS). For a full roster of representatives, see Appendix A.

The remainder of this report includes recommendations on the three tasks listed above, as well as other information as required under TAC Section 351.823.

Introduction

The eHAC is established under Texas Government Code, Section 531.012 and governed by Texas Government Code, Chapter 2110 and TAC Section 351.823.

Pursuant to TAC Section 351.823:

> No later than December 1 of each even-numbered year, the committee files a written report with the HHSC Executive Commissioner and the Texas Legislature covering the meetings and activities not covered in its most recent report filed with the HHSC Executive Commissioner and Texas Legislature through September 30 of the even-numbered year the report is due to be filed. The report includes:
>
> (A) a list of meeting dates;
>
> (B) the members' attendance records;
>
> (C) a brief description of actions taken by the committee;
>
> (D) a description of how the committee accomplished its tasks;
>
> (E) a summary of the status of any rules that the committee recommended to HHSC;
>
> (F) a description of activities the committee anticipates undertaking in the next fiscal year;
>
> (G) recommended amendments to this section;
>
> (H) any policy recommendations; and
>
> (I) the costs related to the committee, including the cost of the HHSC staff time spent supporting the committee's activities and the source of funds used to support the committee's activities.

Note: a full list of acronyms used in this report is available on page 34. This report provides a background for eHAC's recommendations, as well as information on each criterion listed above.

Background

TAC Section 351.823 requires the eHAC to address three tasks:

Task 1: Advises HHS agencies on the development, implementation, and long-range plans for health care information technology and HIE, including use of:

- EHRs, computerized clinical support systems, HIE systems for exchanging clinical and other types of health information, and
- Other methods of incorporating HIT in pursuit of greater cost-effectiveness and better patient outcomes in health care and population health.

Task 2: Advises HHS agencies on incentives for increasing health care provider adoption and usage of EHR and HIE systems.

Task 3: Advises HHS agencies on the development, use, and long-range plans for telemedicine, telehealth, and home telemonitoring services, including consultations, reimbursements, and new benefits for inclusion in Medicaid telemedicine, telehealth, and home telemonitoring programs.

Definitions: Unless stated otherwise in this report, the terms below shall have the following definitions:

"Electronic Health Record" (EHR) means "an electronic record of aggregated health related information concerning a person that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized health care providers across two or more health care organizations" [see Texas Government Code, Section 531.901(1)].

"Electronic Medical Record" (EMR) means "an electronic record of health-related information concerning a person that can be created, gathered, managed, and consulted by authorized clinicians and staff within a single health care organization" (see Texas Government Code, Section 531.901(2)).

"Health Information Exchange" (HIE) means an organization that:

> (1) Assists in the transmission or receipt of health-related information among organizations transmitting or receiving the information according to nationally recognized standards and under an express written agreement with the organizations;

(2) As a primary business function, compiles or organizes health-related information designed to be securely transmitted by the organization among physicians, other health care providers, or entities within a region, state, community, or hospital system; or

(3) Assists in the transmission or receipt of electronic health-related information among physicians, other health care providers, or entities within: (A) a hospital system; (B) a physician organization; (C) a health care collaborative, as defined by Section 848.001, Insurance Code; (D) an accountable care organization participating in the Pioneer Model under the initiative by the Innovation Center of the Centers for Medicare & Medicaid Services (CMS); or (E) an accountable care organization participating in the Medicare Shared Savings Program under 42 United States Code, Section 1395jjj (see Texas Health & Safety Code, Section 182.151; see also Texas Health & Safety Code, Section 481.002(54); see also Texas Government Code, Section 531.901).

"Home telemonitoring service" means "a health service that requires scheduled remote monitoring of data related to a patient's health and transmission of the data to a licensed home and community support services agency, a federally qualified health center, a rural health clinic, or a hospital, as those terms are defined by Texas Government Code, Section 531.02164(a)."

"Telehealth service" means "a health service, other than a telemedicine medical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state [Texas] and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology" (see Texas Occupations Code, Section 111.001(3); see also Texas Government Code, Section 531.001(7)).

"Telemedicine medical service" means "a health care service delivered by a physician licensed in this state, or a health professional acting under the delegation and supervision of a physician licensed in this state, and acting within the scope of the physician's or health professional's license, to a patient at a different physical location than the physician or health professional using telecommunications or information technology" (see Texas Occupations Code, Section 111.001(4); see also Texas Government Code, Section 531.001(8)).

eHAC Meeting Dates

The eHAC met on the following dates in fiscal year 2023–fiscal year 2024:

- December 5, 2022
- March 6, 2023
- June 16, 2023
- September 18, 2023
- December 4, 2023
- March 11, 2024
- June 17, 2024
- September 16, 2024

This document reports on meetings and activities beginning October 1, 2022–September 30, 2024.

Brief Description of Actions Taken by the Committee and Member Attendance

Below is a high-level list of actions taken by the committee at each meeting.

December 5, 2022 (63 percent member attendance)

- HHSC staff reported that eHAC candidates will be referred to the HHSC Executive Commissioner for consideration. The Office of e-Health Coordination extended the eHAC abolishment date to December 2027, effective September 26, 2023.
- Ms. Robinson led the discussion on the December 2022 Biennial Report. The committee approved the December 2022 Biennial Report as presented.
- Ms. Robinson led a discussion on potential topics for educational and pilot project opportunities with multiple topics surfacing; life after the COVID-19 Public Health Emergency (PHE); the value of Continuing Educational Units associated with educational opportunities; and legislative actions during the 88th Legislative session.
- HHSC staff provided an update on the 88th Legislative Session bill filling including House Bill (H.B.) 592, H.B. 594, and Senate Bill (S.B.) 137.
- DSHS staff provided an update on interoperability and data activities.
- HHSC staff shared information regarding the *HHSC 2022 Interoperability Report* required by H.B. 2641 (84th Legislature, Regular Session, 2015) and updated the committee on HIE infrastructure, Emergency Department Encounter Notification (EDEN), and the Patient Unified Lookup System for Emergencies (PULSE). Staff reported on the HHSC Interoperability Center of Excellence (ICOE) including a vision and purpose for the ICOE. Staff additionally reported on the Project US@ address standards that address patient matching.

March 6, 2023 (82 percent member attendance)

- Mr. Gregory Conte, Director, Texas Broadband Development Office, provided a presentation on *Broadband in Texas*.

- HHSC staff provided a legislative update on telemedicine requirements to allow more services to be delivered remotely on a permanent basis at the end of the COVID-19 PHE if clinically appropriate and cost-effective.
- HHSC staff provided status of the HIE Connectivity Project including Medicaid provider connectivity, HIE infrastructure, EDEN, and PULSE.
- HHSC staff shared information on the Performance Management and Analysis (PMAS) database and HIE Connectivity objectives.

June 16, 2023 (80 percent attendance)

- HHSC staff reported that the committee's proposal to extend the committee for an additional two years will be released for public comment in July. The committee now consists of 20 active members with an additional 4 to be appointed.
- HHSC staff provided a state legislative update on House and Senate bills filed including H.B. 2727 and S.B. 30 (88th Legislature, Regular Session, 2023).
- Mr. William "Bill" Zielinski, Chief Information Officer for the City of Dallas, provided a presentation on the City of Dallas' efforts to ensure digital equity including challenges and opportunities.
- HHSC staff provided an update on the HIE Connectivity Project and Medicaid Modernization Technology work, including Medicaid Provider HIE connectivity, HIE infrastructure, EDEN, and PULSE.
- DSHS staff provided an update on interoperability and data activity from DSHS and federal health information activities.
- Ms. Robinson and Mr. Beckett led a discussion on the eHAC educational program needs.

