SUBJECT: Establishing a pediatric telemedicine grant program for rural Texas

COMMITTEE: Public Health — committee substitute recommended

VOTE: 10 ayes — Price, Sheffield, Arévalo, Burkett, Collier, Cortez, Guerra, Klick, Oliverson, Zedler

0 nays

1 absent — Coleman

WITNESSES: For — Stacy Wilson, Children's Hospital Association of Texas; Julie Hall-Barrow, Children's Health; John Hawkins, Texas Hospital Association; (*Registered, but did not testify*: Christine Bryan, Clarity Child Guidance Center; Christine Yanas, Methodist Healthcare Ministries; Greg Hansch, National Alliance on Mental Illness (NAMI) Texas; Annie Spilman, National Federation of Independent Business-Texas; Adriana Kohler, Texans Care for Children; Jamie Dudensing, Texas Association of Health Plans; Nora Belcher, Texas e-Health Alliance; Joel Ballew, Texas Health Resources; Dan Finch, Texas Medical Association; Clayton Travis, Texas Pediatric Society; Brittani Bilse, TORCH; Aidan Utzman, United Ways of Texas; Thomas Parkinson)

Against — None

On — (*Registered, but did not testify*: Emily Zalkovsky, Health and Human Services Commission; Sheryl Swift)

DIGEST: CSHB 1697 would require the Health and Human Services Commission (HHSC) to establish a tele-connectivity resource program that would award grants to rural health care facilities to connect those facilities with pediatric specialists and subspecialists who provide telemedicine medical services.

Pediatric tele-specialty providers, defined as pediatric health care facilities that offer continuous access to telemedicine services provided by pediatric

subspecialists, could assist HHSC in establishing the program and selecting grant recipients. Rural, or "nonurban," health care facilities and hospitals would be defined as facilities serving counties with a population of 50,000 or less.

To be eligible for a grant under the program, a rural health care facility would be required to have:

- a quality assurance program;
- a designated neonatal intensive care unit or an emergency department;
- at least one staff full-time equivalent physician with pediatric training and experience and one person responsible for ongoing nursery and neonatal support and care;
- a commitment to obtaining neonatal or pediatric education from a tertiary facility; and
- the capability of maintaining records and producing reports that measure the effectiveness of a grant received under the program.

A facility could use grant money to purchase telemedicine equipment or modernize its IT infrastructure and support to ensure an uninterrupted two-way video signal compliant with federal health insurance privacy laws. Grant money also could be used to pay a service fee to a pediatric tele-specialty provider under an annual contract, or for other costs associated with telemedicine deemed necessary by HHSC.

The bill would prohibit HHSC from spending state funds to accomplish the program and would not require the commission to award a grant unless the Legislature appropriated money for the program. HHSC could solicit and accept gifts, grants, and donations from any public or private source, and a political subdivision participating in the program could pay part of the costs.

HHSC could establish a work group to assist with developing, implementing, or evaluating the program and preparing a biennial report on results and outcomes of the grants to the governor and Legislature.

Work group members would not be entitled to compensation or reimbursement for travel.

HHSC's executive commissioner could adopt rules to implement the program. The commission would be required to implement the program by December 1, 2017, and to deliver the first report to the governor and Legislature by December 1, 2018.

The bill would take effect September 1, 2017.

SUPPORTERS SAY:

CSHB 1697 would establish a grant program to help rural hospitals purchase telemedicine equipment and contract for access to a telemedicine provider, which could allow less populous parts of the state to access the best pediatric medical care available.

Many rural areas in Texas lack neonatologists and pediatric specialists. This often requires the transportation of local infants and children to urban hospitals. In some cases, these young patients could be cared for in their home communities if the attending physician were able to use telemedicine technology to consult with specialists in other parts of Texas. One Texas provider that has offered neonatal and pediatric emergency telemedicine services to 12 hospitals since 2013 has treated 50 percent of newborns and 75 percent of pediatric emergency room patients in their home communities.

Allowing babies and children to be treated in local hospitals, when appropriate, could eliminate unnecessary transfers, improve patient outcomes, and reduce costs. It also could help parents avoid travel expenses and disruptions associated with their child's medical care. If the patient needed to be transferred for a higher level of care, the transition between treatment teams could be smoothed using telemedicine technology before the move.

The program would award grants to rural hospitals only if the program was funded through appropriations or private donations. Rural hospitals are a critical resource to their communities, but they face fiscal challenges

that could be partially alleviated by the grant program. For instance, the facilities could use the grants to invest in videoconferencing and other telemedicine equipment, upgrade broadband, and offset the service fee for access to a telemedicine provider.

OPPONENTS SAY:

No apparent opposition.

NOTES:

The Legislative Budget Board cited unknown variables such as the number of potential grant recipients and the value of the grants in concluding that the bill could have an indeterminate fiscal impact to the state.

CSHB 1697 differs from the bill as filed in that the committee substitute would rename the grant program, limit it to hospitals in counties with populations of 50,000 or less, and require eligible facilities to have a designated neonatal intensive care unit or an emergency department.