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

As required by

Title 1, Part 15,

Texas Administrative Code,

Section 351.823(d)

February 2020

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Disclaimer

This report was 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, 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 by 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.

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

The eHAC includes health and human services 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, 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. The committee also includes ex-officio representatives from HHSC and an ex-officio representative from DSHS. For a full roster of representatives, please see Appendix 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.

Introduction

The Texas Health and Human Services (HHS) Electronic Health Advisory Committee (eHAC) 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 32.

This report provides a background on how the e-Health Advisory Committee reached its recommendations, as well as information on each criterion listed above. Information on (E) and (G) have been combined into Section 9 of this report.

Background

Texas Code, Section 351.823, requires the e-Health Advisory Committee to address three tasks:

Task 1: 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 and population health.

Task 2: 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: 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 Section 531.901(1), Government Code)

"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 Section 531.901(2), Government Code)

"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 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 [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 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)

List of Meeting Dates

The e-Health Advisory Committee met on the following dates through November 2019:

- March 1, 2019

- June 14, 2019

The committee will next meet on December 9, 2019.

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 70% attendance rate, with the lowest attendance being 56% and the highest 83%. A copy of committee members' attendance records is included in Appendix B, as part of the meeting minutes.

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, included as Appendix B.

March 1, 2019

- The committee reviewed and approved rule amendments related to its scope of work and processes.
- The committee reviewed and approved proposed changes to bylaws regarding management of the eHAC.
- HHSC staff updated the committee on telemedicine, telehealth, and remote patient monitoring legislation being tracked by HHSC. The committee vice-chair provided additional information on legislation that impacts those topics.
- Staff from the Office of the US Health and Human Services Assistant Secretary for Preparedness and Response presented to the committee on use of the emPOWER program and how it relates to the PULSE (Patient Unified Lookup System for Emergencies) platform that the committee has been discussing.
- HHSC staff updated the committee on the implementation of HB 1697 from the 2017 legislative session, which relates to telemedicine, including the status of a pilot project underway in one hospital.
- HHSC staff updated the committee on the implementation of the 2019 Annual Healthcare Common Procedure Coding System update, which impacts remote patient monitoring services in Medicaid.
- The eHAC subcommittee on telemedicine, telehealth, and telemonitoring reported to the full committee on content of their subcommittee meetings and their plans for next steps in developing recommendations for the next eHAC report.
- The eHAC subcommittee on interoperability reported to the full committee on content of their subcommittee meetings and their plans for next steps in developing recommendations for the next eHAC report.
- THSA updated the committee on the status of the PULSE platform.

- The committee received a presentation from Preferred Management Corporation on implementation of the telemedicine-based trauma system in Van Horn, Texas.
- HHS staff briefed the committee on the development of the HHSC Health IT Strategic Plan that is required by the state's 1115 waiver.

June 14, 2019

- The committee received an update from HHSC staff and the committee vice-chair on legislation that passed during the legislative session that impacts telemedicine, telehealth, and telemonitoring.
- The committee received a presentation on the U.S. Core Data for Interoperability (USCDI) data set from THSA staff and discussed the implications of that project for Texas.
- HHSC staff provided the committee with a detailed overview of development of the Health IT Strategic Plan and how it relates to the 1115 waiver and to the CMS Interoperability Toolkit. The committee provided feedback to the agency on potential milestones for the plan.
- The eHAC subcommittee on telemedicine, telehealth, and telemonitoring reported to the full committee on content of their subcommittee meetings and plans for developing recommendations for the next eHAC report.
- The eHAC subcommittee on interoperability reported to the full committee on content of their subcommittee meetings and plans for recommendations for the next eHAC annual report.
- The committee participated in ethics training led by the Deputy Chief Ethics Officer for HHSC.
- The committee was briefed by staff from FirstNet and the US Department of Commerce on the approaches their project is taking to ensure broadband and cellular access during disasters.

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 Appendix 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. e-Health Advisory Committee).

In 2018, the eHAC also created two subcommittees. One focuses on interoperability (Tasks 1 and 2) and the other focuses on telemedicine, telehealth and telemonitoring (Task 3). The committee chair charged the subcommittees with meeting regularly to develop recommendations for the annual report, and to engage directly with HHSC staff for input on the recommendations.

To finalize the recommendations from the subcommittees and complete the report, a volunteer writing team was appointed. The writing team reviewed the previous report's recommendations and the minutes from the 2019 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 included in Section 7 of this report.

Recommendations from the eHAC to HHSC and the Legislature

As noted above, the HHS e-Health Advisory Committee is making recommendations across several areas for which it is responsible. The tables below present the committee's recommendations, related information from HHS agencies regarding the status of each recommendation, and any future planned committee activities.

Task 1 (Section 351.823. eHealth Advisory Committee): Advises HHS agencies on the development, implementation, and long-range plans for healthcare 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 healthcare and population health.

Committee Recommendation	Status	Action Needed
Revise Texas Medicaid Medical Policy including updating the definition of telemedicine.	Complete	Process for on-going review and revision of policy to stay current industry change 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.

Committee Recommendation	Status	Action Needed
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 industry change in telemedicine application.
Continue remote patient monitoring benefit.	Complete	Continued via SB 670 and HB 1063 (2019 Legislative Session).
Recommend expansion of coverage to include substance abuse treatment (recovery services, counseling, e-prescribe).	Ongoing	Scope included in implementation of SB 670 (2019 Legislative Session).
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.

Committee Recommendation	Status	Action Needed
HHS agencies should use HIETexas, when appropriate, to exchange messages with trading partners and collaborate with the state's health information exchanges 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 Immunization 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 behavioral health data from LMHAs through HIEs across the State as needed within legal constraints.	Ongoing	Further discussion is needed.

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

Committee Recommendation	Status	Action Needed
Review all data streams from providers into the HHS system in order 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 IAPD will allow for the consolidation of the number of connections required by health care providers. The Emergency Department Encounter Notification (EDEN) system, also included in the IAPD, will enable the exchange of Admit, Discharge, and Transfer (ADT) messages that may be used by Texas Medicaid and public health to support a variety of programs.
Provide a complete inventory of inbound or outbound streams of clinical data between HHSC and Texas healthcare 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 Powering Texas report. In 2020, the interoperability subcommittee will review the report to see if it fully meets the intent of this recommendation or if changes are needed.

Committee Recommendation	Status	Action Needed
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, establishes as part of the HIE IAPD, will enable easier bi-directional data flows between providers and HHS agencies. DSHS is working to enhance interoperability for systems supporting newborn screening.

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.

eHAC Interoperability Subcommittee Report

This subcommittee report was developed by the Texas e-Health Advisory Committee (eHAC) Subcommittee on Interoperability and is intended to guide eHAC in developing its annual report required by Title 1, Part 15, Texas Administrative Code, Section 351.823(d). As discussed below, this report: (1) lays out the charge of the subcommittee; (2) provides a definition of interoperability; (3) provides an analysis of how interoperability is handled at the patient, regional, state, and national levels; and (4) provides recommendations on interoperability.

Charge of the eHAC Subcommittee on Interoperability

As laid out at the December 2018 eHAC meeting, the purpose of the interoperability subcommittee is to address Tasks 1 and 2 in the eHAC's annual report:

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

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

What is Interoperability?

According to section 4003 of the 21st Century Cures Act (Cures Act), the term "interoperability," with respect to health information technology, means such health information technology 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; and (C) does not constitute 'information blocking'[2] as defined in section 3022(a).[3]

New regulations and guidance from the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC), including the newly released second draft of ONC's Trusted Exchange Framework and Common Agreement (TEFCA), will affect the definition of interoperability as well as the analysis and recommendations in this report.

Interoperability at the Patient, Regional, State, and National Levels

Interoperability is handled through various networks and collaborative efforts at the patient, regional, state, and national levels. Texas HHS should take all of these various efforts into account when crafting policy around interoperability.

Interoperability at the Patient Level

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[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] "21t Century Cures Act, Public Law 114-255, https://www.congress.gov/bill/114th-congress/house-bill/34/text. Retrieved October 10, 2019.