September 18, 2023 (88 percent attendance)

- HHSC staff reported that recommended applicants to fill open positions were under review. Two categories would be re-posted: MCO and a consumer of health services through telehealth.
- HHSC staff provided updates on the eHAC rule amendment related to TAC, Title 1, Part 15, Section 351.823.
- New chair elections were held. Ms. Robinson was re-elected as Chair and Dr. Beckett was re-elected as Vice-Chair.

- HHSC staff provided updates on the HIE Connectivity Project within the Medicaid Modernization Technology team. CMS approved an updated Medicaid Management Information System Advanced Planning Document. The PMAS team migrated data into an internal data repository. CMS funding for Strategies 2 and 3 for PULSE will continue for fiscal years 2024 and 2025.
- DSHS staff provided a report on interoperability and data activities including electronic case reporting readiness. On September 1, 2023, DSHS declared readiness for electronic case reporting for hospitals/critical access hospitals under Medicare's Federal Promoting Interoperability with program requirements.
- Dr. Suja Pillai and Ms. Deborah Norris reported on the Medicaid EHR Incentive Program. The program ended in December 2021 with post payment audits continuing for two years. All federal funds were allocated and the use of EHRs in Texas increased from 43 percent in 2009 to 89 percent in 2022. The program was a success with acknowledgement that behavioral health (BH) providers were not the primary recipients of these funds.
- HHSC staff provided a presentation on ethics addressing common concerns.
- Dr. Phil Beckett provided a presentation on image enablement for Texas. There is an estimated $27 million in savings for the state that may be realized by decreasing duplicate radiology images for Medicaid patients if technology that enables providers to share images is implemented.
- Ms. Robinson and Dr. Beckett provided an update on the eHAC educational program. The purpose of the workshop is to educate agency staff, legislators and their staff, and other professionals associated with HHSC on the healthcare ecosystem. Continuing Medical Education offered 3.25 hours for risk management. The educational session was held in October 2023.

December 4, 2023 (89 percent member attendance)

- HHSC staff reported on eHAC membership appointments and rule amendment for a two-year extension of eHAC. The rule amendment was approved and became effective on November 9, 2023.
- Ms. Robinson provided information on new reporting requirements for the eHAC. Ms. Robinson led a discussion on the eHAC educational program. The committee supported offering additional educational programming in the future.

- HHSC staff provided a status update on the HIE Connectivity Project, EDEN, and PULSE. The data from EDEN will be housed in a centralized repository supported by PMAS.
- DSHS provided an update on HIT and public health including federal HIT, national public health activities, and DSHS activities.
- HHSC staff provided an update on Texas Certified Community Behavioral Health Clinics (CCBHC) and HIT including S.B. 26 reporting requirements.
- Dr. Phil Beckett led a discussion on opportunities regarding image enablement in Texas.
- DSHS staff provided an overview of Electronic Case Reporting in Texas.

March 11, 2024 (61 percent member attendance)

- HHSC staff reported they received 30 applications for the committee. Three applicants were recommended for approval and sent to the Advisory Committee Coordination Office.
- Ms. Robison led the committee in a discussion on the 2024 education program on content and timing.
- HHSC staff reported on the interoperability activities covering general program and interoperability updates as well as the HIE Connectivity Project, EDEN, and PULSE. Ms. Mathis stated that the HIT and HIE team moved from the HHSC Medicaid Technology Modernization program to the HHSC Medicaid Quality and Program Improvement section.
- DSHS staff provided an update on interoperability and data activities including the United States Core Data for Interoperability (USCDI) and the Center for Disease Control on core data for interoperability and its impacts on technology used in public health.
- Dr. Beckett provided an update on image sharing. He provided information from Kentucky on the savings of $4.5 million by eliminating image sharing and decreasing duplicate radiology images.

June 17, 2024 (79 percent member attendance)

- HHSC staff reported that all eHAC vacancies were filled.
- HHSC staff led a discussion in a review of proposed amendments to the eHAC Bylaws. The amendments to the bylaws were approved.

- HHSC staff led the committee in a discussion on the eHAC biennial report to HHSC and the Legislature. Volunteers were gathered to assist with writing the report.
- Dr. Beckett led the committee in a discussion on the eHAC educational program for 2024. Volunteers were garnered to assist with development of the educational program.
- HHSC staff provided an update on implementation of H.B. 2727. Committee members provided thoughts and considerations to HHSC staff on implementation of the legislation.
- DSHS staff provided an update on HIT and public health including federal and state efforts.
- Dr. Beckett updated the committee on image enablement opportunities and the potential value for Texans.

September 13, 2024 (90 percent member attendance)

- HHSC staff reported the agency is assessing its need for this committee in order to determine need for an extension of eHAC.
- eHAC Subcommittee leads provided an update on activities since the June 2024 meeting.
- Dr. Beckett invited Ms. Cox to provide an update on the 2024 eHAC Biennial report due on December 1, 2024. Ms. Cox served on the report writing team.
- Members briefly discussed the proposed eHAC educational session suggested for the same date as the December 6, 2024 eHAC meeting. Ms. Rhames provided an update on the agency's guidance.
- DSHS staff provided an update on HIT and public health, including federal and state efforts.
- eHAC members were presented information on healthcare access and equity for Spanish-speaking population in the United States, by invited guests from the California Department of Public Health and the San Diego Regional HIE.
- eHAC members were presented information on improvement of patient matching in infants and newborns, by invited guest pediatrician faculty member from the University of Texas Southwestern & University of Texas Dallas, Medical Staff at Children's, Parkland, & Clements.

- eHAC members were presented an overview of manual data entry in healthcare in Texas, by invited guest representative from My Health My Resources of Tarrant County.

Recommendations from eHAC to HHSC and the Legislature

As noted in the Background section, the committee has tasks in three primary areas to include in this report. These tasks are being addressed within the three sections below, as determined by the eHAC subcommittees. The Interoperability Subcommittee report and recommendations discuss Tasks 1 and 2. The Telemedicine, Telehealth, & Telemonitoring Subcommittee considers Task 3. The Behavioral Health Subcommittee covers all three tasks within the realm of BH. Prior recommendations and their status are included on pages 25-32.

Interoperability Subcommittee

This subcommittee report was developed by the Texas HHS eHAC Subcommittee on Interoperability and is intended to support the eHAC in the development of its annual report, as required by TAC Section 351.823. As discussed below, this report (1) lays out the charge of the subcommittee; (2) provides a definition of interoperability; (3) provides an overview of the items discussed by the subcommittee this year; (4) discusses interoperability at the regional, state, and national levels; and (5) provides recommendations on interoperability to the eHAC.

Charge of the eHAC Subcommittee on Interoperability

The purpose of the Interoperability Subcommittee is to address Tasks 1 and 2 in the eHAC's enabling rule, TAC Section 351.823.

Task 1. The eHAC advises HHS agencies on the development, implementation, and long-range plans for health care information technology and HIE, including use of:

- EHRs, computerized clinical support systems, HIE systems for exchanging clinical and other types of health information.
- Other methods of incorporating HIT in pursuit of greater cost-effectiveness and better patient outcomes in health care and population health.

