Texas Health and Human Services (HHS) e-Health Advisory Committee

As required by

Title 1, Part 15, Texas Administrative Code,

Section 351.823(d)

December 2018

Table of Contents

Disclaimer

This report was not authored by and does not 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, please see Appendix A.

Executive Summary

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

As directed in the Texas Administrative Code, the Committee is making several recommendations, which fall into three categories:

Task 1 (Section 351.823. e-Health Advisory Committee): Advises HHS agencies on the development, implementation, and long-range plans for health care information technology and health information exchange, including use of:

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

Task 2 (Section 351.823. e-Health Advisory Committee): Advises HHS agencies on incentives for increasing health care provider adoption and usage of an electronic health record and health information exchange systems.

Task 3 (Section 351.823. e-Health Advisory Committee): 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 Committee includes representatives of HHS agencies, other state agencies, and other health and human services stakeholders concerned with the use of HIT, HIE,

[1] See Title 1, Texas Administrative Code, Section 351.823(a) and (b).

telemedicine, telehealth, and home telemonitoring services. eHAC membership includes ex officio representatives from HHSC, an ex officio representative from DSHS, the Texas Medical Board, Texas Board of Nursing, Texas State Board of Pharmacy, the Statewide Health Coordinating Council, managed care organizations, representatives from the pharmaceutical industry, academic health science centers, an expert on telemedicine, an expert on home telemonitoring services, a consumer of health services through telemedicine, a Medicaid provider, a representative from the Texas Health Services Authority (THSA), a representative from a local or regional health information exchange, and representatives with expertise in implementation of electronic health records, computerized clinical support systems, and health information exchange systems for exchanging clinical and other types of health information. For a full roster of representatives, please see Attachment A.

The remainder of this report includes recommendations on the three tasks listed above, as well as other information as required under the Texas Administrative Code.

1. Introduction

The Texas Health and Human Services (HHS) Electronic Health (e-Health) Advisory Committee is established under Texas Government Code Section 531.012 and governed by Texas Government Code chapter 2110 and Title 15, Texas Administrative Code, Section 351.823.

Pursuant to Title 15, Texas Administrative Code, Section 351.823(d)(1), "[b]y February of each year, the committee files an annual written report with the Executive Commissioner covering the meetings and activities in the immediate preceding calendar year. 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; and

(H) the costs related to the committee, including the cost of the HHSC staff time spent supporting the committee's activities and the sources of funds used to support the committee's activities.

Please note that a full list of acronyms used in this report is available on page 27.

This report provides a background on how the e-Health Advisory Committee reached its recommendations, as well as information on each criterion listed above.

2. Background

As laid out below, the HHS e-Health Advisory Committee is making several recommendations, which fall into three categories:

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

- Electronic health records, computerized clinical support systems, health information exchange systems for exchanging clinical and other types of health information, and
- Other methods of incorporating health information technology in pursuit of greater cost-effectiveness and better patient outcomes in health care andpopulation health.

Task 2 (Section 351.823. e-Health Advisory Committee): Advises HHS agencies on incentives for increasing health care provider adoption and usage of an electronic health record and health information exchange systems.

Task 3 (Section 351.823. e-Health Advisory Committee): 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" 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 Section 531.901(1), Government Code)

"Electronic Medical Record" 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 Section 531.901(2), Government Code)

"Health Information Exchange" 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 and Medicaid Services; or (E) an accountable care organization participating in the Medicare Shared Savings Program under 42 U.S.C. Section 1395jjj. (See Section 182.151, Health & Safety Code; See also Section 481.002(54), Health & Safety Code; See also Section 531.901, Government Code)

"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 or a hospital, as those terms are defined by Section 531.02164(a) Texas Government Code. (See Section 531.001(4-a), Texas Government Code)

"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 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 Section 111.001(3), Texas Occupations Code; See also Section 531.001(7), Texas Government Code)

"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 Section 111.001(4), Texas Occupations Code; See also, Section 531.001(8), Texas Government Code)

3. List of Meeting Dates

The e-Health Advisory Committee met on the following dates:

- March 2, 2018
- July 13, 2018

The committee will next meet on December 6, 2018.

4. Committee Members' Attendance Records

The e-Health Advisory Committee (eHAC) is pleased to announce that a quorum was present for the meetings during this reporting period. The committee maintained an average 75% attendance rate, with the lowest attendance being 71% and the highest at 78%. A copy of committee members' attendance records is available in Appendix B, as part of the meeting minutes.

5. A Brief Description of the Actions Taken by the Committee

Below is a high-level list of actions taken by the committee at each meeting. A more detailed summary is available for review in each meeting's official minutes, which are available for review as Appendix B.

March 2, 2018

- Reviewed the 2017 eHAC report to the Commissioner and the Legislature
- Received an update from the subcommittee assigned to a pilot project to determine how to provide incentive payments to providers who utilize a patient's health record when providing new patient and emergency room patient services and have this incentive program integrated into the current MCO strategy.
- Received an update on the implementation of SB 1107, HB 1697, and SB 922.
- Discussed bundling appropriate resources and having external internet connections as a necessity for disasters. The Committee also discussed appropriate and simplistic credentialing in a disaster circumstance.

