



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

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

e-Health Advisory Committee

February 2021

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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.

The eHAC includes HHS stakeholders concerned with the use of HIT, HIE, telemedicine, telehealth, and home telemonitoring services. eHAC membership includes representation from the Texas Medical Board, the Texas Board of Nursing,

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

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.

1. Introduction

The Texas Health and Human Services (HHS) Electronic Health Advisory Committee (eHAC) is established under Texas Government Code Section 531.012 and is 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 44.

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 7 of this report.

2. 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), Texas 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)

3. List of Meeting Dates

The e-Health Advisory Committee met on the following dates from December 2019 through November 2020:

- December 9th, 2019 (in-person meeting). The meeting minutes from this meeting were not finalized prior to the publication of the 2019 report and are included in this report.
- July 17th, 2020 (virtual meeting using telephonic means); at the time this report was being produced, minutes for this meeting had not been finalized)

The April 2020 meeting of the committee was cancelled due to the COVID-19 pandemic. The committee will next meet on December 7th, 2020.

4. Committee Members' Attendance Records

The e-Health Advisory Committee (eHAC) is pleased to announce that a quorum was present for the meetings that were held during this reporting period. The committee maintained an average 95% attendance rate. A copy of committee members' attendance records is included in Appendix B, as part of the meeting minutes.

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

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

December 9th, 2019

- Revised committee bylaws.
- Elected a vice-chair.
- Received updates on telemedicine and network adequacy, SB 670 and HB 1063.
- Continued to follow the implementation of the pediatric tele-connectivity program for rural Texas.
- Discussed the status of the national provider identifier and Texas provider identifier.
- Listened to a presentation on the current status and future of interoperability from Mr. Aneesh Chopra.
- Received subcommittee updates.
- Heard a presentation from the Texas State Board of Pharmacy on the Texas Prescription Monitoring Program.
- Received updates from HHSC staff on the State HIT strategic plan and the Delivery System Reform Incentive Payment program transition plan.
- Received an update from THSA on implementation of the Patient Unified Lookup System for Emergencies.
- Heard from public stakeholders about their support for using HIETexas as an electronic connection in healthcare.

July 17th, 2020

- Received subcommittee updates.
- Received updates on telemedicine, specifically SB 670 and HB 1063.
- Heard an update from HHSC staff on the status of the national provider identifier and Texas provider identifier, the Delivery System Reform Incentive Payment program transition plan and the Medicaid Technology Modernization, Health Information Technology (HIT) and Health Information Exchange program.
- Voted to create a behavioral health subcommittee.

- Received an update from THSA on implementation of the Patient Unified Lookup System for Emergencies.
- Received a presentation from DSHS staff on federal HIT rules and legislation and on the Texas Immunization Registry's implementation of bi-directional data exchange.
- Planned for the development of the next annual report and voted to move to a biennial report.

6.A Description of How the Committee Accomplished its Tasks

The HHS e-Health Advisory Committee accomplished its tasks through a collaborative effort that included input from several different sectors of the healthcare industry, including but not limited to the Texas Medical Board, 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 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 met on a regular basis and engaged 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).

As of the beginning of the 2020 calendar year, the eHAC had 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. At the July 17th, 2020 meeting, the eHAC voted to create a third subcommittee focused on behavioral health issues.

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 2020 meeting including feedback from the subcommittees, 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.

7. 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. Below the table for each task’s recommendations is a summary of the relevant subcommittee work related to the task.

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
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 comply with HB 2641 (84 th Legislative Session), which directs the use of standards.
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.

Committee Recommendation	Status	Action Needed
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	A subcommittee focused on behavioral healthcare has been established. An assessment and gap analysis of HIEs' capacity to support access to behavioral health information should be conducted. This may be coordinated with appropriate HHSC offices.

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.

Recommendation	Status	Future Action Needed
<p>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.).</p>	<p>Ongoing</p>	<p>The connections established between providers and HHS through the current HIE Implementation Advanced Planning Document (IAPD) will allow for the consolidation of the number of connections required by health care providers.</p> <p>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.</p>
<p>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.</p>	<p>Complete/ongoing</p>	<p>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.</p>

Recommendation	Status	Future Action Needed
Create payment incentive for Medicaid providers to engage with Local 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.	Open	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.
Expand bi-directional interoperability for electronic data exchange.	Ongoing	<p>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.</p> <p>DSHS is working to enhance interoperability for systems supporting newborn screening. In June 2020, the ImmTrac2 system established a pathway for bidirectional data exchange of immunization data between DSHS and providers.</p>

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.

Recommendation	Status	Future Action Needed
<p>Incorporate telemedicine and telehealth into healthcare network adequacy regulations in a manner that expands and complements patient access to care and continues current requirements for network adequacy and engagement of local physicians and healthcare service providers.</p>	<p>Ongoing</p>	<p>This is a recommendation of the statewide managed care advisory committee subcommittee on network adequacy</p>
<p>Explore Medicaid financing options for Project ECHO, a telementoring model that links primary care clinicians with specialists via teleconferencing technology.</p>	<p>Ongoing</p>	<p>System wide financing would require legislative appropriation. The 3T subcommittee will examine other possible funding options for pilot studies within the next fiscal year</p>
<p>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.</p>	<p>Ongoing</p>	<p>This would require federal legislative action to modify the strictures on state jurisdiction imposed by the Ryan Haight Act amendment to the federal controlled substances act (21 USC 802 et seq.)</p>

Recommendation	Status	Future Action Needed
<p>A committee of experts representing each medical campus could be established to coordinate with the Texas Division of Emergency Management and create a plan for telemedicine and telehealth usage for medical services, as well as necessary testing, for future disasters.</p>	<p>Proposed</p>	<p>The expertise at HHSC in this subject makes it a possible host for the committee and its work.</p>
<p>Various state participants working in a coordinated manner under the direction of the legislature, could create a statewide healthcare plan for testing and treatment resources during pandemics and other declared public health emergencies.</p>	<p>Proposed</p>	<p>This would require legislative action.</p>

8. 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 and continues current requirements for network adequacy and engagement of local physicians and healthcare service providers.
- Explore Medicaid and other possible financing options for Project ECHO, a telementoring model that links primary care clinicians with specialists via teleconferencing technology.
- Work with the 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.

A significant project of the subcommittee was a survey of Medicaid providers related to telemedicine, telehealth and telepharmacy services. The subcommittee presented its pre-coronavirus results to the full committee at the July meeting. The key takeaways from the survey at that time included:

- Fifty-seven percent of those surveyed were providing telemedicine services (this was pre-COVID-19)
- The following were the most significant barriers identified by the respondents:
 - ▶ Payer reimbursement policies were unclear (57%)
 - ▶ Payers did not offer reimbursement for the services (47%)
 - ▶ Internal telecommunications infrastructure upgrades were needed (22%)
 - ▶ Lack of interoperability with other equipment or EMRs (18%)
 - ▶ Volume of telemedicine services did not support costs (16%)
 - ▶ Unable to obtain telemedicine equipment (16%)
 - ▶ Use of proprietary software or platforms (16%)
- Respondents made the following recommendations regarding current Medicaid policy:
 - ▶ Address funding through increases or paying at the same rates as traditional care

- ▶ Overcome physician reluctance by making payer reimbursement policies clearer, increasing reimbursement based on the variability of care, and creating clear, concise policies with guidance for billing
- Only 12% of the providers surveyed indicated they were participating in home telemonitoring. Recommendations for improvement included:
 - ▶ Increasing awareness about the program among providers
 - ▶ Providing necessary equipment and technical support
 - ▶ Clarification and development of reimbursement categories
- Respondents were also asked if they had heard of or utilized telepharmacy services or remote medication dispensing.
 - ▶ Almost half (49%) of the responses indicated no to both questions, with only 6% reporting utilization
 - ▶ 63% of the responses agreed that these programs would improve adherence and outcomes
 - ▶ 59% of the responses indicated that they treat patients who have challenges or hardships in accessing their pharmacy

The full survey results are available in Appendix D.