Task 2. The eHAC advises HHS agencies on incentives for increasing health care provider adoption and usage of EHR and HIE systems.

What is Interoperability?

According to Section 4003 of the federal 21st Century Cures Act (Cures Act), the term "interoperability," with respect to HIT, means such HIT that:

> (A) enables the secure exchange of electronic health information with, and use of electronic health information from, other health information technology without special effort on the part of the user;
>
> (B) allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable state or federal law;

(C) does not constitute 'information blocking'[2] as defined in section 3022(a).[3]

Overview of Items Discussed by the Interoperability Subcommittee This Reporting Period

The Interoperability Subcommittee met several times throughout the last two years to discuss interoperability challenges and opportunities as they relate to the work of eHAC. The Interoperability Subcommittee provided a full report of its meetings at each scheduled eHAC meeting.

These discussions of the subcommittee included, but were not limited to:

(1) the Texas Immunization Registry, known as ImmTrac 2, and COVID-19 vaccine data,

(2) PHE retention and release of data,

(3) Improving patient matching as a foundation for interoperability with standardized naming conventions and US@ adoption for address capture;

(4) HHSC ICOE and DSHS Interoperability and Data activity, and their relationship with the Texas Medicaid Health IT Strategic Plan;

(5) USCDI data elements and classes;

(6) Review of bills from the 88th Legislative Session relating to Interoperability:

[2] The Cures Act defines information blocking as "a practice that…is likely to interfere with, prevent, or materially discourage access exchange, or use of electronic health information." The Cures Act goes on to apply this definition to not only health information technology developers, exchanges, and networks, but also to healthcare providers. In addition to laying out certain practices that do constitute information blocking, the Act also provides seven exceptions to what constitutes information blocking. More information is available for review in the Cures Act, as well as the Notice of Proposed Rulemaking at 84 Fed. Reg. 7424 (proposed March 4, 2019) (to be codified at 45 C.F.R. pts. 170 and 171).

[3] 21st Century Cures Act, Public Law 114-255, https://www.congress.gov/bill/114th-congress/house-bill/34/text.

- S.B. 342 (Zaffirini) and H.B. 172 (Howard). These bills, which were companions, proposed to modify the consent process for the Texas immunization registry. Neither bill passed.

- S.B. 290 (Johnson). This bill would have modified the governing statute for THSA to allow THSA to collect certain clinical data for treatment, payment, or health plan operations. The bill did not pass.

(7) Quality measuring and reporting alignment across HHS programs;

(8) BH interoperability needs;

(9) Image exchange;

(10) Funding for connecting additional providers to hospitals; and

(11) Data usability efforts to improve data quality and effectiveness.

Background Information on Interoperability at the Regional, State, and National Levels

Interoperability at the Regional Level

Regional HIEs in Texas offer services to health care systems, providers, payors, and hospitals to share health care information primarily for the purposes of payment, treatment, and other healthcare operations. There are five regional HIEs: Greater Houston Health Connect, PHIX (Paso del Norte HIE), C3HIE (formerly HASA), Connxus (formerly ICC) and Connected Care Exchange (formerly Rio Grande Valley HIE). These regional HIEs are non-profit organizations and offer integrated interoperability services with the aim of helping drive participant costs down and/or participants revenues up.

All the regional HIEs use standard, secure connections with strong encryption so that patient data is secure. The HIEs integrate with health care providers' EHR systems where possible so that the access and exchange of the data is accessible within the user's normal workflow. Each provider participant in an HIE signs a business associate agreement defining responsibility for protecting the data and its approved use. Texas does not have a required opt-in or opt-out model, and the HIEs have different models based on local governance, but all patients in any regional HIE have the option to opt out at any participating facility.

Interoperability at the State Level

Pursuant to Chapter 182, Texas Health and Safety Code, the THSA is responsible for statewide HIE. Formed by the Texas Legislature as a public-private partnership, THSA partners with state agencies, regional HIEs, as well as others engaging in the exchange of health information across Texas.

THSA is also responsible for implementing the Texas State HIE Plan, originally created by the HHSC and THSA for submission to the Office of the National Coordinator in 2010. THSA's governor-appointed board of directors supplemented the state HIE plan in 2014 and 2020 to reflect the changing HIE market, interoperability adoption in the public and private sectors and alignment with CMS directives. Also relevant to state-level HIE is public health reporting and HIE with programs such as those provided by DSHS including, but not limited to Electronic Case Reporting, Electronic Laboratory Reporting, the Texas Immunization Registry/ ImmTrac2, Texas Syndromic Surveillance, and the Texas Cancer Registry. Another example of a system that exchanges data with the private sector is the prescription monitoring program (PMP), which is operated by the Texas State Board of Pharmacy.

Pursuant to Texas H.B. 2641, 84th Legislature, Regular Session, 2015, certain registries maintained by DSHS may bidirectionally exchange health information with providers via electronic HIEs. This legislation also required "the commission and each health and human services agency establish an interoperability standards plan for all information systems that exchange protected health information with health care providers."

Interoperability at the National Level

National HIE generally refers to information exchanged through:

(1) eHealth Exchange: The eHealth Exchange is "the largest query-based, health information network in the country. It is the principal network that connects federal agencies and nonfederal organizations, allowing them to work together to improve patient care and public health."

(2) CommonWell Health Alliance: The CommonWell Health Alliance (CommonWell) is "a not-for-profit trade association devoted to the simple vision that health data should be available to individuals and caregivers regardless of where care occurs. Additionally, access to this

data must be built into health IT at a reasonable cost for use by a broad range of health care providers and the people they serve."

(3) Carequality Interoperability Framework: Carequality is "a public-private, multi-stakeholder collaborative developed to create a standardized, national-level interoperability framework to link all data-sharing networks." Carequality implementers are "the adopters of the Carequality Interoperability Framework, and their clients."

(4) Civitas Patient Centered Data Homes: The Civitas Patient Centered Data Home (PCDH) is a "national collaborative representing HIEs and their business and technology partners." The PCDH is "a cost-effective, scalable method of exchanging patient data among HIEs. It's based on triggering episode alerts, which notify providers a care event has occurred outside of the patient's 'home' HIE and confirms the availability and the specific location of the clinical data, enabling providers to initiate additional data exchanges to access real-time information across state and regional lines and the care continuum."

(5) Trusted Exchange Framework and Common Agreement (TEFCA): The Cures Act requires the Office of the National Coordinator for HIT to convene stakeholders to develop a trusted exchange framework and a common agreement among existing, disparate health information networks (HINs) to exchange electronic health information. TEFCA is designed to scale electronic HIE nationwide and help ensure that HINs, healthcare providers, health plans, individuals and many more stakeholders have secure access to their electronic health information when and where it is needed. In July 2024, TEFCA launched with seven qualified HINs committed to promoting interoperability between the networks they represent. TEFCA is a voluntary program with financial incentives from CMS for hospitals and providers to participate, as established by the 21st Century Cures Act.