Patients may use application programming interfaces (APIs) to access their data, leveraging the open APIs for coverage, claims, results, and clinical information required of health plans and providers in regulations released by CMS and ONC in 2019. There are often options for patients to access their protected health information (PHI) at the local, state, and national levels.

Interoperability at the Regional Level

Local health information exchanges in Texas offer services to healthcare systems, providers, payors and hospitals to share health care information primarily for the purposes of payment, treatment and other healthcare operations. These local HIEs are non-profit organizations, and therefore offer services at cost to keep expenses to participants low. Local HIEs also collaborate at the local, state, and national levels so that systems that cover multiple regions can have a single connection.

All of the local HIEs use standard, secure connections with strong encryption so that patient data is secure. The HIEs integrate with electronic health records where possible so that the access and exchange of the data is accessible within the user's normal workflow. Each 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 local 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 Texas Health Services Authority (THSA) is responsible for statewide health information exchange. Formed by the Texas Legislature as a public-private partnership, THSA partners with state agencies, local health information exchanges, 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 Texas Health and Human Services Commission (HHSC) and THSA for submission to ONC in 2010. THSA's governor-appointed board of directors supplemented the state HIE plan in 2014 to reflect the changing HIE market, and specifically how interoperability was being addressed in the public and private sectors.

Also relevant to state-level health information exchange is public health reporting and health information exchange with programs such as the prescription monitoring program (PMP) operated by the Texas State Board of Pharmacy.

Pursuant to Texas House Bill 2641 (84R, 2015), certain registries maintained by the Texas Department of State Health Services may now bidirectionally exchange health information via electronic health information exchange. 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 healthcare providers."[4]

The Texas Prescription Monitoring Program (PMP) "collects and monitors prescription data for all Schedule II, III, IV, and V Controlled Substances (CS) dispensed by a pharmacy in Texas or to a Texas resident from a pharmacy located in another state. Beginning March 1, 2020, pharmacists and prescribers (other than a veterinarian) will be required to check the patient's PMP history before dispensing or prescribing opioids, benzodiazepines, barbiturates, or carisoprodol."[5] Texas recently received funding to connect electronic health record (EHR) systems directly to the state PMP.

Interoperability at the National Level

National health information exchange generally refers to information exchanged through or pursuant to (1) the eHealth Exchange, (2) CommonWell, (3) the Carequality framework, (4) the Strategic Health Information Exchange Collaborative SHIEC Patient Centered Data Home, and/or (5) the Sequoia Project.

The eHealth Exchange is "the largest query-based, health information network in the country. It is the principal network that connects federal agencies and non-federal organizations, allowing them to work together to improve patient care and public health."[6]

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[4] *See* bill text at https://capitol.texas.gov/tlodocs/84R/billtext/pdf/HB02641F.pdf#navpanes=0

[5] www.pharmacy.texas.gov/pmp

[6] www.ehealthexchange.org

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 healthcare providers and the people they serve."[7]

Carequality is "a public-private, multi-stakeholder collaborative developed to create a standardized, national-level interoperability framework to link all data-sharing networks."[8] Carequality implementers are "the adopters of the Carequality Interoperability Framework, and their clients."[9]

The Strategic Health Information Exchange Collaborative (SHIEC) is a "national collaborative representing health information exchanges (HIEs) and their business and technology partners."[10] The SHIEC Patient Centered Data Home (PCDH) is "a cost-effective, scalable method of exchanging patient data among health information exchanges (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."[11]

The Sequoia Project is an "independent, trusted advocate for nationwide health information exchange. In the public interest [the Sequoia Project] steward[s] current programs, incubates new initiative[s,] and educate[s] our community."[12]

ONC recently selected the Sequoia Project as the Recognized Coordinating Entity under the Twenty-First Century Cures Act. The Cures Act requires ONC to convene stakeholders to develop a trusted exchange framework and a common agreement

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[7] www.commonwellalliance.org/about

[8] www.carequality.org

[9] www.carequality.org/members-and-supporters/

[10] www.strategichie.com

[11] www.strategichie.com/initiatives/pcdh/

[12] www.sequoiaproject.org

among existing disparate Health Information Networks (HINs) to exchange electronic health information. TEFCA is designed to scale electronic health information exchange 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. Components required for success include:

- Trusted Exchange Framework – a common set of principles, terms, and conditions for health information exchange;
- Common Agreement to exchange data among existing and future HINs;
- The Recognized Coordinating Entity (i.e., the Sequoia Project); and
- The stakeholder community, including providers, payers, public health, and vendors, which has an opportunity to participate in the development of the future of health information exchange through comments and other participation.

Recommendations

As recommended in previous annual reports, Texas HHS system agencies should not create or recommend standards that deviate from nationally recognized standards for the electronic exchange of health information.

Furthermore, Texas HHS system agencies should leverage the existing EHR and HIE infrastructures described in this report, and should avoid developing new infrastructure, where and when appropriate.

eHAC Telemedicine, Telehealth and Telemonitoring Subcommittee Report

The committee reviewed and discussed the *Telemonitoring in Texas* report as well as the Chronic Care Management Program at Frederick Memorial Hospital. Based on those resources, and the opinions of the committee members, our recommendations going forward include the following:

- Incorporate telemedicine and telehealth into healthcare network adequacy regulations in a manner that expands and complements patient access to care, continues current requirements for network adequacy and engagement of local physicians and healthcare service providers.

- Explore Medicaid financing options for Project ECHO, a telementoring model that links primary care clinicians with specialists via teleconferencing technology.

- Work with the Drug Enforcement Administration (DEA) to modify laws on what is considered a DEA-registered site, to allow prescriptions for controlled substances to be provided via telemedicine in state-regulated settings.

- Explore options for a shared telemedicine and telehealth tech support pool that could provide a combination of onsite and virtual services for rural and underserved areas in Texas.

- Systematically assess, summarize and disseminate experiences and lessons from DSRIP-funded telemedicine and telehealth pilots.

An analysis of Texas Medicaid Teleservice Providers from January 1, 2017 - March 31, 2019 was conducted to provide insight into utilization patterns across the state. The majority of telemedicine encounters were found to be in the following counties:

1. Bexar
2. Harris
3. Webb
4. Dallas
5. Angelina

Clinicians in the top five counties provided services to 176,061 patients, with the highest county serving 72,344 and the fifth highest serving 16,938 patients.

The next five highest county providers of telemedicine services included:

6. Williamson
7. Atascosa
8. Hidalgo
9. Howard
10. Nueces

The most common procedures by CPT code include 99214- Office or other outpatient visit for established patient, 99213- Office or other outpatient visit, Q3014- Telehealth originating site fee, 90792- Psychiatric diagnostic procedures with medical services, and 90791- Psychiatric diagnostic procedures with no medical services.

Services by CPT code, which are frequently denied, included 99204- Office or other outpatient visit for the evaluation and management of a new patient, 99212, 99213, 99214, 99215- Office or other outpatient visit for the evaluation and management of an established patient, Q3014- Telehealth originating site fee (also most commonly billed), 90791- Psychiatric diagnostic evaluation with no medical services (also most commonly billed), 90792 - Psychiatric diagnostic evaluation with medical services, 90832, 90834- Psychotherapy.

It is significant that many of the services most often billed are also the services most often denied. The e-Health Advisory Committee has created a survey which will target the gaps in billing and coding practices. This Council will recommend the appropriate resources, so clinicians can accurately and precisely assign the correct CPT codes to their procedures to allow full reimbursement and alleviate unnecessary administrative processes.

A Description of the Activities the Committee Anticipates Undertaking in the Next Fiscal Year

During the course of its 2019 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 the further development of the interoperability report as required under House Bill 2641 (2015, 84R),

- Monitoring the implementation of telemedicine legislation including Senate Bill 670 (2019, 85R) and House Bill 1063 (2017, 85R), as well as House Bill 1697 (2017, 85R) and the related funding.

- Providing input on Texas' 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 e-Health Advisory Committee is scheduled to meet on December 9th, 2019, where the committee will discuss any additional activities the committee anticipates undertaking in the next calendar year.