The Role of Telemedicine and Telehealth during COVID-19 & Future Considerations

COVID-19 is perhaps the largest health crisis of the current generation. As of September 5, 2020, over 635,000 citizens in our state have been infected, and 13,408 have succumbed to this terrible disease.² It is not an overstatement to say that this pandemic has impacted the life of every Texan, and the repercussions of this natural disaster will linger in the years to come. While our state has a long history of effectively responding to disasters, response to the pandemic required many elements of planning and resources that were not in place in early 2020. Fortunately, health care systems, providers, and officials were ultimately able to leverage available healthcare technologies to shift strategies and address this public health crisis.

Telemedicine and telehealth visits provided clinicians with a way to treat their patients, both those infected with COVID-19 and others, while avoiding the spread

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<https://txdshs.maps.arcgis.com/apps/opsdashboard/index.html#/ed483ecd702b4298ab01e8b9cafc8b83>

of the illness. It is estimated that by mid-July, over 4.5 million telemedicine/telehealth visits had been conducted to the benefit of Texas patients.³ Without these safe treatment options available, the initial waves of the pandemic would have been significantly worse, with more infections and likely more lives lost. There are several recommendations made earlier in this section of this report illustrating how telemedicine and telehealth may be better integrated into available treatment models as everyday tools in healthcare. The focus of this section, though, is how such systems may be better placed within the state's disaster response plan.

Thanks to the foresight of its leaders, Texas has a robust emergency management system overseen by the Texas Division of Emergency Management.⁴ However, the current crisis has highlighted a limitation within the current system; now is an ideal time to address it. Specifically, there is no immediate direct access or pipeline to the testing or medical providers necessary to care for patients on a statewide basis when a pandemic strikes. For each new disaster, the state must try to identify testing, facilities, and healthcare professionals scattered around the state to perform healthcare services. Even with all parties working their fastest, it can take weeks to gather capacity data on who *can* do what, assign the resources appropriately i.e.: who *should* do what, and to agree to contract terms. The legislature now has the opportunity to create a mechanism to address these challenges and provide legislative guidance on how it should be done, so that there is structure in place ahead of a future crisis. Entities that could participate in such an initiative would include the DSHS Hospital Preparedness Program, the Trauma Service Areas, and the related Regional Advisory Councils.

The largest group of health care professionals in the state are those that are employed and affiliated with the academic medical centers. Indeed, the centers were the lifelines for care and testing for untold numbers of citizens during the pandemic. In just the few months between March and September, the academic centers have conducted at least half a million telemedicine and telehealth visits and administered and evaluated tens of thousands of COVID-19 tests. The centers are ideally situated to work on a statewide coverage plan for healthcare for the state. Both their geographic diversity covering the Texas landscape and their already

³<https://www.houstonchronicle.com/business/bizfeed/article/survey-texas-telehealth-pandemic-4-million-survey-15406812.php>

⁴ <https://tdem.texas.gov/>

established goals to provide the best healthcare for Texans make this a feasible and efficient plan for state response.

A committee of experts representing each medical campus could be established to coordinate with the Texas Division of Emergency Management and create a plan for telemedicine and telehealth usage of medical services, as well as necessary testing for future disasters. The expertise at HHS in this subject make it a possible host for the committee and its work.

Various state participants working in a coordinated manner under the direction of the legislature, could create a statewide healthcare plan for testing and treatment resources during pandemics and other declared public health emergencies.⁵ With time available for advance planning, clear areas of responsibility could be established and communication lines could be in place to ensure the resources are correctly allocated and adjusted on an ongoing basis through the crisis.

Additionally, evaluation of vendors and cooperation between the parties would ensure smooth coordination between the various technologies before the ultimate time of need. The legislature would have the information necessary to provide an efficient plan of action to cover the health of all Texans during a disaster and do so via a legislative oversight framework.

Telemedicine, Telehealth and Telemonitoring Flexibilities Extended During the Public Health Emergency

The subcommittee is also actively reviewing a number of flexibilities related to telemedicine and telehealth that were put in place as part of the response to COVID-19 for discussion at the December 9th, 2020 meeting. The following chart is being provided as a reference tool:

⁵ This is a solution employed with success in prior challenging healthcare scenarios, such as caring for the incarcerated population around the state.

Regulatory Changes

Agency	Date	Content
TMB- telephone calls FAQ	March 14, 2020	Telemedicine, including the use of telephone only, may be used to establish a physician-patient relationship. This expanded use of telemedicine may be used for diagnosis, treatment, ordering of tests, and prescribing for all conditions. The standard of care must be met in all instances.
Texas State Board of Pharmacy	March 20, 2020	Allow pharmacists to conduct telephonic consultations and remove regulatory barriers so that pharmacies can operate at full strength.
Texas Secretary of State	April 8, 2020	Temporarily allow for appearance before a notary public via videoconference when executing a self-proved will, a durable power of attorney, a medical power of attorney, a directive to physician, or an oath of an executor, administrator, or guardian.
Texas Department of Licensing and Regulation (updates) Press Release	April 9, 2020	Approved telehealth waivers for speech-language pathologists and audiologists, behavior analysts, hearing instrument fitters and dispensers, and dyslexia therapists and practitioners.
HHSC- Chemical Dependency Treatment Facilities	April 20, 2020	CDTFs are now temporarily permitted to provide certain treatment services via telehealth, telemedicine, or electronic means and to increase the number of clients per counselor caseload in intensive residential programs in response to the COVID-19 pandemic.

Agency	Date	Content
FDA	March 20, 2020	Issued a new policy that allows manufacturers of certain FDA-cleared non-invasive, vital sign-measuring devices to expand their use so that health care providers can use them to monitor patients remotely. The devices include those that measure body temperature, respiratory rate, heart rate and blood pressure.