July 13, 2018

- After a briefing on the Delivery System Reform Incentive Payment Waiver program (DSRIP) from HHSC staff, eHAC members discussed:
    1. How outcome measures are established and approved
    2. How stakeholders can be involved with the discussion of DSRIP
    3. The difference between measure categories C and D
    4. The Transition Plan report requirement
    5. Provider projects and whether they are discontinued or continuing
    6. Stimulating providers to work with HIEs
    7. Centers for Medicare & Medicaid Services (CMS) value-based purchasing road map as a goal for Medicaid managed care
- Received an update on the implementation of SB 1107, HB 1697, and SB 922 that were passed during the 85th Legislative Session.
- Reviewed a new CMS Medicaid Directors' letter on the use of technology to combat the opioid epidemic.
- Received required ethics training.
- Planned for the 2108 report.

- Discussed the use of HIT in emergency preparedness and response.

The next eHAC meeting is scheduled for December 6th, 2018.

6. A description of how the committee accomplished its tasks

The HHS e-Health Advisory Committee accomplished its tasks through a collaborative effort that included input from several different sectors of the healthcare industry, including but not limited to the Texas Medical Board, Texas Board of Nursing, Texas State Board of Pharmacy, the Statewide Health Coordinating Council, managed care organizations, representatives from the pharmaceutical industry, academic health science centers, an expert on telemedicine, an expert on home telemonitoring services, a consumer of health services through telemedicine, a Medicaid provider, a representative from the THSA, a representative from a local or regional health information exchange, and representatives with expertise in implementation of electronic health records, computerized clinical support systems, and health information exchange systems for exchanging clinical and other types of health information. For a full roster of representatives, please see Attachment A.

This diverse group of individuals meets on a regular basis and engages in thoughtful dialogue with input from additional industry experts on eHealth issues. The committee was tasked with making several recommendations, which fall into three categories: Task 1 (Section 351.823. e-Health Advisory Committee); Task 2 (Section 351.823. e-Health Advisory Committee); and Task 3 (Section 351.823. eHealth Advisory Committee).

To make the recommendations that fall into these tasks, a volunteer writing team was appointed. The writing team reviewed the previous report's recommendations and the minutes from the 2018 meetings, and then produced draft recommendations for the report based on that analysis. Those recommendations were then reviewed by the entire eHAC for feedback. Those recommendations, as revised, are available for review in Section 7 of this report.

7. A summary of the status of any rules that the committee recommended to HHSC

As noted above, the HHS e-Health Advisory Committee is making several recommendations, which fall into three categories: Task 1 (Section 351.823. eHealth Advisory Committee); Task 2 (Section 351.823. e-Health Advisory Committee); and Task 3 (Section 351.823. e-Health Advisory Committee). The information in this section contains each recommendation from the eHAC committee broken down into these three tasks. The Committee is pleased to report that every single recommendation presented to the committee was unanimously adopted either "as is" or with minor revisions.

Task 1 (Section 351.823. eHealth Advisory Committee): Advises HHS agencies on the development, implementation, and long-range plans for health care information technology and health information exchange (HIE), including use of (1) Electronic health records, computerized clinical support systems, health information exchange systems for exchanging clinical and other types of health information, and (2) other methods of incorporating health information technology in pursuit of greater cost-effectiveness and better patient outcomes in health care and population health.

Report on Task 1: In today's health care, patients and providers contend with multiple technology interfaces that lack communication and standardization. These technology issues involve the disjointed communication between electronic health records and providers, as well as, between HIEs themselves. The need for multiple systems to access information, without an interconnection of data, delays care and increases cost. It is during times of emergency and disaster response that these issues in health care technology are exacerbated. The need for integration is heightened in these situations to ensure positive outcomes of patients and continuity of care after the emergency is resolved. During the provision of treatment to patients the incorporation of HIEs, EHRs, and PHRs afford the opportunity for greater cost-effectiveness and improved patient population health outcomes. Previous e-Health Advisory Committee recommendations have been made to address the development, implementation, and long-range plans of HIT and HIEs.

In past reports, the Committee recommended Texas HHS be required to consolidate available payer and public health information for Medicaid and CHIP clients in a

standard format that is readily accessible through HIEs, EHRs and PHRs for the purpose of treatment and emergency response. This would allow access to a consolidated Medicaid, public health, payment, and clinical client record, utilizing the existing means while fully incorporating HHSC and HIEs. In the process, relevant data should be made available to support HHSC in the growth of alternative payment methods and the provision of quality initiatives. Along with this notion, is the recommendation by the Committee to review the existing patient consent model for HHS in order to maximize the sharing of clinical, payer and public health information with HIEs, EHRs, PHRs, in the treatment of patients, including mental health treatments. This would allow for the sharing of data and continuity of care for patients.

The e-Health Advisory Committee also recommended that when applicable HHS agencies should use HIETexas. This platform allows for communication and collaboration to take place among trading partners and the state's HIEs, allowing for an increase in the participation of health care providers.