(6) Sequoia Project, which serves as the Recognized Coordinating Entity for TEFCA: The Sequoia Project is an "independent, trusted advocate for nationwide HIE. In the public interest [the Sequoia Project] steward[s] current programs, incubates new initiative[s,] and educate[s] our community." In 2019, the Office of the National Coordinator for HIT selected the Sequoia Project as the Recognized Coordinating Entity for TEFCA. In October 2020, the Sequoia Project

launched the Data Usability Workgroup with a focus on data quality and addressing HIE for provider to provider, provider to public health, and healthcare entity to consumer. The efforts of this workgroup culminated with the release of the Data Usability Implementation Guide in December 2022. The multidisciplinary workgroup continues to meet with the second edition of the Implementation Guide under development.

(7) DirectTrust Secure Messaging: Direct Trust is a "non-profit trade alliance membership organization, community convener and American National Standards Institute accredited standards body. Direct Trust standards enable "push" technology to send messages in a Health Insurance Portability and Accountability Act compliant manner where the information can be ingested into the EHR improving efficiency and accuracy with transmitted information.

Recommendations

As recommended in previous annual reports, Texas HHS system agencies should leverage the existing EHR and HIE infrastructures described in this report, and should avoid developing duplicate infrastructure, to a) better assist healthcare entities in complying with interoperability regulations and initiatives described in this report; b) drive down healthcare costs; c) improve population health; and d) reduce the burden of reporting for both healthcare providers and public health through structured, secure, electronic data exchange.

The following recommendations were submitted to Texas HHS and address Task 1 and Task 2 in the eHAC's enabling rule, TAC Section 351.823 with standardizing data reporting, improving data quality and patient matching in support of cost-effectiveness and better patient outcomes.

- Adopt a policy for alignment of Clinical Quality Measures/electronic Clinical Quality Measures across HHS programs both through the intake process adopted two years ago, and through the biennial report to the executive commissioner and legislature.
- Adoption of the American Health Information Management Association patient naming policy framework and collaboration to educate the Texas Healthcare community on the value of a standardized naming framework.

The Interoperability Subcommittee continues to explore incentives for adoption including funding, clinical effectiveness and cost control with image exchange, and BH expansion along with other use cases.

Telemedicine, Telehealth and Telemonitoring Subcommittee

This subcommittee report was developed by the Texas HHS eHAC Subcommittee on Telemedicine, Telehealth & Telemonitoring. The focus of this section is on Task 3 of the eHAC's enabling rule, TAC Section 351.823.

Task 3: Advises HHS agencies on the development, use, and long-range plans for telemedicine, telehealth, and home telemonitoring services, including consultations, reimbursements, and new benefits for inclusion in Medicaid telemedicine, telehealth, and home telemonitoring programs.

Focus Areas

The subcommittee focused on the following key topics during the reporting period:

1. **Federal PHE Expiration Impact:** The subcommittee members discussed the implications of the Federal PHE conclusion on telehealth across various sectors in the state. Significant attention was devoted to examining the future status of state-level telehealth permissions enacted during the pandemic. The subcommittee also recognized the need for enhanced educational opportunities for telehealth service providers, particularly the importance of ongoing training in this rapidly evolving field. It was agreed that these areas require continued monitoring and potential action in future meetings.

2. **Digital Divide and Digital Literacy:** The subcommittee engaged in a comprehensive discussion on digital health access and literacy. Members explored strategies and examples of good use in the state for closing the digital divide, and they identified the need to consult content experts in this field for further input. The conversation covered digital front door experiences and various digital literacy initiatives. It was noted that some organizations have implemented "digital navigator" roles to assist patients, though affordability remains a significant barrier for many. The subcommittee also examined potential strategies for expanding telementoring programs, as some organizations in the state are great exemplars in how this can be effectively used to improve digital access and

literacy. These topics were recognized as crucial for improving healthcare accessibility and will be further addressed in upcoming meetings.

3. **Assessing Completeness of Telehealth Information Sharing:** The subcommittee reviewed the ongoing collaborative effort with THSA to evaluate major telehealth vendors' practices in sharing Continuity of Care Document information with patients' primary medical homes. Members emphasized the critical importance of ensuring that patient visits conducted through national telehealth vendors and providers are effectively communicated back to the patients' primary care providers within Texas. This initiative aims to maintain continuity of care and prevent fragmentation of medical information.

4. **Remote Patient Monitoring (RPM):** The subcommittee conducted a review of members' experiences with RPM, revealing valuable insights into its implementation and use across various healthcare settings. During the discussion, members noted the substantial volume of data submissions from Texas residents, with one EHR vendor reporting over 100 million submissions alone. This significant figure underscores the widespread adoption and utilization of RPM technologies in the state. Conversations also covered mitigating steps to prevent fraud, waste, and abuse.

5. **Provided Input to HHSC Team on Implementation Planning for Legislation:** The subcommittee engaged in a comprehensive review of several telehealth-related legislative and policy matters. Members provided input on the implementation of H.B. 2056, which pertains to dentistry practice and tele-dentistry services. The discussion then shifted to various aspects of Texas Medicaid telecommunication encounters, where the subcommittee offered feedback on telemonitoring billing; documentation requirements for telemedicine, telehealth, and telemonitoring; eligibility conditions for home telemonitoring; and reimbursement policies. The subcommittee received an update on the implementation of H.B. 2727 and its impact on telemonitoring applications in Rural Health Clinics and Federally Qualified Health Centers. Particular attention was given to the required plan of care for telemonitoring as outlined in H.B. 2727, emphasizing the importance of this provision in the context of expanding telehealth services.

6. **Utilization and Cost Data Review:** The subcommittee obtained and reviewed comprehensive data on the utilization and costs of telemedicine, telehealth, and telemonitoring services in Texas through the Biennial

Utilization and Cost Savings Report. Members emphasized the critical importance of tracking standardized state-level data to accurately assess the usage patterns and deployment limitations of these technologies across various healthcare settings. The discussion extended to strategies for more effective data collection and validation methods to ensure accuracy. This thorough analysis will serve as a foundation for informed decision-making and policy recommendations, enabling the subcommittee to address challenges and optimize the implementation of telehealth services throughout the state.

7. **Impact of and Synergy between State and Federal Regulations:** The subcommittee discussed the proposed calendar year 2025 Medicare Physician Fee Schedule changes and assessed their potential impact on Texas residents. Key points included the continued suspension of frequency limitations for certain inpatient, nursing facility, and critical care consultations through calendar year 2025, enhancing access to these services, and a proposal to allow two-way, real-time audio-only communication for telehealth services when video technology is not feasible, set to begin in 2025. This change could significantly improve telehealth accessibility for those with limited video capabilities and may be useful to assess from a state level regarding services provided by Texas Medicaid. These updates were recognized as important changes impacting telehealth in the evolving landscape of healthcare service delivery to the residents of Texas and items in which synergies between Medicare and Texas Medicaid may benefit healthcare practitioners.

Recommendations

The subcommittee continues to play a crucial role in advising HHS agencies on the development and implementation of telehealth, telecommunication, and telemonitoring services in Texas. As the landscape of healthcare delivery evolves, particularly in the wake of the COVID-19 pandemic, the subcommittee's work remains vital in advising ways to provide accessible, efficient, and high-quality services for Texas residents. The subcommittee makes the following recommendations:

1. Monitor for any potential impact of changes or expirations in telehealth federal and state permissions on utilization and update of telehealth for Texas residents.