Reimbursement Changes

Agency	Date	Content
TDI	March 10, 2020	Waive copays for COVID-related treatments and generally expand telemedicine
TDI TDI Emergency Rule	March 17, 2020	Doctors will be eligible for payment from insurance plans regulated by TDI for medical visits they conduct over the phone instead of in-person at the same rate they would receive for in-person visits.
Medicare- telemedicine reimbursement changes Fact sheet FAQ Code List (released March 30, 2020)	March 17 th , 2020	Medicare can pay for office, hospital, and other visits furnished via telehealth across the country and including in patient’s places of residence starting March 6, 2020. A range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to their patients. Additionally, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

<p>Medicaid- 1135 Waiver</p> <p>Press release</p>	<p>March 30, 2020</p>	<p>Waive any requirements of the state plan that require face to face contacts to allow the services to be performed by telehealth, telemedicine, or telephonic contact as consistent with state law and subject to HHSC requirements. These services originally expired April 30th and have been extended through the end of October of 2020. This includes allowing:</p> <p>Rural health clinics to be paid as distant sites</p> <p>FQHCs to be paid as distant sites</p> <p>PT, OT and speech therapy via telehealth</p> <p>Case management</p> <p>CLASS professional and specialized therapy services</p> <p>Nursing Services for CLASS, DBMD, HCS and TxHmL</p> <p>Billing for telephone (audio-only) medical (physician delivered) evaluation and management services.</p> <p>Billing for telephone (audio-only) behavioral health services delivered by synchronous audio-visual technologies, including web-based video software, or telephone (audio-only).</p> <p>Expedited enrollment of telemedicine/telehealth providers who are not currently Texas Medicaid providers, subject to some conditions like checking the OIG exclusion list.</p> <p>AllCOs and MMPs may use telehealth or telephonic processes to:</p> <p>Coordinate discharge planning for members transitioning from hospitals.</p> <p>Conduct joint meetings with Local</p>
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Agency	Date	Content
		<p>Intellectual and Developmental Disability Authorities (LIDDAs), Case Management Agencies and Direct Service Agencies.</p> <p>Allow providers to provide mental health targeted case management services.</p> <p>Conduct Screening and Assessment Instruments (SAIs) and Individual Service Plans (ISPs) for STAR Kids members not in the Medically Dependent Children’s Program (MDCP).</p>
HHSC- BH and Substance Abuse treatment	<p>March 15, 2020</p>	<p>Telehealth/telephone allowed for general revenue and block grant programs</p>
TDI- Division of Workers’ Compensation FAQ	<p>April 13, 2020</p>	<p>Adopted an emergency rule to allow health care providers licensed to perform physical medicine and rehabilitation services, including physical therapists, occupational therapists, and speech pathologists to bill and be reimbursed for services currently allowed under CMS telemedicine and telehealth billing codes.</p>

Prescribing

Agency	Date	Content
DEA	March 16, 2020	The Drug Enforcement Administration (DEA) has, on their webpage, confirmed that telemedicine can now be used under the conditions outlined in the Controlled Substances Act under the public health emergency telemedicine exception to Ryan Haight. DEA-registered prescribers may issue prescriptions for controlled substances via telemedicine without a prior in-person evaluation if the prescription is for a legitimate medical purpose, real-time two-way audio-video is used, and the practitioner is acting in accordance with state law.
TMB	March 19, 2020	The Texas Medical Board has been given a time limited waiver related to chronic pain and telemedicine/telephone calls that allows for refills via telephone call.
Texas State Board of Nursing	March 23, 2020	An adoption of emergency amendments to allow APRNs to treat chronic pain with scheduled drugs via telemedicine if a patient is an established chronic pain patient of the APRN, is seeking a telephone refill of an existing prescription, and the APRN determines that the telemedicine treatment is needed due to the COVID-19 pandemic.

Privacy/Physician Self-Referral

Agency	Date	Content
HHS Office for Civil Rights	March 17 th , 2020	OCR will not enforce certain HIPAA regulations during this emergency to ease access to telehealth services.
CMS	March 1,2020	CMS has extended exceptions to physician self-referral laws to allow for COVID response.

9. Interoperability Subcommittee Report

This subcommittee report was developed by the eHAC Subcommittee on Interoperability and is intended to support the eHAC in the development of its annual report as 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) discusses interoperability as it relates to the COVID-19 pandemic; (4) provides an overview of interoperability-related funding opportunities; (5) discusses interoperability at the regional, state and national levels; (6) provides an overview of interoperability regulatory issues; and (7) provides recommendations on interoperability.

Charge of the eHAC Subcommittee on Interoperability

The purpose of the interoperability subcommittee is to address Tasks 1 and 2 in the eHAC's enabling rule, *Texas Administrative Code section 351.823*.

Task 1. The eHAC 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
- 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. The eHAC advises HHS agencies on incentives for increasing health care provider adoption and usage of an electronic health record and health information exchange systems.

What is Interoperability?

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

- 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;
- allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable State or Federal law;
- does not constitute ‘information blocking’⁶ as defined in section 3022(a).⁷

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 Exchanged Framework and Common Agreement (TEFCA), will affect the definition of interoperability as well as the analysis and recommendations of this subcommittee.

Interoperability as it Relates to the COVID-19 Pandemic

In March 2020, Congress enacted the Coronavirus Aid, Relief, and Economic Security Act (CARES Act).⁸ The CARES Act responds to the Coronavirus Disease 2019 (“COVID-19”) pandemic and its impact on the economy, public health, state and local governments, individuals, and businesses. COVID-19 stresses our fragmented information exchange infrastructure and can be best addressed when there are efficient modes to make information available where and when it is needed most. A key challenge that has emerged during the response to COVID-19 is around public health agencies’ access to clinical data (e.g., information on comorbidities, hospital admission/discharge, and/or detailed treatment information) and demographic information on patients who have tested positive for the disease.⁹

The extensive amount of data exchanged by health information exchanges (HIEs) is often not accessible to public health agencies nor are the insights HIEs can provide

⁶ 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).

⁷ 21st Century Cures Act, Public Law 114-255, <https://www.congress.gov/bill/114th-congress/house-bill/34/text>. Retrieved October 10, 2019.

⁸ Pub. L. No. 116-136, March 27, 2020.

⁹ See *generally* <https://www.healthit.gov/sites/default/files/page/2020-08/STAR%20HIE%20NOFO%20FINAL.pdf>.

regarding trends within a geographic area. In addition to the many benefits of electronically sharing this data within the private sector, aligning HIEs with public health agencies would also bring an increase of data sharing, as well as more timely and complete data on public health events such as the COVID-19 pandemic.¹⁰

Interoperability-Related Funding Opportunities

Seeing the need for interoperability generally, as well as its use for better-informed decision making in response to the COVID-19 pandemic, ONC recently released the Strengthening the Technical Advancement & Readiness of Public Health via Health Information Exchange (STAR HIE) Program, Notice of Funding Opportunity (NOFO) No. COVID-C3-20-002.¹¹ This NOFO is “designed to strengthen and accelerate innovative uses of health information via HIEs within states, communities, and regions to support public health agencies’ abilities to advance data-driven prevention of, response to, and recovery from public health events, including disasters and pandemics such as COVID-19.”¹² THSA received one of five awards made under this program.

Interoperability at the Regional, State, and National Levels

Interoperability at the regional level

Regional health information exchanges in Texas offer services to health care systems, providers, payers and hospitals to share health care information primarily for the purposes of payment, treatment and other healthcare operations. These regional HIEs are non-profit organizations offering services at a low cost to keep expenses to participants low while helping drive participant costs down and/or participants’ revenues up. Regional 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 regional HIEs use standard, secure connections with strong encryption so that patient data is secure. The HIEs integrate with health care providers’ electronic health record systems where possible so that the access and exchange of 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

¹⁰ *Id.*

¹¹ *Id.*

¹² See <https://www.healthit.gov/topic/onc-funding-opportunities/funding-announcements>. Retrieved September 3, 2020.

approved use. Texas does not have a required opt-in or opt-out model, and the HIEs have different models based on local governance, but all patients in any regional HIE have the option to opt out at any participating facility.

