

SUBJECT: Regulation and reimbursement of telemedicine medical services

COMMITTEE: Public Health — committee substitute recommended

VOTE: 7 ayes — Gray, Coleman, Capelo, Glaze, Longoria, Maxey, Uresti
0 nays
2 present not voting — Delisi, Wohlgemuth

WITNESSES: For — Ralph Anderson; John Drobnic, Texas Academy of Physician Assistants; Dan Dugi, Texas Medical Association, Texas Association of Family Physicians; Gregory Hobbs, Scott and White Clinic; Tony Loggins
Registered but did not testify: Craig Walker, Health Care Vision, Inc.; Tom Banning, Texas Academy of Family Physicians; Patricia Kolodzey, Texas Hospital Association; Linda Rushing, Texas Conference of Catholic Health Facilities; Marc Samuels, Texas Academy of Internal Medicine, Texas Pediatric Society, U.S. Oncology Association; Cyndie Schmitt, Texas Council of Community Mental Health and Mental Retardation Centers, Inc.; Matthew Wall, Texas Hospital Association; Heather Vasek, Texas Association for Home Care

Against — None

On — Jose Camacho, Texas Association of Community Health Centers, Inc.; Patty Patterson, Texas Tech University Health Sciences Center; *Registered but did not testify:* Mike Easley, Center for Rural Health; Beverly Koops, Janet Kres, Texas Department of Health; F.M. Langley, Texas State Board of Medical Examiners; Rob Tessen, Telecommunications Infrastructure Fund

BACKGROUND: Government Code, sec. 531.0217 defines “telemedical consultation” in connection with Medicaid reimbursement in rural areas as “a medical consultation for purposes of patient diagnosis or treatment that requires the use of advanced telecommunications technology, including:

- ! compressed digital interactive video, audio, or data transmission;
- ! clinical data transmission via computer imaging for teleradiology or

- telepathology; and
- ! other technology that facilitates access in rural counties to health care services or medical specialty expertise.”

Utilities Code, sec. 57.042 also defines telemedicine, for purposes of allocating Telecommunications Infrastructure Fund (TIF) grants. This definition includes the provision of health education as well as patient-care services but limits the scope of telemedicine to services or education delivered to certain providers under specific circumstances. As such, telemedicine is provided only “to rural or underserved public not-for-profit health care facilities or primary health care facilities in collaboration with an academic health center and an associated teaching hospital or tertiary center or with another public not-for-profit health care facility.”

The Utilities Code definition is used in Government Code, sec. 531.0216, which requires the Health and Human Services Commission (HHSC) to develop and implement a system to reimburse providers in both rural and underserved areas for Medicaid services performed through telemedicine.

The Legislature created the TIF in 1995 to pay for equipment, wiring, and other costs for public schools and other entities. Funds derived from annual assessments on telecommunications utilities and commercial mobile-service providers are allocated evenly to the public schools account and the qualifying-entities account. The TIF board may use up to 25 percent of the qualifying-entities account to award grants or loans for telemedicine.

Today, the TIF has a balance of about \$458 million. Total deposits to the fund are limited to \$1.5 billion, excluding loan repayments and interest (Utilities Code, sec. 57.048(c)). The limit initially was projected to be reached in 2005, and the TIF board is scheduled to expire in September 2005 unless continued by the Legislature.

DIGEST:

CSHB 1615 would create a standard set of telemedicine definitions to be used in all areas of the code related to telemedicine. The bill also would make regulatory changes relating to the use of telemedicine medical services in Medicaid and CHIP, the state’s health care assistance programs for adults and children below certain income levels. The bill would grant certain regulatory authority to the Texas State Board of Medical Examiners (BME).

It also would create funding grants for health and human services agencies through TIF and would target TIF telemedicine grants.

Definitions. CSHB 1615 would create a standard definition for the terms used to describe telemedicine.

“Telemedical medical service” would mean a diagnosis, treatment, or consultation remotely provided by a health professional.

“Telehealth services” would include all health services that did not fall under the definition for a telemedical medical service such as patient education.

“Health professional” would, for the purposes of telemedicine, would mean a physician, a licensed health care worker, or an individual who was authorized to assist a physician in providing delegated and supervised telemedical services.

This bill would strike definitions in the Government Code for “rural county,” “rural health facility,” “telemedicine,” and “telemedical consultation” for the purposes of codifying telemedical practices and regulations.

Medicaid and CHIP. CSHB 1615 would authorize reimbursement for all telemedical services and would remove the limit on reimbursement to rural health facilities, medical schools, and teaching hospitals.

The bill would direct HHSC to incorporate the following additional considerations into the telemedicine reimbursement system for Medicaid:

- ! establishing a separate provider identifier for telemedicine providers ;
- ! working with the Texas Department of Health to develop a denial process for claims that were medically inappropriate; and
- ! establishing telehealth pilot programs and encouraging physicians, as well as hospitals and clinics, to participate in telemedicine health delivery.

HHSC and the TIF board would establish standards for a telemedicine communications system for Medicaid. This system would include authentication, security, documentation, and storage measures for the

information the system would transmit and store. Medicaid only could reimburse for telemedicine services administered in a facility that used this system. This bill would direct HHSC and the TIF board to adopt these standards by October 1, 2001.