The Committee also recommended changing the participation basis for the immunization registry from opt-in to opt-out in an attempt to afford providers with information that streamlines point-of-care treatments. Another recommendation from the committee, involved the sharing of behavioral health data from LMHAs, while meeting legal constraints, through HIEs, allowing behavioral health information to be provided to providers across HIEs. All of these recommendations, align with the recommendation of the committee that state health agencies should not create or recommend standards that deviate from the national standards. These national data standards are generally utilized in Texas; however, the committee understands there are unique circumstances that make the implementation of these standards difficult. Thus, the committee notes in their recommendation that data standards in Texas may differ from national standards when the relevant agency and appropriate stakeholders concur there is a critical limitation in the national standard that limits the ability to conduct business services. These occurrences should not exceed 10 percent of the total new transaction types defined.

The committee's work in 2018 has continued to review emergency preparedness and the involvement of HIT in emergency preparedness. The work of the committee continues to align with the above recommendations when taking into consideration emergency response in addition to conventional means of patient treatment. As part of this work, the committee has recommended that Texas participate in the Patient Unified Lookup System for Emergencies (PULSE) project, which is a

nationwide health IT disaster response platform that can be deployed at the city, county, or state level to authenticate disaster healthcare volunteer providers. PULSE allows disaster workers to query and view patient documents from all connected healthcare organizations. Based on experiences related to the committee by members that were involved in the response to Hurricane Harvey, the provision of health data to emergency workers in shelters can have enormous benefits during disaster response.

Additionally, the committee has discussed the national opioid crisis, which has led to an additional recommendation. The recommendation is to enable access to the state's prescription drug monitoring program (PDMP) through HIEs to help combat the opioid epidemic. This would extend providers' ability to leverage a single connection- the HIEs-- to access patients' inter-state and intra-state prescription drug history in addition to other patient data. When the prescription drug history of patients is easily accessible to providers, appropriate care methods can be implemented for the patient while properly addressing the opioid crisis.

Task 2 (Section 351.823. e-Health Advisory Committee): Advises HHS agencies on incentives for increasing health care provider adoption and usage of an electronic health record and health information exchange systems.

Report on Task 2: Since the passage of the HITECH Act in 2009, the regulatory landscape governing the incentives for the use of electronic medical records and health information exchange systems has continued to evolve. Specifically, significant changes were made by CMS in 2018, as the "Meaningful Use" program shifted to "Promoting Interoperability." The intent of these changes is to increase interoperability and flexibility while reducing burden and placing a strong emphasis on measures that require the exchange of health information between providers and patients. As an example of increased interoperability, electronic querying of PDMPs will be an optional measure for participating providers in 2019 and will be a required measure in 2020 for the "Promoting Interoperability" program.

Additionally, the State of Texas renewed its Medicaid 1115 waiver program in the fall of 2017, which now includes a requirement that the state develop a plan to require the sharing of Continuity of Care Documents (CCD) when multiple providers are treating the same Medicaid patient. Texas must produce a plan by October of 2019, and the eHAC will be serving as a key stakeholder in the development of that plan.

The previous eHAC recommendations fell into two categories. One set of recommendations addressed the need to improve data submission processes. The eHAC recommended that all data streams from providers into the HHS system be reported out in order to identify opportunities for consolidated reporting and administrative simplification process platforms (MCOs, public health, etc.).), and that HHS 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. Expanding bi-directional exchange for electronic data will also be important to fully integrate data sharing into provider workflows. Streamlined reporting should provide cost benefits to providers and to the state, and this work is underway within the agency. The committee also recommended that HIEs be included in both PDMP reporting at the State Board of Pharmacy and as a standard component in disaster response planning.

The second set of recommendations related to actual incentives to providers. The 2017 report made two specific recommendations: to provide incentive payments for certain services (new patient, emergency) when a patient health record was utilized in the provision of the service to that patient, and to create a payment incentive for Medicaid providers to engage with the community HIE if available in their area.

The second recommendation will be supported through the implementation of the Health Information Technology for Economic and Clinical Health Act (HITECH)-authorized Texas Health Information Exchange Implementation Advanced Planning Document (HIE IAPD), which is a funding mechanism provided by the CMS. HITECH supports incentive payments to eligible professionals and eligible hospitals to promote the adoption and meaningful use of certified electronic health record (EHR) technology to promote health care quality and the exchange of health care information.

The HIE Connectivity Project is a Texas Medicaid HIE initiative funded by CMS through the HIE IAPD. The primary objectives of this Project are to increase HIE use and adoption by Texas Medicaid providers and create additional capacity (e.g., additional HIE organizations) in the State of Texas that can support that use and adoption. The HIE Connectivity Project will accomplish its primary objectives by implementing the following three strategies:

- **Strategy 1:** Medicaid Provider HIE Connectivity. This strategy will help Medicaid providers connect to HHSC-approved local HIE organizations. These connections will facilitate electronic reporting and data exchange between providers and Texas Medicaid. Texas Government Code, Subchapter V, Health Information Exchange Systems, Section 531.901(4), defines a local or regional health information exchange.
- **Strategy 2:** HIE Infrastructure. This strategy includes enhancing the state's HIE infrastructure to support connectivity with the state's Medicaid system and assisting local HIEs in implementing connections to HIETexas, which is a set of state-level shared services managed by the Texas Health Services Authority (THSA).
- **Strategy 3:** Emergency Department Encounter Notifications (EDEN). This strategy will help Texas Medicaid reduce emergency department (ED) utilization and hospital readmissions by enabling better follow-up care through the electronic receipt of Health Level Seven (HL7) Admission, Discharge, and Transfer (ADT) data from hospital EDs and publishing alerts to Medicaid Managed Care Organizations (MCOs) or Dental Maintenance Organizations (DMOs) when a patient in their network is admitted to the ED, facilitating timely care coordination.