Interoperability at the state level

Pursuant to Chapter 182, Texas Health and Safety Code, the 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, regional 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. Most recently, the THSA board voted to amend the State HIE Plan to create alignment with the Medicaid Health IT Strategic Plan.¹³

Also relevant to state-level health information exchange is public health reporting and health information exchange with programs such as those provided by the Texas Department of State Health Services (DSHS) including, but not limited to Electronic Laboratory Reporting, the Texas Immunization Registry/ImmTrac2, Texas Syndromic Surveillance, and the Texas Cancer Registry. Another example of a public health system that exchanges data with the private sector is the prescription monitoring program (PMP) which is operated by the Texas State Board of Pharmacy.

Pursuant to Texas 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 exchanges. This legislation also required "the commission and each health and human services agency establish interoperability standards plan for all information systems that exchange protected health information with health care providers."¹⁴

¹³ See <https://thsa.org/hie/state-hie-plan/>

¹⁴ See bill text at <https://capitol.texas.gov/tlodocs/84R/billtext/pdf/HB02641F.pdf#navpanes=0>

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. As of March 1, 2020, pharmacists and prescribers (other than veterinarians) are now required to check the patient’s PMP history before dispensing or prescribing opioids, benzodiazepines, barbiturates, or carisoprodol.”¹⁵ Texas recently received funding to support connecting health care providers’ 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.”¹⁶

The Commonwell Health Alliance (Commonwell) is “a not-for-profit trade association devoted to the simple vision that health data should be available to individuals and caregivers regardless of where care occurs. Additionally, access to this data must be built into health IT at a reasonable cost for use by a broad range of health care providers and the people they serve.”¹⁷

Carequality is “a public-private, multi-stakeholder collaborative developed to create a standardized, national-level interoperability framework to link all data-sharing networks.”¹⁸ Carequality implementers are “the adopters of the Carequality Interoperability Framework, and their clients.”¹⁹

¹⁵ www.pharmacy.texas.gov/pmp

¹⁶ www.ehealthexchange.org

¹⁷ www.commonwellalliance.org/about

¹⁸ www.carequality.org

¹⁹ www.carequality.org/members-and-supporters/

The Strategic Health Information Exchange Collaborative (SHIEC) is a “national collaborative representing health information exchanges (HIEs) and their business and technology partners.”²⁰ 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 that 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.”²¹

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.”²²

Overview of Interoperability Regulatory Issues

As noted above, new regulations and guidance from CMS and ONC will greatly affect interoperability efforts at the regional, state, and national levels. These new materials include, but are not limited to, ONC’s TEFCA, ONC’s Information Blocking Rule, and CMS’ Interoperability and Patient Access Rule.

TEFCA

In 2019, ONC selected the Sequoia Project as the Recognized Coordinating Entity for TEFCA. The Cures Act requires ONC to convene stakeholders to develop a trusted exchange framework and a common agreement among existing, disparate health information networks (HINs) to exchange electronic health information. TEFCA is designed to scale electronic health information exchange nationwide and help ensure that HINs, healthcare providers, health plans, individuals, and 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;

²⁰ www.strategichie.com

²¹ www.strategichie.com/initiatives/pcdh/

²² www.sequoiaproject.org

- A Recognized Coordinating Entity (RCE) to manage the framework and agreement (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.

Information Blocking Rule

In general, the Cures Act defines “information blocking” as a practice by a certified health IT developer, health information network, health information exchange, or health care provider that, except as required by law or specified by the Secretary of Health and Human Services (HHS) as a reasonable and necessary activity, is likely to interfere with access, exchange, or use of electronic health information (EHI). The Cures Act also provides certain examples which constitute information blocking.

In addition to defining “information blocking” and citing specific practices of information blocking, the Cures Act directed the Secretary to “identify reasonable and necessary activities that do not constitute information blocking.” These exceptions to the general rule of information blocking were seen as necessary to provide guidance as to when an entity is and is not engaging in an activity that may violate the information blocking provisions of the Cures Act.

Based on all these concerns, ONC provided certain exceptions to the general rule on information blocking, including preventing harm, promoting the privacy of EHI, promoting the security of EHI, recovering costs reasonably incurred, responding to requests that are infeasible, licensing of interoperability elements on reasonable and non-discriminatory terms, and maintaining and improving health IT performance.

CMS Interoperability and Patient Access Rule

The CMS Interoperability and Patient Access Rule addresses a variety of policies aimed to enable the fully interoperable electronic exchange of health information, including patient access APIs, provider directory APIs, payer-to-payer data exchange, and Admission, Discharge, and Transfer (ADT) event notifications. Specifically, regarding ADT event notifications, CMS is modifying Conditions of Participation (CoP) to require hospitals, including psychiatric and critical access hospitals (CAHs), to send electronic patient event notifications of a patient’s admission, discharge, and/or transfer to another healthcare facility or to another community provider or practitioner. This will improve care coordination by allowing

a receiving provider, facility, or practitioner to reach out to the patient and deliver appropriate follow-up care in a timely manner. This policy will be applicable 12 months after publication of the final rule.

There are multiple entities at the local and state levels, as described above, that are participating in the Emergency Department Encounter Notification (EDEN) program, which is part of the Texas Medicaid HIE Connectivity project. The EDEN program is designed to assist Texas health care providers in complying with CMS' rule.

Recommendations

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

10. Behavioral Health Subcommittee Report

This subcommittee report was developed by the eHAC Subcommittee on Behavioral Health (BH) 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 the phase 1 goals of the subcommittee.

Why a BH subcommittee?

- Texas Medicaid and Behavioral Health are significant portions of the State budget:
 - ▶ Texas Medicaid spend in 2018 was 29.4% of the total State budget, or 16% of the State-funded budget, approximately \$12.4B of the State-funded budget (<https://www.macpac.gov/wp-content/uploads/2018/04/EXHIBIT-5.-Medicaid-as-a-Share-of-States'-Total-Budgets-and-State-Funded-Budgets-SFY-2018.pdf>)
 - ▶ The Fiscal Year 2019 Coordinated Statewide Behavioral Health Expenditure Proposal provides information regarding \$3.9 billion in behavioral health funding reported from SBHCC member agencies and institutions of higher education (including Medicaid behavioral health funding). <https://hhs.texas.gov/reports/2018/09/statewide-behavioral-health-expenditure-proposal-fy-2019>
- Privacy issues have to be addressed to protect both patients and providers:
 - ▶ “Unless we can overcome privacy concerns and establish robust interoperable EHR systems in behavioral health, we continue to run the risk of further stigmatization and exclusion from the rest of health care. Even worse, patients with behavioral health conditions may not reap the full benefits of expensive, clinical EHR implementations or be harmed by a lack of care coordination that may otherwise be possible” (Erik Vanderlip, MD, MPH; <https://www.psychiatryadvisor.com/home/practice-management/the-importance-of-ehr-interoperability-to-mental-health-treatment/3/>)
 - HHS has written rules to ease the transfer of BH data and provided some estimated costs <https://ehrintelligence.com/news/calculating-the-cost-of-behavioral-health-data-exchange>
- Lack of BH data sharing impacts both patients and providers negatively

- Lack of BH data sharing impacts both patients and physicians:
<https://ehrintelligence.com/news/lack-of-behavioral-health-data-threatens-physician-ehr-use> “Without the integration of behavioral health and other data sources into the primary care EHR, the authors foresee challenges for both providers and researchers alike — the former being handicapped in properly managing mental health patients (e.g., medications, monitoring) and the latter ill-equipped to perform epidemiological and evaluative studies of disease.”