The e-Health Advisory Committee is consigned to the advancement of telemedicine and telehealth across the state of Texas. As such, the subcommittee on telemedicine, telehealth, and telemonitoring created a survey which will be broadly distributed to assess barriers to implementation of telemedicine and telehealth by clinicians. The eventual goal is to increase utilization of telemedicine and telehealth services across Texas.

Synchronous telemedicine occurs when a patient and physician interact in real-time, such as through phone or video and integrated medical devices. This type of medical care offers numerous benefits to rural areas, or other places where there is a shortage of specialty care. A real-time consultation may yield a better use of both

parties' time and may incentivize newer patients and providers to attempt to adopt this model when possible.

There is a growing need for specialized services in Texas, including behavioral and mental health care. Mental health care, despite its growing need, is increasing in shortage with a projected capacity contraction in the near term (Satiani, Niedermier, Satiani, & Svendsen, 2018). According to the Substance Abuse and Mental Health Services Administration (SAMHSA), approximately 48 million adults experienced mental illness in 2018, an increase of one million since 2017, with only 43.3% receiving proper mental health services (SAMHSA, 2019). Aging psychiatrists are expected to exacerbate this problem; more than 60% are set to retire soon (Merritt Hawkins, 2017). Thus, methods to increase capacity and access, uniquely leveraging the current technology trends, are in dire need to combat this growing issue. The growing cost of mental health disorders are consistently some of the highest in the nation, alongside heart disease and cancer (Roehrig et al., 2016).

The e-Health Advisory Committee encourages licensed providers to seek additional information, if they are interested in implementing telemedicine/telehealth into their existing practice. Simple tips for consideration, when adding telemedicine to a practice, are included below:

10 Tips for Starting a Telemedicine Practice

1. Consider your clinical goals: will you provide emergency evaluation? Specialty consultations? Direct to consumer (patients)? Consults to other providers? Offer virtual services in connection with another institution?

2. Consider how you will communicate: Synchronous (live)? Asynchronous using text and pictures? Video and/or Audio only?

3. Maintain the same standard of care as in-person visits. Determine what you are willing to treat without a hands-on physical exam.

4. Establish the patient-provider relationship. Do you want to offer your services as a clinician through an established platform that handles technology, billing, and credentialing; or design a service for your own patients where they only see your providers?

5. Select HIPAA secure technology.

6. Maintain a secure physical environment.

7. Train clinical and administrative staff.

8. Understand legal and regulatory policies.

9. Seek guidance from payors: Medicaid is an excellent option for reimbursement.

10. Engage new patients. Educate existing patients.

Resources

Telehealth Resources in Texas & Louisiana

https://texlatrc.org/

National Telehealth Resource Center, Center for Connected Health Policy

https://www.cchpca.org/

American Academy of Family Physicians

https://www.aafp.org/practice-management/health-it/telemedicine-telehealth.html

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

The e-Health 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 December 31, 2023.

Costs Related to the Committee

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

Acronyms

Acronym	Full Name
CHIP	Children's Health Insurance Program
DSHS	Department of State Health Services
ED	Emergency Department
eHAC	e-Health 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

HHSC e-Health Advisory Committee - Membership

Category	Selection	Business Organization	City	Region, Race, Gender
Representative from **HHSC** *(ex-officio members)*	Erin McManus	HHSC	Austin	7, White, Female
	(Vacant as of 5/31/2019)			
Representative from **DSHS** *(ex-officio member)*	Steve Eichner	DSHS	Austin	7, White, Male
Representative from **Texas Medical Board**	Stephen Brint Carlton, JD	TX Medical Board	Austin	7, White, Male
Representative from **Texas Board of Nursing**	Elise McDermott, RN	TX Board of Nursing	Austin	7, White, Female
Representative from **Texas State Board of Pharmacy**	Adam S. Chesler, PharmD	Cardinal Health	Dallas	3, White, Male
Representative from **Statewide Health Coordinating Council**	Salil Deshpande, MD	UnitedHealth Care Community Plan of Texas	Houston	6, Asian, Male
Representative of a **managed care organization**	Tracy Rico, RN	Superior Health Plan (Centene Corp.)	Austin	7, White, Female
	Stephanie Rogers, MBA	Baylor Scott & White, Scott & White Health Plan	Temple	7, White, Female
Representative of the **pharmaceutical industry**	Melisa McEwen	Otsuka America Pharmaceutical, Inc	Spicewood	7, White, Female

Category	Selection	Business Organization	City	Region, Race, Gender
Representative of a **health science center in Texas**	Billy Philips, Jr., PhD	Texas Tech University Health Sciences Center	Lubbock	1, White, Male
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
Representative 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	Sunset ID Care	El Paso	10, Black, Male
	Thomas C. Wheat	Pediatric Home Healthcare	Dallas	3, White, Male
Representative from **Texas Health Services Authority**	George Gooch	Texas Health Services Authority	Austin	7, White, Male
Representative of a local or regional **health**	Phil Beckett, PhD	Healthcare Access San Antonio	San Antonio	8, White, Male

Category	Selection	Business Organization	City	Region, Race, Gender
information exchange	Sheila M. Magoon, MD	South Texas Physicians Alliance / Buena Vida y Salud, LLC	Harlingen	11, White, Female
Representative with **expertise** related to 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

Appendix B: Member Attendance and Meeting Minutes

The attendance statistics for the committee are as follows:

March 1, 2019 meeting
- ABSENT: 17% (3 of 18)
- PRESENT: 83% (15 of 18)

June 14, 2019 meeting
- ABSENT: 44% (8 of 18)
- PRESENT: 56% (10 of 18)

e-Health Advisory Committee
DRAFT Meeting Minutes
Friday, March 1, 2019
9:00 a.m.

Health and Human Services Commission,
Brown-Heatly Building, Public Hearing Room
4900 N. Lamar Blvd., Austin, TX 78751

Table 1: e-Health Advisory Committee member attendance at the March 1, 2019 meeting.

MEMBER NAME	YES	NO	MEMBER NAME	YES	NO
Dr. Ogechika Alozie	X		Ms. Pamela McNutt	X	
Ms. Nora Belcher	X		Ms. Sara Mills	X	
Dr. Tiffany Champagne-Langabeer	X		Ms. Rebecca Moreau		X
Mr. Stephen Carlton, J.D.		X	Ms. Hope Morgan	X	
Dr. Adam S. Chesler	X		Dr. Billy Philips	X	
Dr. Salil Deshpande	X		Ms. Tracy Rico	X	
Mr. Steve Eichner	X		Ms. Stephanie Rogers	X	
Mr. George Gooch	X		Mr. Thomas C. Wheat		X
Ms. Elise McDermott	X				
Ms. Erin McManus	X				

Agenda Item 1:   Call to Order and Logistics

Dr. Ogechika Alozie, Chair, called the meeting to order at 9:07 a.m. and turned the floor over to Ms. Sallie Allen, HHSC, Advisory Committee Coordination Office. Ms. Allen provided logistical announcements and called roll to determine a quorum was present.

Agenda Item 2:   Welcome and Introductions

Dr. Alozie welcomed Committee members and requested members introduce themselves.

Agenda Item 3: Approval of December 6, 2018 Meeting Minutes

Ms. Allen prompted members to review the December committee meeting minutes provided in their packet and asked if there were any edits. Hearing none, Ms. Allen requested a motion.

MOTION: Dr. Salil Deshpande motioned to approve the December 6, 2018 meeting minutes. Ms. Tiffany Champagne-Langabeer seconded the motion. A voice vote was taken. The motion carried with no objections or abstentions.

Agenda Item 4: e-Health Advisory Committee (eHAC) Membership

Dr. Alozie introduced and turned the floor over to Ms. Adriana Rhames, HHSC, Office of e-Health Coordination. Ms. Rhames provided a status update on membership vacancies and referenced the handout, *eHAC Membership List.* Ms. Rhames stated:

- The solicitation and application templates were being revised thus the posting for the health information exchange (HIE) position had been delayed.
- Applications for the pharmaceutical industry representative were being assessed by the review panel and recommendation documents would be submitted to the Executive Commissioner for appointment approval.

