Assessment of Texas Medicaid Rural Teleservices

Texas Delivery System Reform Incentive Payment Program Transition Plan

Health and Human Services Commission

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TEXAS
Health and Human Services

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Executive Summary

This *Assessment of Texas Medicaid Rural Teleservices* deliverable fulfills one of the eight milestones included in the Delivery System Reform Incentive Payment (DSRIP) Transition Plan[1], which explains how the Texas Health and Human Services Commission (HHSC) will further develop delivery system reform efforts in Texas Medicaid without DSRIP funding. The objective of this milestone is to assess the current capacity and use of telemedicine and telehealth, particularly in rural areas of Texas, to inform next steps to address access gaps.

Rural Texans face certain healthcare access challenges and telemedicine and telehealth (referred to in this report as teleservices[a]) are valuable tools to address challenges. The use of teleservices—for instance, to provide specialty care in remote areas—has been increasing over the years, but significantly accelerated with the onset of the Coronavirus Disease 2019 (COVID-19) public health emergency (PHE). In response to the PHE, insurers, including Medicare and Texas Medicaid, provided flexibility to promote the provision and use of teleservices. Consequently, utilization of teleservices increased dramatically. For example, there was a 3,410 percent increase in the total number of teleservices provided to Texas Medicaid clients after the onset of the PHE.[b] All types of teleservices increased across a wide variety of provider types.

However, teleservice utilization did not increase equally for all. For example, in Texas Medicaid, rural beneficiaries' utilization did not increase as much as utilization by beneficiaries in urban and suburban areas. This may be due at least in part to a lack of broadband access in certain rural areas of the state. However, telephone (audio-only) services appeared to play a more important role in maintaining rural Medicaid clients' access to services during the PHE, particularly behavioral health services.

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[a] The term "teleservices" as used in this report is defined in the Background section.

[b] The percentage increase was from the "pre-COVID-19 period" of September 1, 2019 through February 29, 2020 to the "during COVID-19 period" of March 1, 2020 through August 31, 2020. Service counts are based on distinct procedure codes.

The state continues to take actions to expand teleservices as well as broadband access to help address healthcare access challenges faced by rural Texans. Federal and state collaboration is needed for states to fully realize the potential of teleservices.

1. Background

HHSC submitted a DSRIP Transition Plan[2] to the Centers for Medicare and Medicaid Services (CMS) describing how Texas will further develop delivery system reform efforts in Texas Medicaid when DSRIP funding ends on September 30, 2021. The DSRIP Transition Plan approved by CMS includes five goals and eight milestones. One of the goals is to strengthen supporting infrastructure for increased access to healthcare and improved health for Texans. The milestone associated with this goal is an assessment of the current capacity and use of telemedicine and telehealth, particularly in rural areas of Texas, to inform next steps to address access gaps. This report is the deliverable for this milestone.

Telemedicine medical ("telemedicine") services are defined in Texas statute as healthcare services delivered by a physician or a health professional under physician delegation and supervision to a patient at a different physical location using telecommunications or information technology.[3] Telehealth services are defined in Texas statute as healthcare services delivered by a non-physician health professional to a patient at a different physical location using telecommunications or information technology.[4] Medicare, however, does not differentiate between telemedicine (physician services) and telehealth (healthcare professional services). For the purposes of this report, the term "teleservices" will be used to encompass both telemedicine and telehealth services. This term, however, will not encompass telemonitoring.

The importance of teleservices has been recognized throughout DSRIP. The inclusion of this milestone in the DSRIP Transition Plan was driven by the goal to prioritize access to care when DSRIP funding ends and sustain DSRIP best practices.

- Of the 1,340 DSRIP projects implemented by participating providers during DSRIP demonstration years (DYs) 2-6 (October 1, 2012 – September 30, 2017), 77 (about 6 percent) had a teleservices component.
- In DY 9 (October 1, 2020 – September 30, 2021), providers reported that at least 112 of the 664 Core Activities implemented (at least 17 percent) use teleservices to deliver some services.

- In DSRIP DYs 9-10 (October 1, 2019 – September 30, 2021), providers reported on Related Strategies[c], which included four strategies related to teleservices.
  - In November 2019, 39 percent of providers reported implementing at least one of these teleservices Related Strategies to some extent (101 of 256 providers).
  - Based on the most recent preliminary data as of April 2021, 72 percent of providers reported implementing at least one of these teleservices Related Strategies to some extent (183 of 254 providers).

Additionally, the significance of these teleservices initiatives was highlighted by the Best Practices Workgroup (BPW), a group of 84 DSRIP participating providers, anchors, and Executive Waiver Committee members convened to identify key measures and key practices that impacted the health status of clients served in DSRIP. The third top-rated key practice identified by the BPW was "Telehealth to provide virtual medical appointments and/or consultations with a psychiatrist."