2. Proactively identify and encourage development of methods to bridge the digital divide and improve digital literacy of our residents through innovations such as telementoring.
3. Monitor and work with state partners to ensure appropriate communication of telehealth provisioning of care with primary care physicians within the state to enhance care coordination.
4. Recognizing the complexity of current processes, the subcommittee identified a key objective to review and work with relevant HHSC legislative teams to provide input with simplifying RPM billing requirements for healthcare providers.
5. Continue to provide feedback to HHSC teams to help with streamlining administrative procedures and expanding situations which may potentially encourage broader adoption of RPM systems throughout Texas.

Behavioral Health Subcommittee

The Behavioral Health Subcommittee continues to address the significant barriers that BH providers face in becoming compliant with the data-sharing requirements of the federal 21st Century Cures Act.

Behavioral Health Background

Despite the critical need for integrated care, BH providers were excluded from federal EHR incentive payments, leaving them without the financial support needed to adopt and implement EHR systems over the past decade. As a result, many BH providers are now behind in their implementation and user acceptance of EHRs, further complicating their efforts to meet national interoperability standards.

While many local mental health authorities (LMHAs) have implemented EHRs, these systems often limited interoperability with legacy state systems, which themselves are not accessible using national interoperability standards in part because the national standards do not always adequately support the full range of BH services. Freestanding psychiatric hospitals continue to report low EHR adoption due to high costs of implementation against lower reimbursement rates.

In reviewing the recommendations put forth by this subcommittee in the full December 2022[4] report, it is clear little progress has been made in addressing those recommendations. This lack of advancement is concerning, especially given the increasing pressure at the federal level to share data with other providers and patients through digital applications, as well as the corresponding state-level demands for compliance.

While S.B. 640 (Behavioral Health Technology Readiness) was being worked on during the 87th Legislative Session, one significant concern, aside from interoperability compliance, was that BH providers might miss out on future quality dollars tied to technology measures. Recently, HHSC introduced the Aligning Technology by Linking Interoperable Systems (ATLIS) for Client Health Outcomes Program as part of the hospital supplemental payment program. Interoperability can be achieved by acute care hospitals that benefited from EHR incentive dollars over the past decade, but BH providers, particularly psychiatric hospitals, did not

[4] Texas HHS eHAC, December 2022, https://www.hhs.texas.gov/sites/default/files/documents/hhs-ehac-report-dec-2023.pdf

receive such funding. However, some BH providers may have indirectly benefitted, if they were employed in a Health Information Technology Economic and Clinical Health funded, eligible facility such as a hospital or a Federally Qualified Health Center. These payment programs have questions related to interoperability; however, a low measure may not reveal an underlying issue of low EHR adoption rate in these organizations (see Appendix B). Without the baseline technology infrastructure, these providers risk missing out once again on much-needed dollars to supplement Medicaid managed care. As Medicaid managed care is the largest payer of BH services in the state, and reimbursement rates are historically lower, it is imperative that this segment be fully prepared digitally to qualify for these essential funds in any upcoming program.

Recommendations

State Agencies

HHSC's current BH platform, implemented in 2009, is fragmented and complex due to the continuous addition of new systems and consolidations over time. This has led to a patchwork of technologies that lack cohesion and standardized interoperability protocols. As a result, the platform does not comply with national data sharing standards, making it difficult to achieve a seamless exchange of BH information among all stakeholders.

A University of Texas at Houston bioinformatics master student supporting the THSA Collaborative's Behavioral Health Workgroup with a platform survey found several of the major legacy state BH systems were not certified and did not follow interoperability and data sharing national standards. When new system requirements arise, such as those from S.B. 26, 88th Legislature, Regular Session, 2023, the state invests significant resources to adapt, or work around, the legacy systems, often creating yet another system, pathway, or protocol that further deviates from national standards. Organizations that contract with the state, but capable of interoperable data exchange, are burdened with additional manual work, such as navigating batching protocols or manually entering data to bridge the gaps in the state's disjointed system.

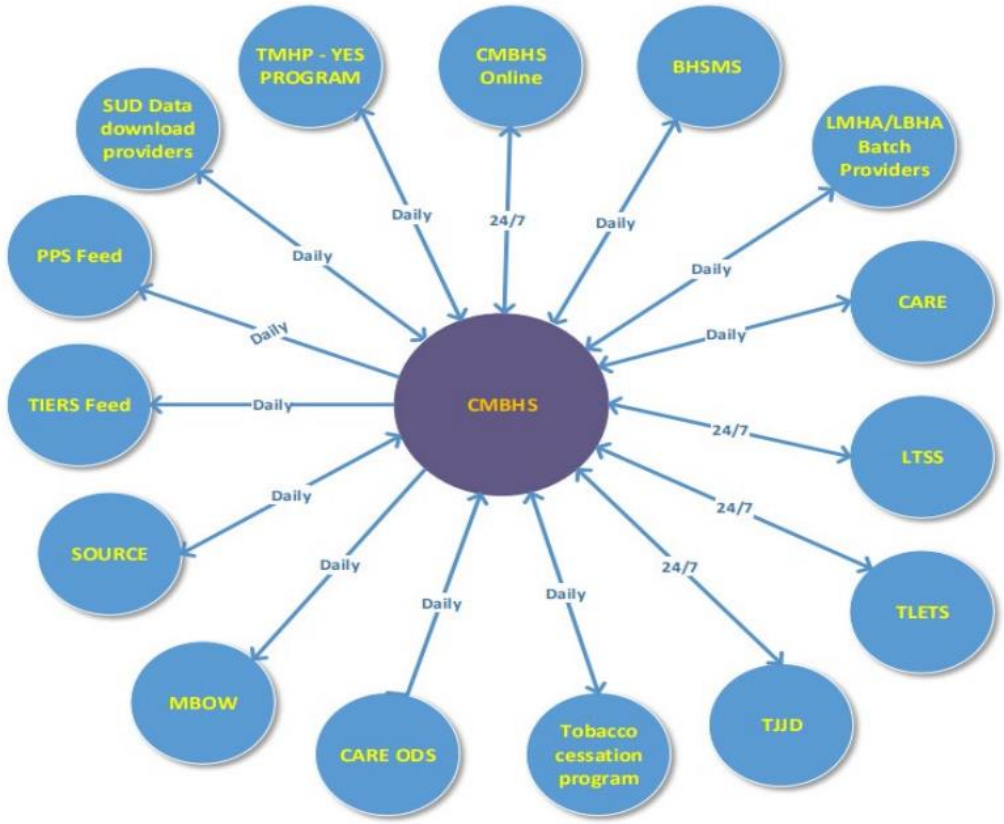

Figure 1: Clinical Management for Behavioral Health Services (CMBHS) is a web-based data management system and EHR developed by HHSC's Behavioral Health Services. Deployed in 2009. Supports tools for state standard levels of care, revenue cycle, and contract monitoring.

- HHSC needs to create standard data exchange protocols to their system using current certified national standards, especially catering to those organizations or providers that are currently required to share per CMS guidelines and the 21st Century Cures Act.
- HHSC needs to develop a strategic plan to move from legacy BH systems and move toward investing in a data-centric platform that allows for standard interoperability for all stakeholders as necessary. The plan needs to include:
    - Appropriate sharing protocols with THSA, HIEs, managed care and contracted providers.
    - The state's role in leading eHealth digital requirements, both locally and federally. The role should also include whether the state should be providing EMR services directly to contracted providers or if those resources and efforts should best be focused elsewhere.