HHSC's telemedicine advisory committee's duties would be expanded to include monitoring of Medicaid telemedicine programs and telemedicine coordination among state agencies.

Federally qualified health centers and rural health clinics and the delegation of services by a physician to an advanced practice nurse or physician assistant would not be affected by HHSC's telemedicine regulations.

HHSC would report on the effects of telemedicine in the state, including the number of participating providers and patients, their geographic distribution, types and costs for services. This information would be reported by December 1 of each even-numbered year to the House speaker and the lieutenant governor.

CSHB 1615 would require that CHIP providers reimbursed telemedical services at a comparable rate to in-person services and would make services performed by different providers available through telemedicine if it were more cost-effective.

State Board of Medical Examiners. HHSC would have to direct facilities and providers of telemedicine services to make a good faith effort to coordinate with existing providers to protect existing health-care systems. If a patient consented, the primary care physician would be informed of the telemedicine services in order to share medical information. HHSC would work with the Texas State Board of Medical Examiners (BME) to ensure compliance with coordination and notification.

BME would be able to adopt rules to ensure adequate supervision of health professionals who were not physicians, but who provide telemedical services. The board also could set the maximum number of health professionals to whom a physician could delegate telemedical services and could require a physician follow-up visit if the patient only were evaluated by the health professional.

Telecommunications Infrastructure Fund. The TIF board would have to use TIF funds for an automated system to integrate client services and eligibility requirements for health and human services across agencies. This authorization would expire September 1, 2003.

TIF grants could be awarded only to hospitals or clinics that were supported by local tax revenue or were nonprofit, or that saw patients in an office visit setting. The utility incentive to provide private network services to TIF grantees would extend only to this group of TIF health grantees. HHSC also would have to authorize TIF grants for other institutions based on the amount they spent on charity care in the previous year and the number of Medicaid and CHIP patients seen by that institution. Institutions that did not provide charity care in the previous year would not be eligible for a grant.

CSHB 1615 would direct state agencies to seek any necessary federal waivers or authorizations needed to implement the provisions of this bill. The agency could delay implementation until the federal waivers or authorization were granted. This bill would direct HHSC to adopt the telemedicine Medicaid rules by January 1, 2002.

The bill would take immediate effect if finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take effect September 1, 2001.

**SUPPORTERS
SAY:**

CSHB 1615 would create a comprehensive plan for telemedicine in Texas. Existing legislation has been implemented piecemeal, resulting in contradictory or confusing definitions, regulations, and authority over programs. This bill would address those issues by creating a uniform set of definitions and awarding authority over specific areas of telemedicine oversight to the appropriate agencies. Telemedicine saves time and travel expenses for providers and patients, allows for reductions or substitutions in medical personnel, reduces the number of redundant medical tests and improves the chances for early diagnosis of disease, when treatment can be effective and less costly. Texas should have an effective telemedicine plan.

This bill would allow Medicaid to reimburse for telemedicine, a vital cost-containment and quality of care component. The Texas prison system uses

telemedicine extensively, allowing the correctional system to reduce its overall medical costs. Telemedicine has proven to be effective for providing good health care services; it should be employed by the state's health care assistance programs.

OPPONENTS
SAY:

CSHB 1615 would go too far under the umbrella of "telemedicine regulation." The bill would authorize grants from the TIF to health and human service agencies to integrate client services and eligibility requirements across agencies, an issue that would far exceed the boundaries of telemedicine. This would be an issue affecting all health and human services agencies and most major programs. It is funded through Strategy A.1.1, System Integration, in HHSC's budget, for which the House-passed version of SB 1, the general appropriations bill, would appropriate \$12 million for fiscal 2002-03. Additional funding for system integration should not be part of a telemedicine bill.

CSHB 1615 would increase Medicaid services, which should be approached with great caution in an environment of rising costs and utilization. Medicaid case loads were higher than expected in fiscal 2000-01, in part, as a result of legislation to keep eligible individuals in Medicaid. Because of this, the state spent \$600 million more than appropriated for Medicaid. Given that costs are projected to continue to rise in the coming biennium, the state should be cautious about adding services at this time.

NOTES:

The fiscal note attached to CSHB 1615 estimates a cost of \$3.1 million in fiscal 2002-03. It assumes the cost would include increased utilization in Medicaid, additional services through the pilot program, and additional administrative costs including staffing.

The House-passed version of SB 1 includes a contingency rider for the filed version of the bill of \$34 million for fiscal 2002-03 in Article 11. The bill as filed had a fiscal note of \$34.5 million.

The committee substitute deleted from the filed version a TIF educational program, required consultation with medical schools in developing telemedicine policies, a home health pilot program, and a CHIP telemedicine plan. The committee substitute would make TIF grants available to health and human services agencies, limit utility companies' private network

services to one group of TIF health grantees, direct HHSC to establish telemedicine pilot programs, require coordination of services between the local and telemedical physicians, and authorize BME the authority to adopt certain rules concerning telemedicine.