Formation:

eHAC Committee member, Phil Beckett, PhD, made a formal proposal at the July 17 eHAC meeting to form a Behavioral Health Subcommittee. The proposal was discussed in detail and a unanimous vote was made for its formation. Phil Beckett agreed to lead the subcommittee and eHAC Liaison, Ms. Adriana Rhames and eHAC Acting Chair and Vice-Chair, Ms. Belcher followed up with eHAC Committee Members for volunteers to join the subcommittee.

Draft proposal submitted and discussed at the eHAC Committee, July 17, 2020:

- Issue
 - ▶ Many behavioral health inpatient and outpatient facilities are not connected to a sharing infrastructure
 - ▶ BH notes have additional sensitivity and privacy requirements
- Opportunity
 - ▶ Value of sharing BH data
 - ▶ A State-wide infrastructure and guard rails to share BH data
 - ▶ Behavioral health data use agreements
 - ▶ Integration with interoperability and T3 sub committees
- Proposed Charter for subcommittee
 - ▶ Identify BH facilities in Texas
 - ▶ Document value use cases for BH providers
 - ▶ Identify legislative barriers and enablers to sharing BH data
 - ▶ Identify existing BH initiatives, overlap, and collaborations
 - ▶ Develop draft agreements for sharing BH data (BAA, DUA)
 - ▶ Review patient privacy and authorization requirements
- Members
 - ▶ Phil Beckett (Lead), HASA
 - ▶ Dipesh Batra, MD, pediatrician
 - ▶ Melisa McEwen, Otsuka Pharmaceuticals
 - ▶ Tracy Rico, Superior Health Plan

- ▶ Mari Robinson, University of Texas Medical Branch- Galveston
- ▶ Adriana Rhames, HHSC Liaison to eHAC and its subcommittees

Meetings:

- August 27, 2020
 - ▶ Proposed deliverables to complete by July 2021:
 - ◇ Provide a comprehensive list of resources barriers, opportunities and gaps in Behavioral Health in Texas.
 - ◇ Value potential of tighter integration of behavioral health providers in the Texas eHealth eco system
 - ◇ Recommendations that would help drive value and outcomes in Behavioral Health in Texas

Tactical goals for Q4 2020:

- Document BH facilities in Texas
 - ▶ HRSA, data.hrsa.gov
 - ▶ DSHS, <https://dshs.texas.gov/chs/hosp/Hosplis2019.pdf>
 - ▶ Health plans
- Current BH initiatives and resources
 - ▶ TCMHCC, CPAN, TCHAT
 - ▶ DSHS - <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers>
- Identify value use cases for BH providers sharing data bidirectionally
- Identify legislative barriers and enablers to sharing BH data
 - ▶ Impact of Meaningful Use incentives on BH providers
 - ▶ Texas Bills related to BH
 - ▶ SAMHSA Certified Community Behavioral Health Clinics
 - ▶ THCIC
- Draft agreements for sharing BH data (BAA, DUA)
- Patient privacy and authorization requirements

The committee is currently working on 3 tasks:

- Privacy issues for sharing BH data
- BH issues related to physician workflows.
- Research past and current inclusion of BH in the Meaningful Use incentive program

Summary:

The eHAC Behavioral Health Subcommittee plans to document initiatives and issues related to BH data sharing in Texas and provide recommendations to the eHAC Committee to streamline, sustain and protect the sharing of BH data to the benefit of providers, patients and the State budget.

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

During the course of its 2020 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, and SB 922 (2017, 85R);
- Continuing to use data from the telemedicine, telehealth and telemonitoring survey to form policy recommendations;
- Developing recommendations related to the use of health information technology to address behavioral health needs, through the new behavioral health subcommittee;
- Developing disaster response planning as it relates to the use of eHealth initiatives; and
- Continuing 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 7th, 2020, where the committee will discuss any additional activities the committee anticipates undertaking in the next calendar year.

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

The e-Health Advisory Committee (eHAC) recommended one amendment to Title 1, Texas Administrative Code, Section 351.823, including but not limited to the following:

- Changing the current annual reporting requirement to a biennial report.

13. Costs Related to the Committee

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

14. 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 System
HHSC	Health and Human Services Commission
HIE	Health Information Exchange
HIT	Health Information Technology
IT	Information Technology
LMHA	Local Mental Health Authority
MCO	Managed Care Organization
MEHIS	Medicaid Electronic Health Information System
PCP	Primary Care Provider

PHR Personal Health Record

PDMP Prescription Drug Monitoring Program

VA Veterans Administration

Appendix A. HHSC e-Health Advisory Committee – Membership

Category	Selection	Business Organization	City	Region, Race, Gender
Representative from HHSC <i>(ex-officio member)</i>	Erin McManus	HHSC	Austin	7, White, Female
Representative from HHSC <i>(ex-officio member)</i>	Deanna Naranjo	HHSC	Austin	7, White, Female
Representative from DSHS <i>(ex-officio member)</i>	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	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
Representative of a managed care organization	Stephanie Rogers, MBA	Baylor Scott & White, Scott & White Health Plan	Temple	7, White, Female

Category	Selection	Business Organization	City	Region, Race, Gender
Representative of the pharmaceutical industry	Melisa McEwen	Otsuka America Pharmaceutical, Inc	Spicewood	7, White, Female
Representative of a health science center in Texas	Mari Robinson, JD	The University of Texas Medical Branch	Galveston	6/5S, White, Female
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	Billy Philips, PhD	Texas Tech University Health Sciences Center	Lubbock	1, White, Male
Medicaid provider or child health plan program provider	Dipesh Batra, MD	Kids Care Pediatrics, PA	Houston	6/5S, Asian/Pacific Islander, Male
Representative from Texas Health Services Authority	George Gooch	Texas Health Services Authority	Austin	7, White, Male
Representative of a local or regional health information exchange	Phil Beckett, PhD	Healthcare Access San Antonio	San Antonio	8, White, Male

Category	Selection	Business Organization	City	Region, Race, Gender
Representative of a local or regional health 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
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	Pamela McNutt	Methodist Health System	Dallas	3, White, Female

Appendix B. Member Attendance and Meeting Minutes

e-Health Advisory Committee

Meeting Minutes

Monday, December 9, 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 December 9, 2019 meeting.

MEMBER NAME	ATTENDANCE
Dr. Ogechika Alozie	Y
Ms. Nora Belcher	Y
Dr. Tiffany Champagne-Langabeer	Y
Mr. Stephen Carlton, J.D.	Y
Dr. Adam S. Chesler	N
Dr. Salil Deshpande	Y
Mr. Steve Eichner	Y
Mr. George Gooch	Y
Ms. Elise McDermott	Y
Ms. Melisa McEwen	Y
Ms. Erin McManus	Y
Ms. Pamela McNutt	N

MEMBER NAME	ATTENDANCE
Ms. Sara Mills	Y
Ms. Rebecca Moreau	N
Dr. Billy Philips	Y
Ms. Tracy Rico	Y
Ms. Stephanie Rogers	N
Mr. Thomas C. Wheat	N
VACANT- ex officio member	N

Attendance: Y = yes N = No

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, called roll and determined a quorum was present.

Agenda Item 2: Welcome and Introductions

Dr. Alozie welcomed everyone and announced two new members, Dr. Phil Beckett and Dr. Sheila Magoon. Dr. Alozie asked members to introduce themselves and provide a brief background.