Successful implementation of the three strategies will result in increased HIE adoption and use by Medicaid providers, creation of new HIE capacity in the State, and bring clinical information into the Texas Medicaid program via HIE[2].

Most of the committee's work on Task 2 in 2018 was focused on a subcommittee established to see if a pilot program could be established between MCOs and providers to actually provide incentive payments for checking patient records. The eHAC set several conditions for the development of the pilot:

- Payments should be incentives and not penalties for not participating in the program;
- Protections for providers to ensure that they still provide all necessary services;
- Integration into the overall MCO strategy instead of a standalone project. The committee recommended that this be structured as a pilot project between MCOs and providers; and

[2] https://hhs.texas.gov/about-hhs/process-improvement/health-informatics-services-quality/local-hie-grant-program

- A clearly stated purpose for what goals are to be achieved by the incentives, which should leverage lessons learned from current projects with MCOs and HIEs.

The subcommittee included HIE and MCO representatives and held several calls to assess the capacity of HIEs to provide data to providers and the interest level of MCOs for providing that type of payment to providers. This led to a discussion about the Texas Medicaid Delivery System Reform Incentive Payment Program (DSRIP) and whether these incentives could be paid out of that program. After presentations to the subcommittee and the eHAC by DSRIP staff, it was clear that the two programs are complimentary but that DSRIP itself cannot be a source of funds for direct incentive payments to providers. The subcommittee will continue to meet into 2019 to see if additional options can be developed to implement this recommendation.

Over the course of 2018, the committee discussed the need to integrate all provider incentives developed through the eHAC with state and federal efforts such as Promoting Interoperability and the 1115 waiver program. The committee also strongly feels that any new requirements placed on providers, such as checking the PDMP, should be made a part of the provider's workflow to avoid creating additional administrative burdens on providers.

Task 3 (Section 351.823. e-Health Advisory Committee): 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.

Report on Task 3: Senate Bill 1107, passed in May 2017, expanded the options for healthcare delivery across the state. The new law allows for Texas physicians, physician assistants, advanced practice nurses with physician-delegated authority to practice medicine through synchronous videoconferencing in the same manner as a traditional face-to-face office visit. Additionally, the new law should encourage continuity of care between episodic telemedicine providers and primary care providers (PCP). Physicians providing a telemedicine encounter must access any relevant clinical history for the patient, which often comes from the patient's PCP. Further provisions in the law specify that the physician must be available for follow-up care after the synchronous telemedicine visit, or otherwise provide for coverage of the patient.

A large percentage of Texas in the western region, Rio Grande Valley, and eastern region is designated by HRSA as a Health Professional Shortage Area (HPSA). Working with providers in more urban areas, telemedicine can make an impact on reaching this population[3]. Specific shortages exist in several counties where there is no physician available. According to a recent report commissioned by the North Texas Regional Extension Center: out of the 50 states, Texas ranks 47th in its number of physicians per 100,000 population, with nearly 60% of physicians practicing in the five most urban counties. There are 35 counties with no physician of any kind.[4]It is well-established that telemedicine can increase quality patient care to rural populations, help with the survival and sustainability of rural hospitals, and assist with mitigation of transportation cost for patients with chronic disease – who otherwise would frequent metropolitan medical centers.

Currently, the Texas Medicaid Medical Policy regarding telemedicine services is undergoing revision in order to bring its policies into compliance with recent changes in statute. Specific changes which are needed include: updating the definition of telemedicine, removing requirements for site presenters, removing the requirement for an initial in-person consultation, and adding guidelines surrounding electronic prescribing during a telemedicine encounter.

Since passage of SB 1107, 85th Legislature, Regular Session, 2017, Texas has seen telemedicine develop in unique use-cases across various provider domains. In the most Medicaid populous regions, such as Harris County, law enforcement officers are providing synchronous telepsychiatry visits; and paramedics are initiating telemedicine visits with emergency medicine physicians in order to schedule primary care visits. Several projects are underway to provide neonatology services to both urban and rural areas where such specialists do not exist. These are cost-effective strategies to meet patients outside of traditional healthcare settings and

[3] Health Professional Shortage Areas. Health Resources and Services Administration. 2018. Accessed 9/19/2018. https://data.hrsa.gov/ExportedMaps/HPSAs/HGDWMapGallery_BHPR_HPSAs_PC.pdf

[4] The Physician Workforce in Texas, North Texas Regional Extension Center. Meritt Hawkins, April 2015. Accessed 9/18/2018. https://dfwhcfoundation.org/wpcontent/uploads/2015/04/mhaNTREC2015studyfinal.pdf

cost-avoidance care that otherwise would have been delivered in an emergency room.

This committee would like to see legislative changes to expand telemedicine coverage to provide substance abuse treatment, including recovery services and counseling. Exemplary programs such as the Telemedicine Wellness Intervention Triage and Referral (TWITR) Project which delivers telepsychiatry services to at-risk middle school and high school students living in rural north Texas should be adapted and further developed across the state to address mental health challenges in young adults.

