SUBJECT: Creating telemedicine pilot programs along the Texas border

COMMITTEE: Public Health — committee substitute recommended

VOTE: 8 ayes — Gray, Coleman, Capelo, Delisi, Glaze, Maxey, Uresti, Wohlgemuth

0 nays

1 absent — Longoria

WITNESSES: For — Gregory Hobbs, Scott and White Clinic; Dan Dugi, Texas Medical Association and Texas Association of Family Physicians; Lynda Woolbert, Coalition for Nurses in Advanced Practice; *Registered but did not testify:* Ralph Anderson; Jose Camacho, Texas Association of Community Health Centers, Inc.; Mayor Carlos Ramirez, City of El Paso; Pat Graham-Casey, Cancer Consortium of El Paso; Craig Walker, HealthCare Vision Inc.; Renee Wizig-Barrios, EPISU; Leah Rummel, Texas Association of Health Plans; Felicia Escobar, National Council of La Raza; Dionicio Alvarez, Texas Pediatric Society and El Paso County Medical Society; Dale Burleson, El Paso County Medical Society; Carlos Gutierrez, El Paso Medical Society, Texas Medical Association, and El Paso Pediatric Society; JoAnn Orrantia; Raul Rivas; Irene Chavez; Jose Rodriguez; Joe Sanchez, Mexican American Legal Defense and Education Fund; Filbert Candeluria, Lieutenant Governor Ysleta del Son Pueblo; David Sanchez, Ysleta del Son Pueblo; Albert Alvidrez, Ysleta del Sur; Tom Dizmond; Brad Shields, Texas Society of Health System Pharmacists; Anne Dunkelberg, Center for Public Policy Priorities; Leslie Hernandez, National Association of Social Workers, Texas; Frank Field, Brownsville Chamber of Commerce; Linda Rushing, Texas Conference of Catholic Health Facilities; Jose Moreno, Community Voices, El Paso; Laura Uribarri, Greater El Paso Chamber of Commerce; Karen Reagan, Texas Federation of Drug Stores

Against — None

On — Beverly Koops and Janet Kres, Texas Department of Health; Kermit Black, Texas A&M Center for Housing and Urban Development; F.M. Langley, Texas State Board of Medical Examiners

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 2700 would establish telemedicine pilot programs along the border, create a border telemedicine advisory board, and make these telemedicine pilot programs eligible for grants from the TIF.

CSHB 2700 would add sec. 531.02171 to the Government Code to direct HHSC to establish pilot telemedicine programs in areas within 150 miles of the Texas-Mexico border. HHSC could reimburse health care professionals for their participation in such programs. In developing these pilot programs, HHSC would:

- obtain support from local officials and the medical community;
- focus on ways to increase access to medical services;
- establish outcome measures for each program;
- consider disease-specific programs; and
- demonstrate that telemedicine services would not adversely affect traditional medical services in that area.

This bill also would repeal Government Code, sec. 531.0217(h), which directed the HHSC commissioner to establish a telemedicine advisory board to assist in creating policies for telemedicine consultation. The advisory committee established under sec. 531.0217(h) would be abolished on the effective date of this act.

CSHB 2700 would add sec. 531.02172 to the Government Code to direct the HHSC commissioner to establish a border telemedicine advisory committee by December 31, 2001, to assist in evaluating policies for the new pilot programs, ensuring efficient use of technology, coordinating state agencies involved in telemedicine, as well as evaluating policies for telemedical consultations.

The advisory committee would serve at the will of the commissioner and would include representatives from:

- HHSC;
- Texas Department of Health;
- Center for Rural Health Initiatives;
- Telecommunications Infrastructure Fund Board;
- Texas Department of Insurance;
- Texas State Board of Medical Examiners;
- Texas State Board of Nurse Examiners;
- Texas State Board of Pharmacy; and
- health science centers, experts in this field, and consumers.

The committee would be required to submit a progress report on the establishment of pilot programs to the governor, the lieutenant governor, the House speaker, and appropriate standing committees of the House and the Senate by September 1, 2003.

The bill also would add sec. 57.0471 to the Utilities Code to make health care facilities participating in a border telemedicine pilot program under Government Code, sec. 531.02171 eligible to receive TIF grants.

CSHB 2700 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 2700 would help encourage innovation in an area that needs it the most. The Texas-Mexico border region has some of the state's most challenging and unique medical problems, with high medical need and low access to health care due to factors including location, economic status, and racial mix. The bill's emphasis on the border region would ensure that providers have incentives to bring innovative solutions to the areas that need the most help.

CSHB 2700 would ensure that the border region remains on the forefront of telemedicine initiatives. The border telemedicine advisory committee would work with agencies to determine how the needs of that region can be met in the larger context of telemedicine across the state.

This bill would help border health centers get the equipment they need to practice telemedicine by making these pilot programs eligible for TIF grants.

The cost of establishing and maintaining the necessary hardware, software, transmission lines, and connectivity can prevent health-care providers along the border from taking part in a telemedicine network. These grants would offset that cost, making it possible for providers to participate.

This bill is an important piece of the telemedicine legislation before members this session because it focuses on a region with significant needs. While the omnibus telemedicine bill, HB 1615 by Maxey would create a foundation for the practice and regulation of telemedicine throughout Texas, CSHB 2700 would focus attention on the border.

Telemedicine already has proven cost-effective in saving lives, preventing unnecessary emergency visits, and providing specialized care in remote areas. Patients who have experienced telemedical consultations generally report high levels of satisfaction with the services, and office-visit videos produced by certain telemedical consultations are proving effective in helping individuals and families conform to doctor-recommended activities for self-care.

OPPONENTS SAY:

CSHB 2700 would single out a region that has telemedicine needs similar to other rural areas of Texas. The law already authorizes telemedicine services in medically-underserved areas, which ensures that those who need telemedical services the most will have access to them. Because individuals living in some border cities actually may have better access to health care than individuals living in other, non-border rural areas of the state, it would be better to focus on medically-underserved areas than the border region.

Access to TIF grants would not provide the amount of financial support border providers would need to participate in a telemedicine program. TIF grants generally pay for equipment and related costs and do not help health-care providers with ongoing connectivity expenses. Continual advancements in hardware and software also make it expensive to maintain and update a telemedicine system.

This legislation is unnecessary and premature in light of the omnibus telemedicine bill, HB 1615 by Maxey, which would create a foundation for the practice and regulation of telemedicine throughout Texas, including Medicaid reimbursement, safeguards to protect quality of services, and

ongoing evaluation of the efficacy of telemedicine. It would create a comprehensive telemedicine initiative for the state, including the border region.

OTHER OPPONENTS SAY:

State involvement in promoting the growth of telemedicine should be limited until telemedicine proves itself. The growth of telemedicine has been driven more by businesses creating and marketing telemedical products and by medical-center initiatives than by demand from consumers or doctors. Further, there are issues about reimbursement, clinical standards, and regulation of telemedicine that this bill would not address.

NOTES:

The companion bill, SB 1483 by Duncan and Madla, was reported favorably, as substituted, by the Health and Human Services Committee on April 11 and was recommended for the Local and Uncontested calendar.

The committee substitute added a reference to the Government Code to identify a section being repealed.