Dr. Alozie turned the floor over to Ms. Nora Belcher who presented a certificate of service to eight members with expiring terms and thanked them for their dedication to the committee.

Agenda Item 3: Approval of March 1, 2019 and June 14, 2019 Meeting Minutes

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

MOTION:

Mr. George Gooch motioned to approve the March 1, 2019 and June 14, 2019 meeting minutes. Dr. Billy Phillips seconded the motion. A voice vote was called for and the motion carried with no objections and one abstention.

Agenda Item 4: e-Health Advisory Committee (eHAC) Committee Vice-chair election

Dr. Alozie 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. Members elected to use the roll call vote or single nominee vote method for the election of their officers. Ms. Nora Belcher was the only nomination received and the floor was opened to the members for other nominations. Receiving no other nominations, Ms. Allen requested a motion be made by unanimous consent or acclamation.

MOTION:

Dr. Billy Phillips motioned to elect Ms. Nora Belcher as the vice chair. Mr. Stephen Carlton seconded the motion. The motion carried unanimously with no objections or abstentions. Ms. Allen turned the floor back to Dr. Alozie.

Agenda Item 5: HHS Update from HHS Executive Commissioner, Dr. Courtney Phillips

Dr. Alozie advised that Dr. Courtney Phillips was unable to attend the meeting and proceeded to turn the floor over to Ms. Adriana Rhames. Before moving on, Dr. Billy Phillips asked if the agenda item would be tabled and brought back at the next meeting. Dr. Alozie stated such was the plan.

Agenda Item 6: Bylaws Revisions

Ms. Adriana Rhames, HHSC, Office of e-Health Coordination, announced that changes were made to the committee's bylaws. After the June 2019 meeting, members discussed and requested they be provided the opportunity to dial-in to the committee meetings. Members were prompted to review the bylaws document and asked if there were any edits or questions. Receiving no edits or changes, Ms. Allen requested a motion.

MOTION:

Dr. Salil Deshpande motioned to approve the revised e-Health Advisory Committee bylaws. Dr. Phil Beckett seconded the motion. A voice vote was called for and the motion carried with no objections or abstentions.

Ms. Allen instructed members to sign the Statement by Members document, leave by their nameplate, and staff would collect them at the conclusion of the meeting. Ms. Allen moved to agenda item 7 and turned the floor over to Ms. Rhames.

Agenda Item 7: e-Health Advisory Committee (eHAC) - status and membership update

Ms. Rhames provided members with an updated membership list in their packets. She advised the committee received a four-year extension and the rules were being amended to reflect a new abolish date of December 31, 2023. In late November the two vacancies for local or regional HIE representatives were appointed and the two members, Dr. Sheila Magoon and Dr. Phil Beckett, were introduced earlier by Dr. Alozie.

The committee will have eight vacancies at the beginning of 2020. According to the bylaws, members are expected to continue to serve until a replacement appointment is made. Those with a term set to expire 12/31/2019 are eligible to re-apply and serve a second term. Ms. Rhames stated she would alert members when the application solicitation process is posted.

Agenda Item 8: Telemedicine and telehealth legislative update

Ms. Belcher introduced Dana Jepson, Senior Policy Advisor to the Deputy Medicaid Director, HHSC and she provided an update on Network Adequacy.

Ms. Jepson advised she is the lead for the network adequacy project and has a staff of thirty members assigned to the project. Three workgroups were created, and they are focused on:

- Improving accuracy of provider directory,
- Integrating network adequacy monitoring measures, and
- Expanding access to telemedicine e-services.

Ms. Jepson added the following details:

- H.B. 1063 requires the calculation of cost savings resulting from the delivery of telehealth services
- HHSC put out a request for proposal (RFP) to Texas public universities to conduct cost savings research
- S.B. 670 requires open reimbursement for all telemedicine services
- Dilemma is whether the service is eligible for reimbursement and is it cost effective and clinically effective. This requirement will be rolled into the RFP.
- Anticipate a signed Memorandum of Understanding (MOU) by end of December; start work in January
- The awarded contract will evaluate the cost savings and develop a methodology to evaluate cost effectiveness and clinical efficacy of delivery of telemedicine services to those enrolled in Medicaid/CHIP
- Report will include a written and oral presentation, a benefit evaluation tool, instructional materials and a webinar directed to staff on how to use the tool and participate in stakeholder meetings. Goal is to have the data for the report by end of summer 2020.

Dr. Billy Philips recommended that Ms. Jepson contact Ms. Becky Bounds at the TexLA Telehealth Resource Center. There is a national consortium for telehealth resource centers which serves regions of the US and it has a myriad of resource tools that could be very beneficial to the group. (TexLA serves the Texas and Louisiana regions.) Dr. Philips will share pertinent contact information with Ms. Jepson.

Ms. Belcher introduced Ms. Erin McManus, Project Manager, Medicaid & CHIP Services, Medical Benefits Policy, HHSC.

Ms. McManus introduced Ms. Morgan Horn, Senior Policy Analyst, Medicaid/CHIP Medical Benefits Policy, HHSC, and she provided the following medical benefits policy updates related to S.B 670.

The following Telemedicine and Telehealth Policy Amendments per S.B. 670 will:

- Prohibit Managed Care Organizations (MCOs) from denying reimbursement for telemedicine or telehealth services for an otherwise covered benefit solely because the benefit was delivered via telecommunications

- ▶ MCOs are directed to use other mechanisms of determining reimbursement for tele-delivered services, such as cost-effectiveness and clinical effectiveness.
- Remove the requirement for a provider to be present with a student during a school-based telemedicine service.

Items pending:

- SB 670 permits HHSC to add Federally Qualified Health Centers as patient site and distant site providers so long as the legislature appropriates funds to do so or if HHSC has available funds to implement the provision.
- The legislature did not appropriate funds to implement FQHCs as patient site or distant site providers and we are still awaiting a response from leadership to determine if it is feasible to implement this provision.
- Policy amendment implementation is anticipated for July 2020

Ms. Heather Duncan, Senior Policy Analyst, Medicaid/CHIP Medical Benefits Policy, HHSC, provided the following updates:

- HB 1063 expands telemonitoring services to include Medicaid clients 20 years of age or younger with the following conditions:
 - ▶ End-stage solid organ disease
 - ▶ Organ transplant recipients
 - ▶ Requiring mechanical ventilation
- Medical Benefits initiated a policy review to update current policy and the Prior Authorization (PA) form to include pediatric clients with specific conditions and extend the authorization period from 60 days to 180 days. The implementation date is tentatively set for summer of 2020.
- HHSC Children's Health System of Texas Dallas Children's Hospital, is one of the largest pediatric transplant facility in the US, and authors of the H.B. 1063 bill.
- Approximately 30 transplant patients are using the Telemonitoring Services through Children's Health and services are expected to increase to approximately 300 patients by the end of 2020.
- Children's Health provides families with a kit that includes an oximeter, blood pressure monitors and a scale. The parents receive continued education to ensure they are familiar with the use of the equipment and they may submit the data through a device such as a smartphone.
- Additional technology assists transplant patients with medication and the medications are embedded with a sensor to allow physicians to know if the patient has been taking their medications.

Ms. Erin McManus provided the following updates regarding rule amendments, early childhood intervention and healthcare common procedure coding system (HCPCS).