Research should be explored in the area of telemedicine utilization post SB 1107. A survey of providers to understand reasons for low utilization may help the committee understand persistent barriers and recommend further solutions to expanded usage. Possible barriers could be the low rates of reimbursement. Analyses are provided for Medicaid utilization during FY 2017 for the top 20 procedure codes across all categories of telemedicine, telemonitoring, and telehealth. Results show the average amount paid to providers for the top 20 categories are currently reimbursed at approximately 42% of the amount billed. (See Table). The committee proposes a survey of physicians in partnership with the Texas Medical Association to discern other barriers which may exist including low rates of reimbursement, lack of education of procedural codes, or the billing process.

Top 20 Categories of Telemedicine and Telemonitoring Procedures in FY 2017 for Texas Medicaid

RANK	Procedure Description	Procedure Code	Procedure Count (n)	Total Amount Billed ($)	Average Billed per Service ($)	Total Amount Paid ($)	Average Paid per Service ($)	Amount Paid per Amount Billed (%)
1	TELEHEALTH ORIGINATING SITE FACILITY FEE	Q3014	25,343	$3,155,391	$125	$1,362,155	$54	43%
2	VISIT FOR THE EVALUATION AND MANAGEMENT, ESTABLISHED PATIENT (Moderate Complexity)	99214	17,077	$5,169,399	$303	$2,109,047	$124	41%
3	VISIT FOR THE EVALUATION AND MANAGEMENT, ESTABLISHED PATIENT (Low Complexity)	99213	11,374	$3,245,868	$285	$1,005,227	$88	31%
4	PSYCHIATRIC DIAGNOSTIC EVALUATION WITH MEDICAL SERVICES	90792	10,529	$2,798,931	$266	$1,752,628	$166	63%
5	ANALYSIS OF INFORMATION DATA STORED IN COMPUTERS (EG, ECGS, BLOOD PRESSURES, HEMATOLOGIC DATA)	99090	9,780	$9,866,847	$1,009	$8,389,837	$858	85%
6	ONLINE EVALUATION AND MANAGEMENT SERVICE PROVIDED BY A PHYSICIAN TO AN ESTABLISHED PATIENT	99444	8,527	$8,237,814	$966	$6,890,742	$808	84%
7	PSYCHIATRIC DIAGNOSTIC EVALUATION	90791	2,675	$692,520	$259	$466,542	$174	67%

RANK	Procedure Description	Procedure Code	Procedure Count (n)	Total Amount Billed ($)	Average Billed per Service ($)	Total Amount Paid ($)	Average Paid per Service ($)	Amount Paid per Amount Billed (%)
8	VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT (Not Complex)	99212	1,537	$150,572	$98	$74,535	$48	50%
9	VISIT FOR THE EVALUATION AND MANAGEMENT, ESTABLISHED PATIENT (High Complexity)	99215	1,445	$290,649	$201	$165,874	$115	57%
10	EVALUATION AND MANAGEMENT OF A NEW PATIENT (Moderate Complexity)	99204	1,360	$325,875	$240	$114,408	$84	35%
11	TELEHEALTH CONSULTATION, EMERGENCY DEPARTMENT OR INITIAL, 30 MINUTES	G0425	494	$90,014	$182	$36,902	$75	41%
12	PSYCHIATRIC THERAPY, 30 MINUTES WITH THE PATIENT	90832	405	$165,945	$410	$45,220	$112	27%
13	VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT (Low Complexity)	99203	372	$64,012	$172	$24,094	$65	38%
14	FOLLOW-UP CONSULTATION, COMPLEX, 35 MINUTES	G0408	349	$144,812	$415	$13,324	$38	9%
15	FOLLOW-UP CONSULTATION, COMPLEX, 25 MINUTES	G0407	338	$110,720	$328	$11,319	$33	10%

RANK	Procedure Description	Procedure Code	Procedure Count (n)	Total Amount Billed ($)	Average Billed per Service ($)	Total Amount Paid ($)	Average Paid per Service ($)	Amount Paid per Amount Billed (%)
16	PSYCHIATRIC THERAPY, 45 MINUTES WITH THE PATIENT	90834	316	$85,628	$271	$27,889	$88	33%
17	PSYCHIATRIC THERAPY, 35 MINUTES WITH THE PATIENT	90833	297	$42,393	$143	$8,042	$27	19%
18	VISIT FOR THE EVALUATION AND MANAGEMENT, NEW PATIENT (High Complexity)	99205	249	$72,658	$292	$32,675	$131	45%
19	VISIT FOR THE EVALUATION AND MANAGEMENT, ESTABLISHED PATIENT, 5 minutes	99211	242	$9,133	$38	$4,457	$18	49%
20	TELEHEALTH CONSULTATION, EMERGENCY DEPARTMENT OR INITIAL, 50 MINUTES	G0426	190	$53,533	$282	$12,240	$64	23%

Average % Medicaid Pays per Claim: 42%

Additionally, the committee would like to see reimbursement provided for additional remote monitoring categories. Monitoring of chronic diseases, such as diabetes and hypertension, has proven effective at reducing readmissions; therefore, the committee would like to see reimbursements for additional diseases or conditions. These may include oncology services, pediatric epilepsy, and neonatology services, among others.