- Needs for ongoing integration and data sharing with physical health and social determinant items.
- Standard integration plans to other state systems that require behavioral information such as child welfare or criminal/juvenile justice.
- Planning and implementation of this plan be executed in a timely manner. Delays will hinder progress and prevent the state from keeping pace with ongoing and evolving healthcare standards and the needs of providers. A more agile approach is essential to avoid inefficiencies and ensure that new technologies are implemented swiftly to meet current demands and improve outcomes across the BH system.
- Guidelines for future changes or purchases related to non-standard needs. Consider the need versus the resources to maintain non-standard systems and the cost to all stakeholders.

LMHAs and State Hospitals

The state hospitals were allocated $39 million in the 88th Legislative Budget specifically for technology. While it was not directed how those funds should be spent, the subcommittee recommends that some of that money be used to get the state hospitals fully interoperable per current standards and connected to an HIE for data sharing.

The LMHAs must be interoperable to pass CCBHC certification but must also continue to batch data to the state systems daily to comply with contractual requirements, creating inefficiencies in the system. It is crucial, as mentioned above, that the state puts something in place as timely as possible to prevent duplicate efforts.

The current Directed Payment Program also incentivizes the LMHAs to connect to an HIE and data share with other community providers. While these measures are critical for quality payments to the LMHAs, this interoperability will be meaningful for integrated health and inpatient psychiatric stays.

- The state hospitals and the LMHAs should get interoperable, connect to an HIE, and begin to share with community-based providers by the end of fiscal year 2026.

Freestanding Psychiatric Hospitals

Freestanding psychiatric hospitals still have a lower-than-normal EMR adoption rate due to high costs of technology implementations with no prior federal incentive dollars and lower-margin reimbursement rates. Psychiatric hospitals provide contract beds that are currently being expanded; sharing of inpatient information is key to ongoing outpatient care coordination and readmission prevention.

With the upcoming ATLIS supplemental funding, it is now imperative that psychiatric hospitals have EMRs to meet the interoperability criteria or miss out on those much-needed quality and supplemental dollars.

- Develop a one-time grant opportunity, or a rider in the budget, to allow psychiatric hospitals to purchase and implement an EMR platform with connectivity to an HIE. (This was recommended during the last legislative session and did not get funded).

Prior Recommendations

As noted above, the HHS eHAC is making recommendations across several areas for which it is responsible. The table below presents the committee's previous recommendations from earlier reports and related information from HHS agencies regarding the status of each recommendation.

Committee Recommendation	Status	Action Needed
Revise Texas Medicaid Medical Policy including updating the definition of telemedicine.	Complete	Process is in place for on-going review and revision of policy to stay current with industry changes in telemedicine application.
Recommend removal of the requirements for site presenters.	Complete	No further action needed at this time.
Remove the requirement for an initial in-person consultation.	Complete	No further action needed at this time.
Add guidelines surrounding electronic prescribing during a telemedicine encounter.	Complete	Medicaid providers can generate a valid electronic prescription from a telemedicine encounter. All federal and state law and rule requirements would need to be met.
Ensure all Medicaid MCOs include reimbursement for virtual services covered same as in-person.	Complete	Process for on-going review and revision of policy to stay current with industry changes in telemedicine application.
Continue RPM benefit.	Complete	Continued via S.B. 670 and H.B. 1063.
Recommend expansion of coverage to include substance abuse treatment (recovery services, counseling, e-prescribe).	Ongoing	Scope included in implementation of S.B. 670, as well as H.B. 4.

Committee Recommendation	Status	Action Needed
National data standards work for Texas and state health agencies should not create or recommend standards that deviate from national standards.	Complete/Ongoing	State health agencies, to date, have not recommended standards that deviate from national standards. This should continue into the future.
HHS agencies should use HIETexas, when appropriate, to exchange messages with trading partners and collaborate with the state's HIEs to increase participation by health care providers.	Complete/Ongoing	HHSC signed a contract with THSA to incorporate HIETexas into the HIE Connectivity Project. This project will be implemented over the next several years.
Change requirement for ImmTrac2, the Texas immunization registry, from opt-in to opt-out.	Incomplete	Current state law specifies that the state immunization registry operates on an opt-in basis. Legislative action is required to change the registry to an opt-out system.
Encourage data sharing of BH data from LMHAs through HIEs across the state as needed within legal constraints.	Ongoing	eHAC is working with HHSC on implementation of S.B. 640.
Review all data streams from providers into the HHS system to identify opportunities for consolidated reporting and administrative simplification process platforms (MCOs, public health, etc.).	Ongoing	The connections established between providers and HHS through the current HIE Implementation Advance Planning Document (IAPD) will allow for the consolidation of the number of connections required by health care providers. The EDEN system, also included in the IAPD, will enable the exchange of Admit, Discharge, and Transfer messages that may be used by Texas Medicaid and public health to support a variety of programs.

Committee Recommendation	Status	Action Needed
Provide a complete inventory of inbound or outbound streams of clinical data between HHSC and Texas health care providers, how much data is flowing in each, what data and transport standards are in use for each, whether there are existing national/industry standards that could be used for each type of data, and what the plan is to move toward those standards.	Complete/Ongoing	Much of this material is contained in the Interoperability for Texas: Powering Health reports. The 2020, 2022, and 2024 interoperability report versions include information about the agency's use of standards for data exchange. The full eHAC membership, including, eHAC's Interoperability, Behavioral Health and Telemedicine, Telehealth and Telemonitoring Subcommittees, reviewed these reports.
Provide incentive payments for certain services (new patient, emergency) when patient health record was utilized in the provision of the service to that patient (proof of compliance would be summary of care document or health record number).	Discontinued	Due to the special terms and conditions of the 1115 waiver related to requiring data sharing among Medicaid providers who are treating the same patient for the same condition, this recommendation is being discontinued.
Create payment incentive for Medicaid providers to engage with HIE if available in their area.	Ongoing	This is being accomplished through Strategy 1 of the Medicaid HIE IAPD.
Since HIEs are allowed by statute to receive PMP data, direct the State Board of Pharmacy to facilitate a cost-effective integration for data sharing with HIEs within statutory constraints.	Ongoing	HHSC does not have this authority. The PMP is managed by the Texas Board of Pharmacy. Legislative action would be required.
Include HIEs as a standard component in disaster relief planning.	Ongoing	Planning for this activity is referenced in the draft version of the Health IT Strategic Plan.

Committee Recommendation	Status	Action Needed
Expand bi-directional interoperability for electronic data submission.	Ongoing	The connection between HHS and HIETexas, established as part of the HIE IAPD, will enable easier bi-directional data flows between providers and HHS agencies. DSHS is working to enhance interoperability continuing to improve interoperability consistent with H.B. 2641, including enhancing ImmTrac2's capabilities and services to both receive and share data with authorized providers. DSHS' laboratory systems have also expanded their capacity to both receive orders and share results.
The full eHAC should continue in existence beyond its Sunset date currently scheduled for December 31, 2023, and instead should be extended to December 31, 2027.	eHAC was extended for two years until December 31, 2025	Continuation of the committee through December 31, 2027.
Increase funding and support for teleservices, such as the establishment of a combined tech support pool and additional trainings and educational classes for stakeholders.	Ongoing	Establishment of a tech support pool would require legislative action. The eHAC educational session in October 2023 addressed teleservices.
Enable and fund targeted pilot projects to insert tele-service solutions in appropriate care settings to improve healthcare outcomes and access within the state.	Ongoing	Pilot projects would require legislative action.