Members expressed concern about the HIE appointment not being approved before the next (June 2019) meeting and recommended that a subject matter expert (SME) from the local HIE agency provide the committee with a state update, until such eHAC vacancy is filled.

MOTION:

Dr. Ogechika Alozie motioned to approve having a representative from the local HIE office provide a state HIE update at the next meeting. Mr. George Gooch seconded the motion. A voice vote was taken. The motion carried with no objections or abstentions.

Agenda Item 5: e-Health Advisory Committee (eHAC) Rule Amendment Status

Ms. Adriana Rhames, HHSC, Office of e-Health Coordination, gave an update on the rule amendments and referenced handout, *eHAC Rules Amended document.*

- All of the recommended rule amendments were approved and became effective February 25, 2019.
- The committee abolish date was approved for December 31, 2019.
- The Office of Advisory Committee Coordination (ACCO) along with an executive leadership team will conduct a review and assessment of all the advisory committees in late May 2019 and determine the outcome of committees affected by an upcoming abolishment.

Agenda Item 6: Review Revised Bylaws

Ms. Rhames, HHSC, Office of e-Health Coordination, provided and update and referenced the bylaws handouts, *eHAC Bylaws (tracked changes), eHAC Bylaws (clean), and Bylaws Statement by Members.*

- Members were asked to sign the Statement by Member page.
- Dr. Billy Philips asked for a clarification definition regarding Section 11.2b. telephone conference call. The following clarification was provided.
  - Agency bandwidth limitation does not allow for Virtual, GoToMeeting or Webex communications for public meetings.
  - Directive from Governor Abbott's office is for all state agencies to continue to follow the rule of the Open Meetings Act, where all advisory committee meetings be conducted as a webcast for public viewing.

MOTION:

Dr. Salil Deshpande motioned to accept the revised bylaws as written. Dr. Adam Chesler seconded the motion. A voice vote was taken. The motion carried with no objections or abstentions.

Dr. Philips asked for clarification of the Statement by Member document in reference to new members being compliant with training requirements. Ms. Rhames informed that members have completed two of the three training courses, and the third, Ethics Policy training, will be offered at the June 14, 2019 meeting.

Agenda Item 7: Telemedicine and Telehealth Legislative Update

Ms. Erin McManus provided a brief overview of the various legislative house bills (HB) and senate bills (SB). She also noted the HHSC disclaimers which states that HHSC cannot support or oppose legislation; cannot provide a recommendation on whether to pursue statutory amendments; however, HHSC does provide estimated program impacts, cost estimates, and recommendations for changes to proposed legislation to aid in implementation.

Following is a list of Bills being tracked by HHSC:

Telemedicine/Telehealth

- H.B. 870/S.B. 670 - Changes to telemedicine and telehealth benefit structure for Texas Medicaid.
- H.B. 871 (DSHS) – Proposes use of telemedicine services to meet trauma level of care designations.
- H.B. 1738 - Adds additional conditions for Texas Medicaid home tele-monitoring reimbursement; Add targeted case management, peer support services, and substance use disorder counseling services to the definition of telehealth services; repeal home tele-monitoring sunset provision.
- H.B. 1756/S.B. 792 - Creates statutory definition of tele-dentistry services; adds tele-dentistry services as a required benefit for Texas Medicaid and CHIP; creates delegated scope of practice for dental hygienists.
- H.B. 1782 - Tasks HHSC, with assistance from associations and Texas Health Professions Council, with developing a telemedicine and telehealth services action plan with short-term and long-term recommendations.
- S.B. 749 (DSHS) - Prevents on-call telemedicine and telehealth services for rural hospitals with neonatal and maternal level of care designations of I, II, and III from being excluded or prohibited from use.
  S.B. 1265 - Changes to Texas Insurance Code requirements for health plan coverage of telemedicine and telehealth services.

Home Tele-monitoring

- H.B. 1063 - Adds additional conditions for Texas Medicaid home tele-monitoring reimbursement; repeal home tele-monitoring sunset provision.

- H.B. 2062 - Adds additional conditions for Texas Medicaid home tele-monitoring reimbursement; require reimbursement in the event of unsuccessful data transmissions if certain conditions are met; repeal home tele-monitoring sunset provision.
- H.B. 1738 – Also addresses home tele-monitoring

Ms. Nora Belcher provided additional information on the following Bills:

- Remote Patient Monitoring - three bills have been filed. From an advocacy perspective, the filing groups are engaged in active conversation to ensure a clean plan is aligned. Although the bills are similar, but not identical, do not want one bill to impede another or have a language misinterpretation.
- H.B. 1782 – Statewide Telemedicine Plan - original initiative came from the Texas Silver Haired Legislature; if passed the e-HAC would potentially be a component involvement with this bill.

The following Bills contain telemedicine/telehealth as a subcomponent:

- S.B. 10, H.B. 1448 – Texas mental health consortium bill – pulls all the chairs of psychiatric department of our health science centers into a structure intended to improve access to mental health services specific to telemedicine and telehealth as a component to the bill. This is an emergency item and a priority for the Governor's office and it is moving very quickly.
- H.B. 10 is not a companion to S.B. 10. It addresses similar issues around behavioral health, behavioral health in schools, expansion of mental health access, contains first statutory definition of tele-psychiatry. These two bills will need to be aligned and reconciled.
- S.B. 71 – designed to establish a statewide telehealth center to support sexual assault forensic nurse examiners; provide expertise services to rural areas that do not have trained staff onsite.
- H.B. 1706 – tele-pharmacy bill designed to increase access to medically underserved areas in urban populations for patients released from mental health centers. Another bill is being considered to address the 22-mile distance requirement between designated pharmacies.
- H.B. 1960 – creates a Governor's Broadband Council to coordinate research and conduct a study to determine if lack of broadband is a true barrier for access to care.

Agenda Item 8:   Patient Unified Lookup Systems for Emergencies (PULSE) and emPower in emergency shelters

Dr. Alozie introduced and turned the floor over to Ms. Kristen Finne, Program Manager, US HHS emPOWER Program, Office of US Assistant Secretary for Preparedness and Response. Ms. Finne referenced the PowerPoint, *The HHS emPOWER Program and PULSE in Shelters*. Some fine points of the program are provided below:

- In June 2013, conducted a pilot in partnership with CMS and City of New Orleans Health Department to identify and locate at-risk population that relied on electricity-dependent oxygen via Medicare claims data.
- Work with community partners, to better plan and prepare for disasters and have critical services in place for individuals in need of electricity-dependent medical equipment and essential healthcare services.
- The emPOWER Map locates the Medicare at-risk population by zip code and the emPOWER REST service enables the deidentified Medicare at-risk population dataset to easily integrate as a layer within geographic information systems (GIS).
- The emPOWER dataset is generated monthly and identifies up to fourteen electricity-dependent medical devices.
- In March 2019 launched an in-depth online training program – outline healthcare needs in community, resource tools: how to use, share, implement, etc.
- Partnered with CMS to generate datasets from state-operated Medicaid and CHIP, developed an instructional manual to replicate a dataset to share with local public health authority.
- Generated first dataset pilot with Nevada in 2017 and conducted first statewide exercise and found additional 10,000 at-risk individuals.
- The future plan is to standardize the emPOWER program across the country to generate an automatic update of information.
- PULSE provides patient electronic health information to ensure continuity of patient-centered care and complements the emPOWER program.

Members discussed:

- Patient Unified Lookup System for Emergencies (PULSE), Sequoia data vs. claims data; physician limits to accessibility

- Nevada pilot: implementation, resources required a claims analyst and a programmer, approximately 2-4 weeks, each
- Dataset process/collection is rather quickly, holdup may occur between partnerships: Medicaid, state agencies, leadership review, etc.
- Implementation Advanced Planning Document, Medicaid will consider additional funding for resource needs
- A longer-term goal of emPOWER is to incorporate Medicaid, CHIP, and Medicare data; will take another 2-3 years to finalize approach
- Any data on monetary savings related to secondary conditions –
  o Not a large amount of research
  o Ike hurricane, dialysis treatment, Emergency Department vs. facility, $8K difference in cost
  o 2003 New York blackout, #1 EMS call and #1 admission was power respiratory device failure
  o Continuing to collect data

Agenda Item 9: Break

15 Minute break.

Agenda Item 10: H.B. 1697 (85th Legislature) Implementation

Dr. Alozie reconvened the meeting at 11:17 a.m. and turned the floor over to Ms. Hope Morgan, Interim Director of Office of e-Health Coordination, and she provided a brief update on the implementation of H.B. 1697.