8. A description of the activities the committee anticipates undertaking in the next fiscal year

During the course of its 2018 meetings, the eHAC discussed several activities that it anticipates undertaking during the next fiscal year. To date, these items include, but are not limited to:

- Continuing to work on implementing a pilot for the integration of Managed Care Organizations (MCOs) with (HIEs) in alignment with Task 2, Recommendation number 3 above,
- Continuing the further development of the interoperability report as required under House Bill 2641 (2015, 84R),
- Monitoring the implementation of telemedicine legislation including Senate Bill 1107 (2017, 85R), Senate Bill 922 (2017, 85R), and House Bill 1697 (2017, 85R),
- Providing input on the State Health Information Technology Strategic Plan as required by the 1115 waiver,
- Developing disaster response planning as it relates to the use of eHealth initiatives; and
- Continue to work with HHSC on implementation of the Committee's recommendations contained in this report.

The eHealth Advisory Committee is scheduled to meet on December 6th, 2018, where the committee will discuss any additional activities the committee anticipates undertaking in the next calendar year.

9. Recommended Amendments to this section (15 Tex. Admin Code, Section 351.823)

The eHealth Advisory Committee (eHAC) recommended multiple amendments to Title 1, Texas Administrative Code, Section 351.823, including but not limited to the following:

- A change to the maximum number of eHAC members from 15 to 24, which is the maximum allowed by Texas Government Code §2110.002(a). This allows the committee more flexibility to have more than one expert or representative from a category listed in subsection (f)(1) of the rule.
- A change to the terms that expire each year. This amendment is related to the maximum membership change recommended. Additionally, the number of terms an individual may serve on the committee is specified as two, two-year terms which may be served consecutively or nonconsecutively.
- A change to the voting rights of HHSC and Department of State Health Services ex officio representatives from voting to non-voting to avoid any potential or perceived conflicts of interest.
- Proposed changing the Committee abolish date to August 31, 2022. This proposed change was not permitted as the agency is preparing to conduct a full assessment of all committees.

10. Costs Related to the Committee

For a description of costs related to the committee, please see Appendix C.

11. Acronyms

Acronym	Full Name
CHIP	Children's Health Insurance Program
DSHS	Department of State Health Services
ED	Emergency Department
eHAC	eHealth Advisory Committee
DoD	Department of Defense
EHR	Electronic Health Record
EMR	Electronic Medical Record
HHS System	Health and Human Services Enterprise
HHSC	Health and Human Services Commission
HIE	Health Information Exchange
HIT	Health Information Technology
IT	Information Technology
LMHA	Local Mental Health Authority

MCO	Managed Care Organization
MEHIS	Medicaid Electronic Health Information System
PCP	Primary Care Provider
PHR	Personal Health Record
PDMP	Prescription Drug Monitoring Program
VA	Veterans Administration

Appendix A: HHSC e-Health Advisory Committee - Membership

Category	Selection	Business Organization	City	Region, Race, Gender
Representative from **HHSC** *(ex-officio members)*	1 - Erin McManus 2 - Hope Morgan *(interim OeHC Director)*	HHSC	Austin	7, White, Female 7, Black, Female
Rep. **DSHS** *(ex-officio members)*	Steve Eichner	DSHS	Austin	7, White, Male
Rep. **Texas Medical Board**	Scott M. Freshour, J.D.	TX Medical Board	Austin	7, White, Male
Rep. **Texas Board of Nursing**	Elise McDermott	TX Board of Nursing	Austin	7, White, Female
Rep. **Texas State Board of Pharmacy**	Adam S. Chesler, PharmD	Cardinal Health	Dallas	3, White, Male
Rep. **Statewide Health Coordinating Council**	Salil Deshpande, MD	UnitedHealthCare Community Plan of Texas	Houston	6, Asian, Male
Representative of a **managed care organization**	Will Rodriguez	Texas Tech University Health Sciences Center	Lubbock	1, Hispanic, Male
Rep. of the **pharmaceutical industry**	AJ Patel	Walgreens Company	Austin	7, Asian, Male
Representative of a **health science center in Texas**	Billy Philips, Jr., PhD	Texas Tech University Health Sciences Center	Lubbock	1, White, Male

Category	Selection	Business Organization	City	Region, Race, Gender
Expert on **telemedicine**	Tiffany Champagne-Langabeer, PhD	The School of Biomedical Informatics, The University of Texas Health Science Center at Houston	Houston	6, White, Female
Expert on **home telemonitoring services**	Sarah Mills	Texas Association for Home Care and Hospice	Austin	7, White, Female
Rep. of **consumers of health services provided through telemedicine**	Rebecca Moreau	Epilepsy Foundation Texas	Houston	6, White, Female
Medicaid provider or child health plan program provider	Ogechika Alozie, MD Thomas C. Wheat	Texas Tech University Health Sciences Center El Paso Pediatric Home Healthcare	El Paso Dallas	10, Black, Male 3, White, Male
Rep. **Texas Health Services Authority**	George Gooch	Texas Health Services Authority	Austin	7, White, Male
Representative of a local or regional **health information exchange**	Gijs Van Oort, PhD	Healthcare Access San Antonio	San Antonio	8, White, Male
Representative with **expertise** related to	Elizabeth Adamson	Doctors Hospital at Renaissance	Edinburg	11, Hispanic, Female

Category	Selection	Business Organization	City	Region, Race, Gender
the implementation of electronic health records, computerized clinical support systems, and health information exchange systems for exchanging clinical and other types of health information	Nora Belcher	Texas e-Health Alliance	Austin	7, White, Female
	Pamela McNutt	Methodist Health System	Dallas	3, White, Female
	Gerald Nissley, PhD	Private Practice	Marshall	4, White, Male

Appendix B: Member Attendance and Meeting Minutes

e-Health Advisory Committee
Meeting Minutes
Friday, March 02, 2018
9:00 a.m.