Committee Recommendation	Status	Action Needed
Develop a one-time capital grant opportunity, or a rider in the budget, to allow for freestanding psychiatric hospitals to purchase and implement an EMR platform with connectivity to an HIE.	Ongoing	Would require legislative action.
HHSC should develop an incentive program, as a supplement to the Comprehensive Hospital Increase Reimbursement Program and its HIE measure, for recipients that connect to an HIE by the end of fiscal year 2025 to improve overall statewide interoperability and compliance with the Cures Act.	Ongoing	Partially addressed by ATLIS.
Consider developing a new directed payment program for EHR adoption.	Ongoing	Would require HHSC action and possibly legislative action.
Support interoperability and integration as part of the systems of care of the serious mental illness and serious emotional disturbance population.	Ongoing	Interoperability and collaboration between the responsible agency and the provider community has been a foundational component since the development of CMBHS was initiated.
Consider budget allocation similar to the one-time Community Mental Health grants. Allow different funds for a) providers that need to implement a technology platform and b) those that have a platform but need to become interoperable.	Ongoing	Would require legislative action.

Committee Recommendation	Status	Action Needed
Enable sharing of digital consent through national standards [Health Level Seven V2, Extensible Access Control Markup Language, Fast Healthcare Interoperability Resources] and opportunities to manage consent/authorization through patient portals/applications.	Ongoing	HHS and the provider community need to develop a process to set priorities and agree on the standards needed to implement consent management across the HHS programs, given that the different programs use varying methods to document consent. This may also require legislative action.
Standardize e-consent process by addressing the lack of uniformity and clarity around how patient consent is collected, for both treatment and sharing purposes.	Ongoing	Would require legislative action.
Ensure that state laws related to data sharing, data collection, and patient data privacy are aligned with federal law whenever possible and address any conflicts around these issues in state statutes.	Ongoing	Would require legislative action.
Provide incentives for compliance with state and federal consent and security laws by state contractors.	Ongoing	Would require legislative action.
Expedite access to Federal Drug Administration-approved prescription digital therapeutics and allow providers to prescribe these treatments, as part of a broader course of treatment, for patients as indicated by the standard of care.	Ongoing	The legislature considered a bill to address this during the 2023 session, but the bill did not pass.

Committee Recommendation	Status	Action Needed
Change the managed care contracts to include requirements set forth by the CMS Interoperability and Patient Access[5] final rule.	Ongoing	HHS would need to evaluate the requirements and develop a process for adding them to the managed care contracting process.
Develop metrics to measure success and consider expansion of the ombudsman office to take patient/provider concerns and complaints.	Ongoing	Would require HHSC action.
Connectivity interoperability to state required platforms such as CMBHS, Texas Health Care Information Collection, and the Star Health platform to prevent duplicative data entry, and possible errors, in multiple systems.	Ongoing	The Texas Health Care Information Collection currently uses a national standard for receiving data. LMHAs and substance abuse services providers utilize CMBHS as a reporting system and/or an EHR, but many substance abuse providers do not have the technology to send the required data electronically. The STAR Health Passport is an electronic system that supports the delivery of medical services to participants in Texas' foster care system. Since each system is governed by a different statute and was built for a different purpose, legislative action and funding would be required to streamline the reporting process for providers.

[5] https://www.cms.gov/newsroom/fact-sheets/interoperability-and-patient-access-fact-sheet, March 2020.

Committee Recommendation	Status	Action Needed
Develop a common strategy to collect and share data as it relates to social determinants of health that can be shared with agencies, stakeholders, and platform vendors.	Ongoing	At the national level, the Gravity Project is already working on this topic. Texas is participating in the development of standards that could be used to develop this strategy. Would require HHSC action.
Leverage existing infrastructure while allocating new resources in ways that encourage accountability, across all settings of care in the healthcare ecosystem.	Ongoing	Would require HHSC action to implement inside the HHS system, and would require legislative action to engage across all settings of care.

Costs Related to eHAC

The following eHAC support-related time and cost information is reported by the Office of e-Health Coordination's designated committee liaison. Costs reflect staff time and related supplies and materials purchases. eHAC members are not reimbursed for travel or any other committee participation-related expenses. For this reporting period, one HHS agency staff assisted in supporting the eHAC and its three subcommittees at a cost of approximately $69,600. All eHAC activities were supported using HHS appropriated funds.

List of Acronyms

Acronym	Full Name
ATLIS	Aligning Technology by Linking Interoperable Systems
BH	Behavioral Health
CCBHC	Certified Community Behavioral Health Clinic
CMBHS	Clinical Management for Behavioral Health Services
CMS	Centers for Medicare & Medicaid Services
DSHS	Department of State Health Services
EDEN	Emergency Department Encounter Notification
eHAC	e-Health Advisory Committee
EHR	Electronic Health Record
EMR	Electronic Medical Record
H.B.	House Bill
HHS	Health and Human Services
HHSC	Health and Human Services Commission
HIE	Health Information Exchange
HIT	Health Information Technology
HIN	Health Information Networks
IAPD	Implementation Advance Planning Document
ICOE	Interoperability Center of Excellence
IT	Information Technology
LMHA	Local Mental Health Authority
MCO	Managed Care Organization
PCDH	Patient Centered Data Home
PHE	Public Health Emergency
PMAS	Performance Management and Analysis System
PMP	Prescription Monitoring Program
PULSE	Patient Unified Lookup System for Emergencies
RPM	Remote Patient Monitoring
S.B.	Senate Bill
TAC	Texas Administrative Code
TEFCA	Trusted Exchange Framework and Common Agreement
THSA	Texas Health Services Authority
USCDI	United States Core Data for Interoperability

Appendix A. HHSC e-Health Advisory Committee Membership

Category	Selection	Business Organization	City	Region & Gender
Representative of a **health science center in Texas (eHAC Chair)**	Mari Robinson, JD	The University of Texas Medical Branch	Galveston	6/5S, Female
Representative of a **local or regional HIE (eHAC Vice-Chair)**	Phil Beckett, Ph.D.	C3HIE	San Antonio	8, Male
Medicaid provider or child health plan program provider	Waridibo E. Allison, MD	University of North Texas Health Science Center at Fort Worth	Fort Worth	2/3, Female
Representative with **expertise related to the implementation of EHRs, computerized clinical support systems, and HIE systems for exchanging clinical and other types of health information**	Dashiell Ballarta, MSHCT, MPAff, CHCIO	Texas A&M University Health Science Center	Bryan	7, Male
Representative of **consumers of health provided through telemedicine**	Sarah Boyd	Experian	Austin	7, Female
Representative with **expertise related to the implementation of EHRs, computerized clinical support systems, and HIE systems for exchanging clinical and other types of health information (Behavioral Health**	Christine Bryan	Clarity Child Guidance Center	San Antonio	8, Female