- Held a soft-kickoff on January 28, 2019 at Navarro Regional Hospital, a tentative site for the pilot
- Representatives from Children's Hospital and HHSC attended
- First time for hospital to participate in an accredited telehealth/telemedicine program
- Interest expressed to extend program in their emergency department (ED) as well as the Neonatal Intensive Care Unit (NICU)
- Level One hospital, 4 pediatricians and 16-18 nurses
- Navarro staff was extremely receptive to the virtual courses for continuing education credits being offered

- Funding for the pediatric telemedicine grant program was in both the House and Senate versions of the budget and, as a result, Commissioner Philips pulled the exceptional item

Agenda Item 11: 2019 Annual Healthcare Common Procedure Coding System (HCPCS) update

Dr. Alozie introduced and turned the floor over to Ms. Erin McManus and she referenced three handouts, Overview of Telemonitoring Benefit Changes for Texas Medicaid, Providers Must Resubmit some Home Telemonitoring Services Claims, and TMHP to Process Payments for some Home Telemonitoring Services Claims for the month of January 2019. She referenced an HHSC disclaimer statement and advised there is still active litigation concerning the 2019 annual HCPCS updates for home tele-monitoring services, which cannot be commented on, however all the information presented is publicly available.

Following is background on the updated codes:

- CMS end-dated code 99090, effective January 1, 2019.
  - Code 99090 was used to reimburse for home tele-monitoring equipment installation and set-up.
  - Code 99090-GQ was used to reimburse for daily monitoring services.
- HHSC initially proposed replacing code 99090 with new code 99453 and code 99090-GQ with 99454.
  - Code 99454 specifies monthly reimbursement in its description.
- New codes 99453 and 99454 were presented at the January 14, 2019 rate hearing.
- Following the rate hearing, codes 99453 and 99454 were replaced with code S9110 and modifiers U1-U4 and U7-U9.
  - Code S9110 with the U1 modifier will be used to reimburse for home tele-monitoring equipment installation and set-up.
  - Code S9110 with the U2-U4 and U7-U9 modifiers will be used to reimburse for 5 day increments of daily monitoring services per rolling month.
  - Code S9110 with the U2-U4 and U7-U9 can be reimbursed once per month.
- Code S9110 and modifiers U1-U4 and U7-U9 were presented at the February 7, 2019 rate hearing.

- HHSC released three provider notifications on February 22nd and February 26th (included in meeting materials) on the Texas Medicaid and Healthcare Partnership (TMHP) website to address the coding changes, prior authorization updates, and claims filing requirements for January and February 2019.
- The Texas Medicaid Provider Procedures Manual (TMPPM) has been updated as of today (March 1, 2019).

Ms. Sarah Mills, eHAC member, expressed her gratitude to the Commission for listening to their concerns and working out a very good compromise with the codes. Ms. McManus also extended gratitude to the clinical policy and the rate analysis teams who were instrumental in brainstorming the modifier setup.

Agenda Item 12: eHAC Subcommittee Report on Telemedicine, Telehealth and Telemonitoring

Ms. Tracy Rico, eHAC member, provided the subcommittee report and referenced the handout, *THIN Report: Catalyzing Adoption of Telemedicine for Population Health and Health Equity in Texas*. The subcommittee is charged with assessing and identifying gaps in the areas of telemedicine, telehealth and telemonitoring. After two meetings, the subcommittee core area of focus is to:

- Promote and work with payers and providers, by identifying grant state funded opportunities to enable providers to offer telemedicine;
- Encourage managed care organizations and commercial payers to partner on projects related to enabling providers to welcome and offer opportunities through educational potential incentives;
- Look at proposed rates for telemonitoring, and
- Determine gaps and opportunities in service by reviewing available data from current providers and reach out to the top volume providers to solicit best practices.

Ms. Rico referred members to the THIN report and advised that their committee plans to devote some of their time to help explore some of the recommendations listed. Ms. Morgan commented the H.B. 1697 Workgroup created some technical requirements and perhaps they could be leveraged and put into practice. Ms. Belcher suggested a telemedicine Medicaid providers directory be created. Dr. Chesler would like to see a pharmacist involved and volunteered to serve on this subcommittee. Dr. Alozie asked for clarification on whether DSHS is creating or

collaborating on a telehealth guide and Steve Eichner stated he would research and bring information back to the committee. Ms. McManus stated she has shared numerous telemedicine and telehealth policy updates with Brian Rosemond, Nurse Consultant, DSHS, who works at the Ryan White Clinic.

ACTION ITEM:

Arrange for Brian Rosemond and Erin McManus to provide policy updates on telemedicine and telehealth at June 14 meeting.

Agenda Item 13: eHAC Subcommittee Report on Interoperability

Ms. Pamela McNutt, eHAC member, provided the subcommittee report and referenced the PowerPoint, eHAC Interoperability Subcommittee Update, and handout, CMS Advances Interoperability & Patient Access to Health Data through New Proposals.

- The proposed Centers for Medicare & Medicaid Services (CMS) rules are scheduled to post on the federal website Monday, March 4, 2019; with a 60-day comment period
- Some concern is the increased frequency of exchange of information for dual eligible patient
- The proposed Office of the National Coordinator (ONC) rules will affect the software capabilities for vendors
- Vendors want to charge providers for use of Sequoia software
- There are seven exceptions to "information blocker" classification; need clarity
- New data sets are being proposed for interoperable data exchange
- National Provider Identifiers (NPI) will become the proxy for physician digital addresses

ACTION ITEM:

Eric Heflen, Chief Technology Officer, Texas Health Services Authority, helped develop the new USCDI code. Ms. Belcher requested Mr. Heflin be invited to present at the June 14 meeting and walk the members through the transition and provide a clear explanation of the new proposed data sets and what is driving such changes.

Agenda Item 14: BREAK

Agenda Item 15: Disaster Response in HIT

Dr. Alozie reconvened the meeting at 12:50 p.m. and turned the floor over to Mr. George Gooch, eHAC member, Executive Director of TX Health Services Authority. He provided an update on disaster response in HIT and referenced the PowerPoint, *Patient Unified Lookup System for Emergencies (PULSE).* Key points of his presentation included:

- Hurricane Harvey disaster statistics:
  - approximately 39,000-42,000 individuals were displaced
  - approximately 5,359 individuals sought medical care in an
  - alternative care facility (shelter, university, tent, etc.)
- Regional and local HIE support statistics:
  - Provided 24/7 care over a period of 2-3 weeks
  - Over 225 hours FTEs support over 17 days
  - Over 450 records accessed; with two-thirds medication history
- PULSE is resource tool (view only format) to allow disaster response volunteers to access patient information (including medication histories) obtained via real-time connections to healthcare organizations
- CMS support would allow state Medicaid agencies to potentially secure infrastructure funding (federal match) for emergency disaster plans
- Work with local, state and national partnerships to promote adoption of PULSE in state's emergency response plan
- PULSE relies on internet connectivity to function. It can leverage 5G networks, or potentially be accessed via satellite

Mr. Gooch stated the need to ensure shelters are equipped with Internet connectivity and medical volunteer workers are registered so their credentials are in place to access the patient information exchange during disaster response.

ACTION ITEM:

Ms. Belcher requested someone from FIRSTNet be invited to present at the June 14 meeting to provide members with an overview of services and what type of hinderance or barriers may need to be adopted.

Agenda Item 16: TORCH Update on Van Horn, TX

Ms. Belcher provided a disclaimer with regards to the original agenda description posting. Dr. Phillips suggested staff from Texas Organization of Rural and Community Hospital (TORCH) provide an update on this project. TORCH recommended that Mr. Mike Easley, Vice President for Hospital Operations, Preferred Management Corporation give the presentation. Mr. Easley does not represent with TORCH, however he is a state subject matter expert and provided a telemedicine update on the Van Horn project and referenced the handout, *Preferred Management Corp Telemedicine Protocols.* The handout outlined the policy, procedures and guidelines related to Avera Emergency Services for patients in need of emergent, urgent and critical care in a hospital setting.