Brown Heatly Building Public Hearing Room
4900 North Lamar., Austin, Texas 78751

Table 1: e-Health Advisory Committee member attendance at the March 02, 2018 meeting.

MEMBER NAME	YES	NO	MEMBER NAME	YES	NO
Ms. Elizabeth Adamson		X	Ms. Rebecca Moreau	X	
Dr. Ogechika Alozie	X		Ms. Hope Morgan		X
Ms. Nora Belcher	X		Dr. Gerald Nissley	X	
Dr. Adam S. Chesler		X	Mr. AJ Patel	X	
Dr. Salil Deshpande	X		Dr. Billy Philips	X	
Mr. Steve Eichner	X		Mr. Will Rodriguez	X	
Mr. Scott M. Freshour		X	Dr. Gijs Van Oort	X	
Mr. George Gooch	X		Mr. Thomas C. Wheat	X	
Ms. Erin McManus	X		VACANT		
Ms. Pamela McNutt	X		VACANT		
Ms. Sara Mills	X				

Agenda Item 1: Call to Order and Logistics

Dr. Ogechika Alozie, Chair, called the meeting to order and turned the floor over to Ms. Stephanie Gutierrez, HHSC Advisory Committee Coordination. Ms. Gutierrez provided logistical announcements and called roll to determine a quorum.

Agenda Item 2: Welcome & Introductions

Dr. Alozie thanked members and the public who were in attendance and introduced himself as well as requested members introduce themselves.

Agenda Item 3: Approval of December 01, 2017 Meeting Minutes

Dr. Alozie turned the floor over to Ms. Gutierrez. Ms. Gutierrez prompted the Committee to review the minutes from their packet and asked if there were any edits. Ms. Gutierrez requested a motion to approve the December 01, 2017 meeting minutes. Dr. Billy Philips made a motion with Dr. Salil Deshpande seconding. A voice vote was taken with all in favor. The motion carried.

Agenda Item 4: e-Health Advisory Committee Rules Revisions Update

Dr. Alozie introduced and turned the floor over to Ms. Adriana Rhames, HHSC Office of e-Health Coordination (OeHC). Ms. Rhames informed the Committee that the request to remove ex-officio voting rights and to increase the membership total to 24 have been approved internally and need approval from the executive council. The OeHC has proposed changing the Committee's abolish date to August 31, 2022 from July 2020. However, currently the agency is assessing the need of each committee/council and internal approval for the change has not been obtained. More information will be given in May 2018.

Agenda Item 5: Update on eHAC vacancies, member, officer term expirations, and accept chair nominations

Ms. Rhames notified the Committee there are two vacancies; a representative from the Board of Nursing and the "expert on telemedicine". The Committee membership application was being reviewed and the Board of Nursing has recommended a representative to finish out the previous representative's term on the eHAC. Ms. Rhames stated that current members who have a term expiring this year will need

to re-apply if they want to serve again on the Committee. Ms. Rhames stated that Dr. Alozie's term as chair expires in July 1, 2018 and nominations for Chair would be open at this meeting. Dr. Alozie can serve two consecutive terms, if elected.

Ms. Gutierrez read the Officer Election Process to the Committee for adoption. Ms. Gutierrez requested a motion to adopt the Officer Election Process. Mr. George Gooch made a motion with Dr. Billy Philips seconding. A voice vote was taken. The motion carried.

Ms. Gutierrez read the responsibilities and roles of the Chair. Ms. Gutierrez informed the Committee that Chair nominations are now open and will remain open until 5:00 p.m., Friday, July 6, 2018. Members were instructed to email Ms. Rhames with nominations for Chair. Mr. Gooch nominated Dr. Alozie to serve another term as Chair. Dr. Alozie accepted his nomination for Chair.

Agenda Item 6: eHAC report to Commissioner and Legislature Update
Dr. Alozie introduced and turned the floor over to Mr. Gooch. Mr. Gooch gave a presentation to the Committee and referenced the PowerPoint and handout titled, *Texas Health and Human Services (HHS) e-Health Advisory Committee As Required by Title 1, Part 15, Texas Administrative Code, Section 351.823(d)*.

Agenda Item 7: eHAC Subcommittee Update
Dr. Alozie introduced and turned the floor over to Ms. Nora Belcher. Ms. Belcher presented to the Committee and referenced the PowerPoint and handout titled, *eHAC Subcommittee Update Presentation to the HHSC eHAC March 2, 2018*.