- Rule amendment update.
 - ▶ There will be one consolidated rule project for SB 670 and HB 1063, as well as SB 1107 and SB 922 from the 85th Regular Session in 2017.
 - ▶ HHSC previously took informal comments for amendments related to SB 1107 and SB 922. These will be incorporated into the new project.
 - ▶ The consolidated rule project is going through the internal approval processes.
 - ▶ Updates will be given to the committee once the rules are available for informal public comment on the HHSC website and formal public comment in the Texas Register.
- ECI telehealth update.
 - ▶ Effective March 1, 2020, HHSC will be reimbursing Early Childhood Intervention (ECI) contractors for telehealth occupational therapies, speech therapies, and specialized skills training rendered to clients who are eligible for Medicaid coverage of ECI services.
 - ▶ Updates will be reflected in the March 2020 version of the Texas Medicaid Provider Procedures Manual.
- 2020 annual HCPCS updates.
 - ▶ Effective January 1, 2020, code 99444 (physician review of telemonitoring data) will be deleted.
 - ▶ Code 99444 will be replaced with 3 timed codes.
 - ▶ Codes 99421, 99422, and 99423.
 - ▶ HCPCS Special Bulletin will be published at the end of December.
 - ▶ The rate hearing will be held at the end of January.
 - ▶ A specific date is still being determined.

Agenda Item 9: Implementation of pediatric tele-connectivity program for rural Texas update

Dr. Alozie introduced Ms. Deanna Naranjo, Director of Medicaid Modernization Project.

Ms. Adriana Rhames advised that Ms. Naranjo was not available, and she provided the update on the Pediatric Tele-Connectivity Resource Program for Rural Texas.

- 85th legislative session directed HHSC to establish and administer a pediatric telemedicine grant program; funding and requested FTEs were not appropriated

- 86th session appropriated \$5 million in funding but no FTEs
- Currently surveying providers to reassess interest in and barriers to implementation of telemedicine services
- Rules for the program were being drafted
- Analysis of survey information expected to be completed in January

Agenda Item 10: National provider identifier and Texas provider identified follow-up

Ms. Erin McManus provided the following update:

- Provider Management and Enrollment System (PMES) project is designed to streamline and modernize Texas healthcare program enrollment.
- The project was placed on hold in August 2019.
 - ▶ Provider notification posted to the TMHP website on August 5, 2019.
 - ▶ HHSC will provide further updates on this project as they become available.

Agenda Item 11: BREAK

Dr. Alozie called for a 10-minute break.

Agenda Item 13: eHAC interoperability subcommittee update

Dr. Alozie reconvened at 10:15 and introduced Mr. George Gooch, eHAC member and Executive Director of Texas Health Services Authority. Mr. Gooch provided the following Interoperability Subcommittee report.

The subcommittee addressed three tasks:

- To advise HHS agencies on development, implementation and plans for healthcare information technology and HIE
- To advise agencies on the incentives for increasing healthcare provider adoption and usage of electronic health record and HIE systems
- To analyze how interoperability is handled at patient, regional, state and national level

Based on the tasks above, recommendations associated with interoperability were provided in the annual report for review by the committee.

Agenda Item 12: Presentation on current status and future of interoperability in the United States

Dr. Alozie pivoted back to agenda item 12 and introduced Mr. Aneesh Chopra, President of CareJourney.

Mr. Chopra referenced a PowerPoint handout, *Connecting Dots; How Open Data, APIs and Payment Reform Will Fuel Care Delivery Reform* and reviewed it with the committee. This presentation provided an overview of interoperability from the national perspective. Following are some highlights of the presentation:

- Care quality and networks represent a form of interoperability
- New regulations are moving to internet-based technology
- Medicare Blue Button 2.0, transfers prescription info; estimates cost
- The Cures Act is key legislation for this chapter of interoperability; built entirely on internet-based API technology
- Smart Onfire framework allows for substitutable applications
- Argonaut Project has published implementation guides, available for real-world testing
- CMS adopted FHIR API-based Interop portfolio; allows legacy data connection
- Health information fiduciary's toolkit outlines five digital enablers

Agenda Item 14: eHAC telemedicine, telehealth & telemonitoring subcommittee update

Dr. Alozie introduced Ms. Tracy Rico to provide the subcommittee update.

Ms. Rico and Dr. Tiffany Champagne-Langabeer co-presented the update to the committee. Following are highlights of the update:

Ms. Rico provided background on the focus of this Subcommittee and recommendations provided for the eHAC annual report:

- Where are the gaps and why are providers not using telemedicine?
- Who is using telemedicine, where, what for; what is being reimbursed/denied?
- Requested full data set of all Medicaid reimbursement claims for past two years, up to date through 2019
- Looked at top ten regions for providers and narrowed to top 5 top counties: Bexar, Harris, Webb, Dallas and Angelina
- Most common billed services denied were due to CPT codes

Recommend providing appropriate resources to assist clinicians with accurately assigning codes, and develop a ten-step educational reference to establish a telemedicine practice

Dr. Champagne-Langabeer introduced a survey produced by the Subcommittee to assess telemedicine, telehealth, telemonitoring and tele-pharmacy interest and discussed steps taken in the development:

- Developed a survey to gather information about telehealth, telemedicine, telemonitoring, and tele-pharmacy services
- Prefer to run through a sample group of physicians to gauge what is applicable, then deploy through an online survey system

Dr. Billy Phillips offered his services and staff at TTHSC to conduct the pre-pilot survey test and include nursing and pathology associations and collect data for the subcommittee.

Dr. Alozie recommended using the best resources, TTHSC, TMA, Nursing association, etc. to distribute the survey and collect meaningful data.

Agenda Item 15: eHAC annual report update

Ms. Nora Belcher provided a status update on the annual report. She advised the e-HAC subcommittee chairs provided input for the report and based on feedback from the members, there were some factual problems that needed to be fixed. She noted a status report on previous recommendations was reviewed and if recommendations were still pending, they would be removed from the report and sent back to the subcommittees for future work. The goal is to have a final draft ready for review by mid-December.

Agenda Item 16: Lunch break.

Agenda Item 17: Effective use of the Texas Prescription Monitoring Program

Dr. Alozie reconvened the meeting at 1:15pm and introduced Ms. Linda Yazdanshenas, Research Analyst, Prescription Monitoring Program (PMP), TX State Board of Pharmacy.

Ms. Yazdanshenas referenced a PowerPoint handout, *Texas Prescription Monitoring Program*, and reviewed it with the committee. The presentation addressed the history of the program and provided an in-depth overview of the regulations, reporting requirements and processes for pharmacy prescribers. Following are some highlights of the presentation.

- Texas State Board of Pharmacy took ownership of the program in September 2016
- Electronic database collects and monitors outpatient prescription data for all Schedule II, III, IV and V levels.
- Is a patient care tool for prescribing practices and address drug misuse and diversion.
- Issued new prescription form in September 2018; contains red Rx heat-sensor and embedded Texas seal watermark to prevent fraudulent reproduction
- Implemented a requirement to only allow use of the new form effective June 1, 2019
- Reviewed the Texas PMP login, registration, processes, functionality and reporting features

Agenda Item 18: Health Information Technology (HIT) Strategic Plan update

Dr. Alozie introduced Mr. Cliff Luckey, Director of Medicaid Technology Modernization, HHSC.