- The hospital in Van Horn is in a fairly remote location, it sits on a major interstate 120 east of El Paso and 185 west of Midland/Odessa
- Due to the remoteness of the location physician recruitment was difficult and the hospital was about to close
- Examined other models for delivering care and found that telemedicine physician supervision was used
- To maintain Level 4 trauma status requires physician to present within 30 minutes
- November 2016, State health department granted waiver to staff emergency department with physician assistant and nurse practitioner with a telemedicine assisted physician
- Established fiber optics cable connectivity to the hospital
- Contracted with telemedicine physician provider in Sioux Falls, SD
- Local staff is in charge, board certified telemedicine physician provides expert advice and guidance
- Real-time interaction with telemedicine physician
- Installation is approximately 12 months
- All rural hospitals could benefit from this type of service
- Licensing of the telemedicine physicians was a lengthy process and involved delegated credentialing.

Agenda Item 17: Health IT Strategic Plan

Ms. Hope Morgan, Interim Director of Office of e-Health Coordination provided an update on the Health IT strategic plan. Ms. Morgan referenced the handout, *draft HIT Strategic Plan Outline-Last Update 12/2018.*

In December 2017, HHSC's 1115 Waiver was approved with Special Terms and Conditions that required HHSC to produce a Medicaid Health IT Strategic Plan by October 2019. The plan will include information on HIT projects in progress and outline potential future projects. Key points made included:

- Work in progress regarding provider directory, enterprise data governance and the health services gateway
- Plans for leveraging clinical data on the Medicaid population to augment Medicaid business processes including utilization review, value-based care, medical benefits and care coordination.
- How public health information can be leveraged for care coordination
- Leveraging connectivity with THSA and Health Information Exchanges (HIEs) to exchange clinical data with HHS systems
- Strategies for connecting providers to HIEs and promoting the sharing of clinical data across the Health IT ecosystem.
- Leveraging Texas academic resources for their expertise in working with clinical data
- A draft copy of the plan will be distributed to eHAC members in late March for feedback

Agenda Item 18: Public Comment

No public comment was made.

Agenda Item 19: Next Meeting Planning

Dr. Alozie advised the next meeting is scheduled for June 14, 2019 in the Moreton Building public hearing room and the last meeting is scheduled for December 9, 2019 in the Brown Heatly Building.

Agenda Item 20: Adjournment

Dr. Alozie adjourned the meeting at 2:03 p.m.

The web address for the meeting:
 https://texashhsc.swagit.com/play/03012019-738

e-Health Advisory Committee
DRAFT Meeting Minutes
Friday, June 14, 2019
9:00 a.m.

Health and Human Services Commission,
Brown-Heatly Building, Public Hearing Room
4900 N. Lamar Blvd., Austin, TX 78751

Table 1: e-Health Advisory Committee member attendance at the June 14, 2019 meeting.

MEMBER NAME	YES	NO	MEMBER NAME	YES	NO
Dr. Ogechika Alozie	X		Ms. Erin McManus	X	
Ms. Nora Belcher	X		Ms. Pamela McNutt		X
Dr. Tiffany Champagne-Langabeer		X	Ms. Sara Mills	X	
Mr. Stephen Carlton, J.D.		X	Ms. Rebecca Moreau		X
Dr. Adam S. Chesler	X		Dr. Billy Philips		X
Dr. Salil Deshpande		X	Ms. Tracy Rico	X	
Mr. Steve Eichner	X		Ms. Stephanie Rogers	X	
Mr. George Gooch		X	Mr. Thomas C. Wheat		X
Ms. Elise McDermott	X				
Ms. Melisa McEwen	X				

Agenda Item 1:   Call to Order and Logistics

Dr. Ogechika Alozie, Chair, called the meeting to order at 9:05 a.m. and turned the floor over to Ms. Sallie Allen, HHSC, Advisory Committee Coordination Office. Ms. Allen provided logistical announcements and called roll to determine a quorum was not present.

Agenda Item 2:   Welcome and Introductions

Dr. Alozie welcomed Committee members and requested members introduce themselves.

Agenda Item 3:   Approval of March 1, 2019 Meeting Minutes

Due to the lack of a quorum, approval of the minutes was postponed until the next meeting.

Agenda Item 4:   e-Health Advisory Committee (eHAC) membership- status of vacancies

Dr. Alozie introduced and turned the floor over to Ms. Adriana Rhames, HHSC, Office of e-Health Coordination. Ms. Rhames stated two recommendations for appointment to the vacant local or regional HIE representative seat had been submitted to HHSC executive leadership for review. Once the appointment is approved, she will share the information with the members.

Agenda Item 5:   e-Health Advisory Committee (eHAC) Committee Vice-chair election

Dr. Ogechika Alozie, Chair, turned the floor over to Ms. Sallie Allen, HHSC, Advisory Committee Coordination Office. Ms. Allen reviewed the new procedure for election of officers and the process for conducting an officer election with the members. Since a quorum was not established, the members postponed the adoption of the procedure until the next meeting. Election of a vice-chair was also postponed until the December 2019 meeting.

Agenda Item 6:   Telemedicine and telehealth legislative update

Dr. Ogechika Alozie, Chair, turned the floor over to Ms. Nora Belcher and Ms. Erin McManus to provide legislative update on several Senate and House bills related to telemedicine and telehealth.

Ms. Belcher provided updates related to Senate Bill 670, authored by Dr. Dawn Buckingham; a follow-up bill to S.B. 1107 from the 2017 legislative session. Ms. Belcher shared the following highlights:

- Puts in coverage parity provision for telemedicine for Medicaid MCOs

- MCOs cannot deny a request for payment for a service; whether it be telemedicine vs. in-person service
  - Gives MCOs flexibility to work with providers to cover all types of services, not just the traditional office visit
- Federally qualified health centers (FQHC) can fully participate in telemedicine as a presenting or distant site, whichever is appropriate; it does not allow for double payment to FQHC
- Language clarification to protect providers' choice of telemedicine platform
- Statute language revised: now it does not require patient site presenters anywhere (originally it was only required for school-based clinics)
- Additional House floor amendments: 1) statutory definition of "direct patient care" now acknowledges telemedicine and telehealth; and 2) added FQHC to eligible sites for tele-pharmacy, and lastly
- Provided clean up to the Medicaid code: old statute required annual or bi-annual comparison of Medicaid/Medicare telemedicine payments. This statutory requirement removed from the books.

Final two items addressed previously observed concerns:

1. School-based clinic models had not been coordinating with Medicaid PCPs. Language in the bill, states if a patient has sought a telemedicine consult, and agrees to, the telemedicine provider must communicate this to the PCP. Because Texas has a medical home- based model, the patient may choose to not have their consult coordinated with the PCP. Although not mandated, this coordination is encouraged to enable comprehensive care provided by the PCP.
2. Added a safety net repealer for sunset date on the remote patient monitoring benefit. This allows for telemedicine encounter data sharing via this benefit.

Ms. Belcher turned the floor over to Ms. Erin McManus to provide additional updates on S.B. 670 and H.B. 1063.

Ms. McManus provided the following additional information regarding Senate Bill 670:

- Additional flexibility granted to the MCOs for coverage of telemedicine and telehealth services.

- o Current requirement: MCOs must at least meet the fee-for-service (FFS) benefit that a Medicaid client could receive, as specified in the Texas Medicaid Provider Procedures Manual (TMPPM).
- o Ensuring coverage equity.
  - ▪ Workgroup with stakeholders during implementation – including MCOs, associations, client advocacy groups – to develop a telemedicine and telehealth coverage consensus statement. Consensus statement:
    - o Would allow minimum coverage across all health plans and FFS for telemedicine and telehealth services.
    - o Could replace information in the Texas Medicaid Provider Procedures Manual in the Telecommunication Services Handbook.
    - o There is more information to follow as bill implementation plan is developed and finalized. Ms. McManus will reach out to eHAC members as the workgroup is being developed.
- ● Reimbursement to FQHCs as telemedicine and telehealth distant site and patient site providers.
  - o HHSC is required to implement these reimbursements only if a specific appropriation is made by the Texas Legislature. HHSC may implement these reimbursements using other appropriations.
  - o Additional follow-up with HHSC Budget Management is needed to determine what funding exists to implement these reimbursements.
  - o More information to follow as bill implementation plan is developed and finalized.