Ms. Belcher reminded members about the purpose of the Subcommittee requested by Dr. Alozie at the December 2, 2017 meeting. In her update, Ms. Belcher explained the Subcommittee's purpose (to explore a pilot project to determine how to provide incentive payments to providers who utilize a patient's health record when providing new patient and emergency room patient services, and have this incentive program integrated into the current MCO strategy), noted the Subcommittee has met three times and have agreed to review the HIT-related language in the Texas 1115 Transformation Waiver and the CMS Approval Letter (12/21/17) documents.

The Committee discussed incentive payments, dual eligible MCO's, provider groups funded by federal dollars, exchanging information easier, and CMS and TEFCA influencing the process.

ACTION ITEM: Ms. Rhames agreed to send the Texas 1115 Transformation Waiver link to the Committee.

Agenda Item 8: Telemedicine Update

Dr. Alozie introduced Ms. Erin McManus and Ms. Belcher. Dr. Alozie turned the floor over to Ms. McManus. Ms. McManus updated the Committee on Senate Bill (SB) 1107 and SB 922 implementations. SB 1107 will be taking public comment.

ACTION ITEM: When available, Ms. McManus will provide the link for public comment to Ms. Rhames to distribute to the Committee.

Ms. Belcher presented to the Committee an update for House Bill (HB) 1697. Ms. Belcher referenced the PowerPoint and handout titled, *Telemedicine - HB 1697 Update Presentation to the HHSC eHAC March 2, 2018*.

The Committee shared experiences and knowledge in support of Ms. Belcher's presentation.

Agenda Item 9: Break

15 Minute break.

Agenda Item 10: Disaster Response in Health Information Technology

Dr. Alozie introduced and turned the floor over to Mr. Steve Eichner. Mr. Eichner presented to the Committee about disaster preparedness. Mr. Eichner referenced the PowerPoint and handout titled, *Disaster Preparedness and Health Information Technology Update for the eHealth Advisory Committee- March 2, 2018*.

The Committee discussed bundling appropriate resources and having external internet connections as a necessity for disasters. The Committee also discussed appropriate and simplistic credentialing in a disaster circumstance.

Agenda Item 11: Public Comment

No public comment was made.

Agenda Item 12: Next Meeting Planning

Dr. Alozie informed the Committee that the next meeting is July 13, 2018 at 9:00 a.m. in the Brown Heatly Public Hearing Room. Dr. Alozie referenced the handout titled, *2018 eHAC Meeting Schedule*. Dr. Alozie stated the third meeting will be November 30, 2018. Mr. Gooch requested a refresher training on Ethics in Government by HHSC.

Agenda Item 11: Adjournment

Dr. Alozie adjourned the meeting at 11:07 a.m.

The web address for the meeting: https://texashhsc.swagit.com/play/03022018-531

NOTE: Minutes for the July 13, 2018 meeting were pending approval at the time this report was produced. Meeting attendance record is reflected below.

e-Health Advisory Committee
***from* DRAFT Meeting Minutes**
Friday, July 13, 2018
9:00 a.m.

Brown Heatly Building Public Hearing Room
4900 North Lamar., Austin, Texas 78751

Table 1: e-Health Advisory Committee member attendance at the July 13, 2018 meeting.

MEMBER NAME	YES	NO	MEMBER NAME	YES	NO
Ms. Elizabeth Adamson		X	Ms. Pamela McNutt		X
Dr. Ogechika Alozie	X		Ms. Sara Mills	X	
Ms. Nora Belcher	X		Ms. Rebecca Moreau		X
Dr. Tiffany Champagne-Langabeer	X		Ms. Hope Morgan	X	
Dr. Adam S. Chesler	X		Dr. Gerald Nissley		X
Dr. Salil Deshpande	X		Mr. AJ Patel		X
Mr. Steve Eichner	X		Dr. Billy Philips	X	
Mr. Scott M. Freshour		X	Mr. Will Rodriguez	X	
Mr. George Gooch	X		Dr. Gijs Van Oort	X	
Ms. Elise McDermott	X		Mr. Thomas C. Wheat	X	
Ms. Erin McManus	X				

Appendix C: Costs Report

The following eHAC support-related time and cost information is reported by the Office of e-Health Coordination's (OeHC) designated Committee liaison. Costs reflect staff time and related supplies and materials purchases. eHAC Committee members do not claim travel reimbursement.

The designated eHAC liaison reports dedication of approximately 55% of worktime to the management of eHAC. Committee management includes coordination of Committee and Sub-committee meetings, preparation of meeting notices, development and publication of agendas in coordination with eHAC chairs and HHSC Facilitation Services team, documentation of eHAC and eHAC subcommittees' activities and recommendations, preparation of presentation materials, membership application review and coordination of member appointment process, ongoing stakeholder communications, and collaboration with other HHS agency teams as well as external stakeholders.

The second highest percentage of time dedicated to the management of the eHAC is reported at 25% by the OeHC Interim Director who also serves on the Committee. In these roles, the OeHC Interim Director collaborates with the eHAC liaison and Chairs in developing meeting agendas, preparing presentation materials, and communicating eHAC initiatives and activities to agency management.

For this reporting period, a total of 12 HHS agency staff assisted in supporting the eHAC at a combined cost of $84,313. The OeHC also reported a materials and supplies expenditure of approximately $50.

All eHAC activities were supported using HHS appropriated funds.