Mr. Luckey provided the following update:

- Health IT is a deliverable for the 1115 Waiver from CMS
- The plan outlined milestones, projects, tracking and measurable entities
- Original deliverable date to CMS was October 1, 2019; although it was not mandated by CMS
- HHSC decided to send out for public comment and CMS was in favor
- HHSC determined the plan warranted review by the Governor's office
- HHSC Executive Commissioner will sign-off before it is distributed
- New deliverable date to CMS is slated for end of March 2020.

Agenda Item 19: Delivery System Reform Incentive Payment program transition plan update

Dr. Alozie introduced Ms. Emily Sentilles, Director Healthcare Transformation Waiver, HHSC.

Ms. Sentilles referenced a PowerPoint handout, *DSRIP Transition Update*, and reviewed it with the committee. She provided following highlights:

- December 2011, the 1115 demonstration waiver was approved by CMS for five years through September 31, 2016

- 1115 Waiver extension created two funding pools - uncompensated care (UC) and delivery system reform incentive payment (DSRIP)
- May 2016, the waiver authority was extended 15 months
- December 2017, CMS approved another five-year extension; UC for five years, and DSRIP for four years
- The two pools draw down federal matching funds with locally funded intergovernmental transfers
- CMS required Texas to submit DSRIP transition plan
- HHSC submitted plan to CMS 9/30/2019 and must obtain approval of final plan by 3/30/2020
- Milestone M-9 of transition plan addresses telemedicine/telehealth assessment particularly in Texas rural areas; due December 31, 2019

Ms. Sentilles asked for feedback on the best manner for collaborating with this committee.

Agenda Item 20: Disaster response in HIT

Dr. Alozie introduced Mr. George Gooch, eHAC member and Executive Director of the Texas Health Services Authority (THSA).

Mr. Gooch referenced a PowerPoint handout, *Patient Unified Lookup System for Emergencies (PULSE)*, and reviewed it with the committee. He provided following highlights:

- Hurricane Harvey disaster infographic highlights the number of patients provided with medical care
- PULSE is a real-time health IT solution to help support response volunteers and patients through a statewide standardized system
- Allows volunteers to query and view patient documents as needed
- Other states are utilizing federal match funding to deploy PULSE at state level
- Governance structure must be established to activate PULSE and support configuration of IT infrastructure
- Volunteers must be trained on use of the system and workflow
- Next steps – THSA will work with stakeholders to develop steps towards PULSE implementation in Texas.

Agenda Item 21: Support for HIE Texas as an electronic connection in healthcare

Dr. Alozie introduced Ms. Susan Bradshaw, Baylor Scott & White, and Dr. Manish Naik, Austin Regional. Dr. Naik provided the following highlights:

- The Texas Epic Collaborative has exchanged over 300 million records with 1300 clinics in Texas and almost 12,000 nationally
- Volume of scope includes 1858 hospitals, 1700 emergency rooms, and 41,000+ clinics
- Supports HIETX to serve as the super-highway for electronic connection for all healthcare entities
- Creating one medical record for an individual, provides clinical communication by aggregating the data, regardless of the delivery platform
- Decrease administrative burdens of multiple hand-offs
- Utilizing HIETX as the gateway, improves care delivery coordination and communication to all healthcare delivery space

Agenda Item 22: Public Comment

Public Comment was received from Mr. Ives Soto, Director of Provider Relations, Coordination Centric. His comment related to the deletion of telemonitoring code 99444. He stated it negatively impacted patient compliance and overall participation in the state's program. The new code CMS issued does not adequately reflect the physician's work (24/7) under the program. He requested the committee, along with HHSC, champion a new code to adequately reflect the HB1063 and the Texas in-home telemonitoring program.

Agenda Item 23: Next Meeting Planning

Dr. Alozie stated the next meeting is scheduled for April 3, 2020 in the Brown Heatly Building.

Agenda Item 24: Adjournment

Dr. Alozie thanked members and staff and adjourned the meeting at 3:09 p.m.

The web address for the meeting: <https://texashhsc.swagit.com/play/12092019-702>

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 55% of worktime to the management of eHAC. Committee management includes coordination of Committee and Sub-committee meetings, preparation of meeting notices, development and publication of agendas in coordination with eHAC chairs and HHSC 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.

For this reporting period, staff time for support of this Committee plus materials and supplies expenses total approximately \$44,050.

All eHAC activities were supported using HHS appropriated funds.

Appendix D: Full Telemedicine, Telehealth and Telemonitoring Survey Results

Question 1: Do you provide telemedicine services?

- 57.1% of respondents stated their facilities provide telemedicine services.

Question 2: Indicate any barriers to providing or receiving telemedicine services you have identified (check all that apply).

- Payer reimbursement policies were unclear (51.0%) --
- Volume of telemedicine services did not support costs (16.3%) --
- Lack of interoperability with other equipment of EMRs (18.4%) --
- Payers did not offer reimbursement for the services (46.9%) --
- Use of proprietary software or platforms (16.3%) --
- Unable to obtain telemedicine equipment (16.3%) --
- Unable to locate distant site provider who offers needed services (6.1%) --
- Unable to configure EMR to support telemedicine visits (10.2%) --
- Internal telecommunication infrastructure upgrades were needed (22.4%) --
- No barriers identified (16.3%) --
- Unable to obtain needed technical assistance (12.2%) --

Changes to the Texas Medicaid Telemedicine/Telehealth Policy that would be beneficial to the service

- Funding
 - ▶ Provide increase funding
 - ▶ Telemedicine should be reimbursed at same rates as traditional care
- Physician reluctance
 - ▶ Increased reimbursement with variability to standard of care. Physicians are weary of participation in a program where they are held to the same standard as an in-office visit.
 - ▶ Make payer reimbursement policies more clear
 - ▶ Clear concise polices with guidance on billing.

Do you offer telemonitoring/remote monitoring to your patients?

- 65.3% – no
- 12.2% – yes
- 22.4% - blank

Do you offer telemonitoring through a hospital or a home care agency?

- 69.4% – we do not offer telemonitoring services.
- 22.4% – blank
- 8.2% – home care agency

Are there other conditions, populations, and/or provider types that you think should be added to the benefit?

- 20.4% – yes
- 40.8% – no
- 38.8% - blank

Please describe any changes to the Texas Medicaid Telemonitoring Policy (TMHP Tmppm) that would be beneficial to the service.

- To create awareness among providers about this program so that those willing to participate can enroll in it.
- To provide the necessary equipment and technical support to set up.
- Clarification and development of reimbursement categories
- More details on the nature of revenue stream and financial value appropriation
- We are new to the Medicaid program so just learning of the benefits
- Specific conditions that apply. Extremely vague right now.
- Commercial remote monitoring should at minimum follow Medicare reimbursement schedules
- Telemonitoring is not a service we offer yet, due to digital deserts in our area. We are exploring options, and any policy that assists in the development of not only rural but urban digital deserts would be extremely useful.
- Don't know enough about this system to comment.
- Procedure codes get updated quickly with prices set for payment.

Have you heard of or utilized telepharmacy services or remote medication dispensing?

- 49.0% – have not
- 22.4% – have heard
- 6.1% – have utilized
- 22.4% – blank

Do you feel a pharmacist home-monitoring patient therapy would improve adherence and outcomes?

- 63.3% – yes
- 28.6% – blank
- 8.2% – no

Do you treat any patients who have challenges or hardships in accessing their pharmacy?

- 59.2% – yes
- 16.3% – no
- 24.4% – blank