Ms. Belcher continued her update with information regarding House Bill 1063.

H.B. 1063 provided for three key items; previously recommended by and discussed within eHAC:

- ● Repeal the sunset data for the remote patient monitoring benefit.
- ● Adds cost savings analysis for telemedicine, telehealth, and home telemonitoring services in HHSC's biennial report.
  - o Develop a definition for cost effectiveness.
  - o Define scope of the analysis.
  - o Cost savings analysis would most likely be completed by an external entity, such as an institute of higher education.
- ● Added 3 pediatric services for remote patient monitoring; reimbursement for pediatric clients who meet the following criteria:
  - o Are diagnosed with end-stage solid organ disease;

- o   Have received an organ transplant; or
- o   Require mechanical ventilation.

Ms. McManus stated that for HHSC, the costs savings analysis for telemedicine and telehealth was key. She added the agency needs to develop some definitions and define the cost savings or cost effectiveness and define the scope of the analysis. She added the agency will seek an external entity such as an institute of higher education to conduct the analysis.

Ms. McManus added the newly added reimbursements for pediatric telemedicine – end-stage solid organ disease, receipt of organ transplant and required mechanical ventilation – are tied to specific pieces of legislation and appropriations so HHSC will need to work with the budget team to identify funding or implement using other appropriations.

Ms. McManus also introduced and welcomed team member, Dr. Carina Luther, who will be assisting with implementation of both pieces of legislation.

Ms. Belcher thanked Ms. McManus and continued her update on other legislation, including some budget items.

The following bills have been signed by the Governor:

- House Bill 3345 guarantees providers' choice of platform for private insurance with health plans regulated by the state. Same language as in SB 670.
- House Bill 871 guarantees telemedicine counts toward trauma designation for rural hospitals. Signed by Governor.
- Senate Bill 749 – similar to HB 871 - integrates telemedicine into designations related to maternal and child healthcare. Signed by Governor.
- Senate Bill 11 - a school safety bill which incorporated significant amendments from SB 10 (created Texas Children's Mental Health Consortium), received a $100m in general revenue funding to do telemedicine and telehealth for child mental health. This bill will address school shootings and mental health crisis in schools. Signed by Governor.
- Senate Bill 71 establishes a telehealth center to support Sexual Assault Nurse (SAN) Examiners who provide support and services for sexual assault victims and will also protect the chain of evidence. This bill received $10 million in funding. Signed by Governor.

- House Bill 4455 was a priority for the Governor's office and came from the Texas National Guard. Clarifies if military personnel establish a mental health treatment relationship in Texas and are deployed or transferred, they can continue to receive treatment wherever they are stationed. Ms. Belcher stated this bill was expected to be signed.
- HHSC Executive Commissioner Phillips conveyed to the legislature that funding for HB 1967 was in the base budget and explained this was legislation from the 2017 Session relating to the tele-NICU grants program that did not get funded in the last budget cycle.

Agenda Item 7: House Bill 1697, 85th Legislature, Regular Session, 2017 implementation

Ms. Belcher introduced and turned the floor over to Ms. Erin McManus, HHSC Project Manager, Medicaid & CHIP Services, Medical Benefits Policy.

Ms. McManus stated approximately $1.2m in funding for each fiscal year for the Pediatrics tele-connectivity research program, which is HHSC budget Rider 94. Ms. Adriana Rhames advised she will research the Rider 94 funding items and provide an update at the next meeting.

Agenda Item 8:   U.S. Core Data for Interoperability (USCDI) structure: impact on Texas

Dr. Alozie introduced and turned the floor over to Mr. Eric Heflin, Chief Technology Officer-Contractor, CISSP, Texas Health Services Authority. Mr. Heflin reviewed and discussed the PowerPoint and handout, *"USCDI: Background and Potential Impact to Texas"*.

Members discussed:

- Concerns about the USCDI minimum necessary data set
- Issues the Office of the National Coordinator for Health Information Technology (ONC) is working to resolve
- Limited opportunities for public health to participate in development of the data classifications
- Reviewed the nine USDCI Task Force recommendations
- Relationship between HITAC USCDI and TEFCA, and the anticipated requirements

- Expand pediatrics demographics data set elements

Agenda Item 9: Break

15 Minute break.

Agenda Item 10: Health Information Technology strategic plan

Dr. Alozie introduced Mr. Jimmy Blanton, Mr. Steve Eichner and Mr. Andy Slack. Mr. Slack dialed-in to the meeting and led the discussion related to the PowerPoint and handout, *Health IT Strategic Plan Update, June 2019*.

Mr. Andy Slack presented remotely on the Medicaid Health IT Strategic Plan Origin and Purpose.

- Discussed what the 1115 Waiver requires of HHSC
- Electronic exchange of clinical data
- Creation of master patient index
- Service provider directory
- Integration of additional types of data such as behavioral health broadening of provider specialties to include long-term care and among other specialties, infrastructure, and system improvements to enable the exchange of data
- Solid quality measurement strategy to develop and provide better care Mr. Slack introduced seven components of the Centers for Medicaid Services (CMS) Toolkit used to develop the Medicaid Health IT Strategic Plan:
- Promoting and funding provider adoption of health IT
- Use of standards in health IT procurements
- Leveraging state health IT ecosystem
- Accountable oversight and rules of engagement – governance
- Advancing use of health IT to support quality measurement
- Identity management, provider directories and attribution
- Health IT and security delivery for improved service delivery

Mr. Slack then introduced Mr. Jimmy Blanton, Director, Quality and Program Improvement, HHSC Medicaid.

Mr. Jimmy Blanton, Director, Quality and Program Improvement, Medicaid, discussed the milestones associated with the 1115 Waiver.

- Required to create a Delivery System Reform Incentive Payment (DSRIP) program transition plan and report to CMS
- Requires development of a HIT strategic plan related specifically to the 1115 Waiver
- Allow ease of transition to a value-based system, better healthcare coordination, and collaborate with MCOs and providers for improved health information exchange

He added the team developing the document is at a point to seek the eHAC's input on this Health IT Strategic Plan. There is a desire to include milestones that help with health information exchange. Seeking eHAC members' input.

Mr. Steve Eichner, member, DSHS representative, identified the following approaches that the HIT Strategic Plan is using to achieve the following:

- Include achievable goals, but not setting specific timeframes for achieving goals, not necessarily set specific timeframes
- Present goals in order of priority; recognize dependencies across goals to better support outcomes
- Include "easy wins" with less focus on complicated goals to help ensure the Plan's vision may be realized
- Establish a good core roadmap to be shared with CMS and stakeholders and update the plan as needed
- Address how the work associated with DSRIP projects will be continued

Mr. Blanton asked members for their input on the CMS Health IT Topics:

Promoting and Funding Provider Health IT Adoption:

- Baseline - where are we today; what kind of technology are we talking about (EMR, HIE, Portal, ACO, CIN, IDN, etc.)
- As a State - what are our goals, what are we trying to do with it, improve connectivity, improve adoption, etc.
- Maintain focus on CMS' request, particularly CCDA exchange (the language in our waivers term and conditions); work with non-hi-tech providers especially those who are 100 percent Medicaid
- Educational efforts for mental/behavioral health data exchange
- Incentivizing – paper charting, share funding going forward

- Trip transition in DSRIP transformation – how do we put ED navigators, community health workers, transportation, programs, etc. in a health IT plan
- What percentage of our Medicaid clients see 2, 3, 4 providers; what does it look like, need to visualize.
- In high utilization populations, we need to define the patterns, connection/services for each program type are going to be different

Accountable Oversight and Rules of Engagement – Governance

- Mental health, pharmacy process/data exchange is big area to standardized processes, from field, provider, advocacy perspective
- More concentration towards outreach, education – public consumer input is significant to ensure we address the daily impact on clients
- Expand collaborative footprint with organizations, i.e. AARP

Due to time constraints, Dr. Alozie asked how the e-HAC committee could contribute to the plan. Mr. Eichner suggested we leverage the assistance of the current eHAC workgroups to work through the milestones. For the DSRIP part, Lisa Kirsch, subject matter expert from UT Dell Medical will work with the group on the DSRIP transition plan.