In part because of DSRIP, the use of teleservices—for instance, to provide specialty care in remote areas—has been slowly increasing over the years, including in the Texas Medicaid program.[5] The COVID-19 PHE, however, significantly accelerated this upward trend in utilization. The PHE required changes in the way healthcare is delivered to reduce healthcare staff exposure to ill persons, preserve personal protective equipment, and minimize the impact of patient surges on facilities.[6] Healthcare systems adjusted the way they triage, evaluate, and care for patients using methods that do not rely on in-person services.[7] Teleservices provided a means, at least in part, to meet this challenge and continue providing caring for patients while minimizing risks faced by healthcare personnel and patients.[8]

Texas Governor Greg Abbott has recognized the key role of expanded teleservices in helping the state respond to the COVID-19 PHE.[9,10] House Bill (H.B.) 4, 87th Texas Legislature, 2021, builds on the state's recent experience with teleservices,

[c] DSRIP Related Strategies related to teleservices include: 1) Telehealth to provide virtual medical appointments and/or consultations with a primary care provider; 2) Telehealth to provide virtual medical appointments and/or consultations with a specialty care physician (physical health only); 3) Telehealth to provide virtual medical appointments and/or consultations with a psychiatrist; and 4) Telehealth to provide virtual appointments and/or consultations with a dentist.

making permanent many teleservices flexibilities provided by Texas Medicaid and other health and human services programs during the PHE.[11]

A range of HHSC advisory committees have also recommended ideas for expanding teleservices in the state, including, but not limited to, the State Medicaid Managed Care Advisory Committee,[12] the e-Health Advisory Committee[13], the Texas Value-Based Payment and Quality Improvement Advisory Committee[14], the Statewide Behavioral Health Coordinating Council's Behavioral Health Workforce Workgroup,[15] the State of Texas Access Reform (STAR) Kids Advisory Committee, and the Palliative Care Interdisciplinary Advisory Council.[16] These recommendations are consistent with actions taken by the 87th Texas Legislature (2021).

In addition to support for teleservices, state leadership has also supported an expansion in broadband access. H.B. 5, 87th Legislature, Regular Session, 2021 creates a state broadband development office and broadband development program that could make a significant contribution toward narrowing the digital divide in Texas, particularly for residents of rural counties.[17]

2. Rural Healthcare Access Barriers and the Role of Teleservices in Addressing Them

Rural Healthcare Access Barriers

Approximately 25.1 million people reside in Texas, more than 3 million, about 12 percent of the population, in rural areas.[d] As of March 2020, 473,000 of these rural residents received healthcare services through the state's Medicaid program. Under Texas Medicaid, managed care organizations (MCOs) operating in 13 service areas (see Appendix A) coordinate and ensure the delivery of necessary care for almost 95 percent of Medicaid beneficiaries. Within each service area, MCOs act with significant flexibility to innovate, but are required to establish adequate networks to deliver necessary primary, specialty, behavioral health, home health, pharmaceutical, and facility-based care and to meet other contractual standards. Ten of the Medicaid service areas include rural members and two-thirds of the state's rural Medicaid beneficiaries reside in the three Medicaid rural service areas (MRSAs), generally encompassing the population and healthcare resources of rural and smaller metro and suburban counties (see Table 1).

[d] 2010 U.S. Census. Rural areas include counties: 1) not designated by the Office of Management and Budget as Metropolitan; or 2) not part of a larger Metropolitan Statistical Area.

Table 1. Texas Medicaid Clients by Service Area and Client County of Residence, March 2020*

Service Area	Rural	Suburban	Urban	Total
MRSA Northeast	142,995	13,578	84,118	240,691
MRSA West	109,255	6,829	91,466	207,550
MRSA Central	58,122	20,328	113,471	191,921
Hidalgo	48,835	-	399,022	447,857
Nueces	30,247	15,650	74,471	120,368
Jefferson	27,920	41,541	42,055	111,516
Lubbock	23,224	13,114	63,026	99,364
Harris	13,229	212,114	681,471	906,814
Travis	9,659	75,301	107,472	192,432
Dallas	9,410	112,175	379,529	501,114
Tarrant	-	97,263	249,002	346,265
El Paso	-	879	152,516	153,395
Bexar	-	53,621	292,620	346,241
Total	**472,896**	**662,393**	**2,730,239**	**3,869,605**

*Clients whose county of residence was unknown were excluded from the table but included in the Grand Total. Therefore, the column and row totals do not sum up to the Grand Total.

Data Source: Healthcare Statistics, 2020 Historical Medicaid Enrollment by County. Retrieved April 7, 2021, from https://hhs.texas.gov/about-hhs/records-statistics/data-statistics/healthcare-statistics.

Prepared by: Value-based Initiatives, HHSC. (2021, April).