Category	Selection	Business Organization	City	Region & Gender
Subcommittee Chair/Lead)				
Expert on home telemonitoring services	Nora Cox	Texas e-Health Alliance	Austin	7, Female
Representative from **DSHS** (ex-officio member)	Steve Eichner	DSHS	Austin	7, Male
Representative from **HHSC** (ex-officio member)	Brad Fitzwater, MD	HHSC	Austin	7, Male
Expert on telemedicine	John Gachago, DHA	Texas Tech University Health Sciences Center	Lubbock	1, Male
Expert on home telemonitoring services	Mario Garza, MSW, MBA	APEX Remote Monitoring Services	Edinburg	11, Male
Representative from the **Statewide Health Coordinating Council**	Kenneth Holland	Statewide Health Coordinating Council	Austin	7, Male
Representative of an **MCO**	Janel Lujan	El Paso Health	El Paso	9/10, Female
Representative from the **THSA**	Katherine Lusk	THSA	Austin	7, Female
Representative of the **pharmaceutical industry**	Aimee Lusson, PharmD., MBA	Walgreens	San Antonio	8, Female
Representative of a **local or regional HIE** **(Interoperability Subcommittee Chair/Lead)**	Sheila Magoon, MD	South Texas Physicians Alliance / Buena Vida y Salud, LLC	Harlingen	11, Female
Expert on telemedicine **(Telemedicine, Telehealth, and**	Brett Moran, MD	Parkland Health and Hospital System	Dallas	2/3, Male

Category	Selection	Business Organization	City	Region & Gender
Telemonitoring) Subcommittee Chair/Lead)				
Representative from **HHSC** (ex-officio member)	Deanna Naranjo	HHSC	Austin	7, Female
Medicaid provider or child health plan program provider	Neema Navai, MD	The University of Texas – M.D. Anderson Cancer Center	Houston	6/5S, Male
Representative from the **Texas Medical Board**	Christopher Palazola	Texas Medical Board	Austin	7, Male
Representative from the **Texas Board of Nursing**	Kathy Shipp, MSN, APRN, FNP	Texas Board of Nursing	Austin	7, Female
Representative from **Texas State Board of Pharmacy**	Todd Unruh, R.Ph.	Texas State Board of Pharmacy	Austin	7, Male
Representative of a **health science center in Texas (eHAC Chair)**	Mari Robinson, JD	The University of Texas Medical Branch	Galveston	6/5S, Female
Representative of a **local or regional HIE (eHAC Vice-Chair)**	Phil Beckett, Ph.D.	C3HIE	San Antonio	8, Male
Medicaid provider or child health plan program provider	Waridibo E. Allison, MD	University of North Texas Health Science Center at Fort Worth	Fort Worth	2/3, Female
Representative with **expertise related to the implementation of EHRs, computerized clinical support systems, and HIE systems for exchanging clinical**	Dashiell Ballarta, MSHCT, MPAff, CHCIO	Texas A&M University Health Science Center	Bryan	7, Male

Category	Selection	Business Organization	City	Region & Gender
and other types of health information				
Representative of **consumers of health provided through telemedicine**	Sarah Boyd	Experian	Austin	7, Female
Representative with **expertise related to the implementation of EHRs, computerized clinical support systems, and HIE systems for exchanging clinical and other types of health information** **(Behavioral Health Subcommittee Chair/Lead)**	Christine Bryan	Clarity Child Guidance Center	San Antonio	8, Female
Expert on home telemonitoring services	Nora Cox	Texas e-Health Alliance	Austin	7, Female
Representative from **DSHS** (ex-officio member)	Steve Eichner	DSHS	Austin	7, Male
Representative from **HHSC** (ex-officio member)	Brad Fitzwater, MD	HHSC	Austin	7, Male
Expert on telemedicine	John Gachago, DHA	Texas Tech University Health Sciences Center	Lubbock	1, Male
Expert on home telemonitoring services	Mario Garza, MSW, MBA	APEX Remote Monitoring Services	Edinburg	11, Male
Representative from the **Statewide Health Coordinating Council**	Kenneth Holland	Statewide Health Coordinating Council	Austin	7, Male

Category	Selection	Business Organization	City	Region & Gender
Representative of an **MCO**	Janel Lujan	El Paso Health	El Paso	9/10, Female
Representative from the **THSA**	Katherine Lusk	THSA	Austin	7, Female
Representative of the **pharmaceutical industry**	Aimee Lusson, PharmD., MBA	Walgreens	San Antonio	8, Female
Representative of a **local or regional HIE** **(Interoperability Subcommittee Chair/Lead)**	Sheila Magoon, MD	South Texas Physicians Alliance / Buena Vida y Salud, LLC	Harlingen	11, Female
Expert on telemedicine **(Telemedicine, Telehealth, and Telemonitoring) Subcommittee Chair/Lead)**	Brett Moran, MD	Parkland Health and Hospital System	Dallas	2/3, Male
Representative from **HHSC** (ex-officio member)	Deanna Naranjo	HHSC	Austin	7, Female
Medicaid provider or child health plan program provider	Neema Navai, MD	The University of Texas – M.D. Anderson Cancer Center	Houston	6/5S, Male
Representative from the **Texas Medical Board**	Christopher Palazola	Texas Medical Board	Austin	7, Male
Representative from the **Texas Board of Nursing**	Kathy Shipp, MSN, APRN, FNP	Texas Board of Nursing	Austin	7, Female
Representative from **Texas State Board of Pharmacy**	Todd Unruh, R.Ph.	Texas State Board of Pharmacy	Austin	7, Male

Appendix B. HHSC's State Fiscal Year 2025 Structure Measure Questions, September 2024

Comprehensive Hospital Increase Reimbursement Program C-105 and Directed Payment Program Behavioral Health Services B1-105

1. As of August 31, 2024, does your organization connect to (send data to or receive data from) any of the following:
   - A state or local HIE: THSA's HIETexas EDEN system, C3HIE (formerly Health Access San Antonio), PHIX (formerly Paso del Norte HIE), GHH, Connxus (formerly ICC), or Connected Care Exchange HIE (formerly Rio Grande Valley HIE);
   - A national HIE (e.g., eHealth Exchange, Carequality, CommonWell); or
   - An EHR that incorporates HIE capabilities (e.g., Epic CareEverywhere)?
2. Which of the following HIEs is your organization connected to:

   a. HIETexas EDEN via a direct connection with THSA (not via a local HIE);

   b. One of the following local HIEs: C3HIE (formerly HASA), PHIX (formerly Paso del Norte HIE), GHH, Connxus (formerly ICC), or Connected Care Exchange HIE (formerly Rio Grande Valley HIE);

   c. A national HIE network (e.g., eHealth Exchange, Carequality, CommonWell); or

   d. An EHR that incorporates HIE capabilities (e.g., Epic CareEverywhere)?
3. Is your organization sending data to, or receiving data from, HIETexas EDEN? (HHSC suggests contacting your HIE to confirm the answer to this question).

   a. Yes because our organization is connected directly to THSA's HIETexas EDEN.

   b. Yes, because our organization is connected to a local HIE, and that local HIE is sending our data to HIETexas EDEN.

c. No, our organization is not sending data to HIETexas EDEN.

4. Does your organization send or receive data via an HIE that goes to the following types of recipients:

   a. Hospitals;

   b. Other non-hospital providers; or

   c. Medicaid MCOs?

5. Which of the following types of data formats is your organization sending or receiving via the HIE?

   a. Admissions, discharges, and transfer data.

   b. Consolidated-Clinical Document Architecture data.

   c. Fast Healthcare Interoperability Resources standard data.

6. If you answered "No" to all of the options in Question 5, what data format are you able to use to export data and is that format proprietary?

7. Describe why your organization is not planning to connect to an HIE listed in Question 1.

8. To what extent are your organization's implementation decisions related to this activity influenced by [directed payment program] participation?