ACTION ITEM:

Recommend Mr. Blanton attend December meeting and provide update on the Medicaid HIT Strategic Plan submitted to CMS and the DSRIP transition plan.

Agenda Item 11: eHAC Subcommittee report on telemedicine, telehealth, and telemonitoring

Dr. Alozie introduced and turned the floor over to Ms. Tracy Rico, eHAC member. Ms. Rico began by stating the charge of this Subcommittee: to assess and identify gaps and provide feedback to the agency in the areas of telemedicine, telehealth and telemonitoring (3T). She provided the Subcommittee's goals and introduced the technical specifications developed by the HB 1697 (85th Legislature, Regular Session) implementation workgroup; handout, *HB 1697 Technical Specifications and Requirements.*

The following points were stated and/or posed as questions to subcommittee members:

- A goal of this subcommittee is to create awareness about telemedicine in provider networks
- Want to enable providers to select their own telemedicine platform
- Need to scale down technical requirements to allow small provider practice options
- What is an appropriate ratio of psychiatrists in a virtual environment?
- Prescription limitation; how can we expand remote dispensing facilities
- Need to link medical records to patients' medical homes – identify how to share the information to reach the appropriate medical record.

Additional discussion included responses to Ms. Rico's question about companies willing to provide telemedicine as MCOs, suggestion of a 3T Subcommittee visit with the HHSC team working on network adequacy standards and reporting back to the full eHAC, the appropriate number of psychiatrists in a virtual environment, prescription limitations for behavioral health, and consensus guidelines in place of technical specifications and requirements.

Ms. Belcher added that in recent legislation HHSC's requirement for technical specification due to variations was repealed so she supports the idea of consensus guidelines that can be communicated without being a barrier to providers for telemedicine participation. Ms. Belcher, who helped author the *HB 1697 Technical Specifications and Requirements* handout, offered to help craft consensus guidelines.

Agenda Item 12: eHAC Subcommittee report on interoperability

Dr. Alozie introduced and turned the floor over to Mr. Steve Eichner, ex-officio member representing DSHS. Mr. Eichner presented on the progress being made but the Interoperability Subcommittee.

The Interoperability Subcommittee has been focusing on the following areas:

- Ensure a clear definition of standard terminology such as "interoperability"
- Exchange and transport of content from one place to another to be stored in the local environment; real-time operability of live data between distant systems
- Developing recommendations for technologies at both the state and private sector to support required levels of interoperability and meet business needs

- Ensure providers and patients are getting information when and how they need it, in the most effective way possible
- The subcommittee is also monitoring changes occurring at the federal level - such as the Trusted Exchange Framework and Common Agreement (TEFCA) - and discussing how it will affect Texas as it is implemented

Agenda Item 13: LUNCH

Committee broke for lunch at 12:07 p.m.

Agenda Item 14: Health and Human Services Ethics review

Ms. Belcher reconvened the meeting at 1:10 pm and turned the floor over to Ms. Toya Bell, Deputy Chief Ethics Officer, HHSC. Ms. Bell reviewed and discussed the PowerPoint handout, *HHSC Ethics Overview*.

Agenda Item 15: FirstNet's discussion on pros and cons of broadband during disasters

Ms. Belcher introduced and turned the floor over to Mr. Brian Maholic, Regional Director, FirstNet Texas, and Mr. Thomas Randall, Senior Public Safety Advisor for First Responder Network Authority, entity of the U.S. Department of Commerce.

Mr. Maholic and Mr. Randall discussed the PowerPoint handout, *FirstNet: Benefits and Disaster Recovery Solutions*.

- FirstNet is a public/private partnership; AT&T is construction vendor for FirstNet, a 25-year program with AT&T
- Improve cellular data connection to public safety
- Improve radio/network communications
- 2012 legislation enacted by Congress; created FirstNet, First Responder Network Authority
- Public safety network created nationwide allowing each state to opt in
- Legislation also required substantive rural coverage in Texas
- Infused with $7 billion of funds to build out network nationally
- AT&T partnership - limited timeframe, 5-year buildout for the national network
- Public safety roadmap initiatives: Collaborate, Engage, Develop and Invest

- Anticipate receiving approximately $18 billion over 25 years in re-investment funds from AT&T
- Five key domains of public safety network:
  - Coverage and capacity
  - Situational awareness
  - Voice communications
  - Secure info exchange
  - User experience
- Continue to engage stakeholders, public safety, build roadmaps and invest additional resources and applications
- Network is designed to manage and share data to be more collaborative and more productive
- Work with current vendors, Apple, Samsung, MiFi's, etc., and go through a level of scrutiny to be utilized on the FirstNet network
- Setup a separate core network, ensures security on your traffic
- BAND 14 – the spectrum (700Mhz) is specifically designed and available for first responders and public safety, especially in the mobile settings for emergency disasters

Mr. Eichner asked about efforts of resource connectivity; on a receiving side for first responder trying to access information system that is not necessarily plugged directly to FirstNet to support connectivity on the other side.

Mr. Randall commented if it is a phone connectivity, there are methods through WPS or GETS. If looking at data connectivity, 911 centers/PSAPS, might use a cellular cradle backhaul as a backup in the event their system is down. As for data center exchange, if it is an enterprise network there is an attempt to move data to FirstNet. How the two systems communicate is a challenge. On the FirstNet network, they are going to have priority on the

enterprise side, depending on what they are riding over and their method of transport of the data as to how it's going to get into FirstNet's network is the challenge we are still working on.

Prioritizing transfer of data for first responders, depends on transport of data. The challenge is the breakdown of silos, firewalls, and to have the trusted networks and trusted Icams solutions and making sure the networks can communicate to each other and override a system that can transport the data and still have a similar priority to what FirstNet is looking for as we're sending it over our network.

Ms. Belcher thanked the presenters and requested they come back in a year and give an update on the program and what challenges they face and how they overcome them.

Agenda Item 16: Annual report planning

Ms. Belcher advised the committee is waiting on the new reporting template, guidelines, website accessibility, level of reviews, deadline for submission, etc. The committee will have until February 2020 to submit their report.

Agenda Item 17: Public Comment

No public comment was made.

Agenda Item 18: Next Meeting Planning

Ms. Belcher stated the next meeting is scheduled for December 9, 2019 in the Brown Heatly Building. Topics considered for the next meeting are:

- DSRIP and HIT Strategic plan update
- Annual report discussion
- HB 1697 grant program update (Rider 94 funding items?)
- SB 670 updates
- NPI and TPI

Agenda Item 20: Adjournment

Ms. Belcher thanked members and staff and adjourned the meeting at 2:54 p.m.

The web address for the meeting:
 https://texashhsc.swagit.com/play/06142019-749

Appendix C: Costs Related to the Committee

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 are not reimbursed for travel or any other Committee participation-related expenses.

The designated eHAC liaison reports dedication of approximately 65% 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 Legal and facilitation Services team, documentation of eHAC and eHAC subcommittees' activities and recommendations, preparation of presentation materials, membership application reviews, recommendations, 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 35% and is a combination of a former Interim OeHC Director and a new colleague from the Medicaid Technology Modernization, HIT and HIE team. This Program Supervisor collaborates with the eHAC liaison in preparing for meetings, serving on the review and recommendations panel for identification of membership candidates, communicating with members, and communicating eHAC initiatives and activities to agency management. The former Interim OeHC Director also served on the Committee and had an active role in communicating Committee initiatives and activities to agency management

For this reporting period, a total of three HHS agency staff assisted in supporting the eHAC at a combined cost of approximately $80,838. The OeHC also reported a materials and supplies expenditure of approximately $75.

All eHAC activities were supported using HHS appropriated funds.