Rural residents often encounter barriers to accessing healthcare services, regardless of the type of health insurance they may have.[18] A primary barrier is distance—rural populations are more likely to travel long distances to access healthcare services.[19] According to the Texas Organization of Rural & Community Hospitals, 74 of Texas' 254 counties do not have a hospital, and some parts of Texas are more than 75 miles from the nearest hospital.[20] This can be a significant burden in terms of travel time, cost, and time away from the workplace.[21]

Lack of reliable transportation can be another barrier to healthcare access for rural residents.[22,e] In urban areas, public transit is generally an option for patients to get to medical appointments; however, these transportation services are often unavailable in rural areas. Rural communities often have more elderly residents with chronic conditions that require multiple visits to outpatient healthcare facilities.[23] It can be challenging for them to make it to appointments without available public or private transportation.[24]

Healthcare provider shortages are a third barrier to healthcare access in rural areas—a barrier that has become even harder to surmount during the current PHE.[25] Across the nation, the Health Resources and Services Administration (HRSA) identifies Health Professional Shortage Areas (HPSAs) based on a standard methodology that includes population to provider ratios, percent of the population living below the federal poverty level, travel time to the nearest source of care for residents of the area and other relevant metrics. Of Texas's 172 rural counties:

- 96.5 percent currently are designated as whole county or partial county HPSAs; and
- 100 percent are whole county mental health HPSAs.[26,f]

In addition, 26 rural Texas hospitals have closed (permanently or temporarily) since the beginning of 2010.[27] When hospitals close, rural communities lose access not only to inpatient and emergency care, but to preventive and specialty services as well, as local physicians may relocate out of the impacted region. Experts believe the rural hospital closures stem from a difficult mix of demographic, social, and economic pressures. These underlying trends include high poverty and lower rates of private insurance in rural communities, lower average incomes and loss of population. They have been further exacerbated by shifts in healthcare consumption caused by COVID-19.

Finally, social stigma and privacy concerns are more likely to be healthcare access barriers in rural areas where there is little anonymity.[28] Rural residents can have concerns about seeking care for mental health, substance abuse, sexual health,

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[e] Texas Medicaid's Medical Transportation Program provides non-emergency medical transportation for Medicaid clients who need help going to a healthcare provider for covered health services.

[f] Data do not include facility HPSAs, previously withdrawn or proposed for withdrawal.

pregnancy, or even common chronic illnesses due to unease or privacy concerns.[29] Patients may have healthcare providers or others working in healthcare facilities in their personal social networks or may have apprehensions that friends, family members or co-workers may notice them using services for health conditions that are typically not openly discussed, such as counseling or HIV testing services.[30]

Role of Teleservices in Addressing Rural Healthcare Access Barriers

Expanding the availability of teleservices is a key strategy for addressing rural healthcare access issues, as, in many circumstances, these services can reduce travel and provide more timely care in remote, rural areas.[31] Many rural communities are losing providers and having difficulty recruiting new ones, which makes teleservices an appealing way to augment limited provider resources.[32] Patients do not have to find childcare, transportation, or parking.[33] Providers have found that it can decrease patient no-show rates.[34,35] Increased teleservices may also give providers a better capability to assess a patient's living environment and how it contributes to health outcomes.[36]

Teleservices have become even more critical during the COVID-19 PHE, helping healthcare providers to maximize their community impact and patients to maintain access to care while minimizing the risk of exposure to the virus.

While teleservices present these opportunities, the "digital divide" poses a major challenge to realizing them.[37]

The Digital Divide

The ability to fully benefit from digital services, such as teleservices, largely depends on three factors: 1) a connection to broadband or highspeed internet; 2) routine access to or ownership of hardware technologies, such as audio/visual enabled desktops, laptops, and smartphones and 3) the digital literacy to effectively operate these technologies. The 'digital divide' is the gap between meeting and not meeting these conditions.[38]

Rural residents may be particularly impacted by inequities that exist in access to different forms of broadband technologies. According to a study by the Harvard School of Public Health, 21 percent of Americans living in rural areas reported that access to high-speed internet was a problem for them or their households in 2019.[39] According to Connected Nation Texas, as of December 2020, broadband

internet was available to 96 percent of households (though not all of these households were connected);[g] however, at least 316,700 households remained unserved, about 89 percent of which are rural households.[40] While much of the focus on broadband has been on fixed technologies, such as fiber optic cables, mobile technology is growing in importance as a means for ensuring access to teleservices for rural Texans.

Even where high speed internet is available, individuals may have difficulty connecting due to financial and other reasons. In 2016, for example, only 58 percent of households with an annual income below $25,000 in Texas reported usage of any type of broadband subscriptions.[41] Rural areas, which tend to be lower income than urban and suburban areas, may be disproportionately impacted by the cost of broadband services. People living in rural areas also report lower rates of ownership of computer technology needed to use the internet.[42]

Technology literacy is the ability of an individual to effectively use technology tools to access, manage, integrate, evaluate, create and communicate information. Accessing teleservices requires patients to use the required technology (such as a desktop, laptop or smartphone) to communicate with their provider. According to the US Department of Education, close to 32 million Americans face challenges with technology literacy.[43] Rural areas, with higher populations of older and lower-income residents, may benefit from increased focus on improving technology literacy.

[g] The Federal Communication Commission (FCC) speed benchmark for fixed broadband is a download speed of at least 25 megabits per second (Mbps) and an upload speed of at least 3 Mbps. See Federal Communications Commission "2020 Broadband Deployment Report." Online. Available: https://www.fcc.gov/reports-research/reports/broadband-progress-reports/2020-broadband-deployment-report. Accessed: February 8, 2021.

3. Medicare and Texas Medicaid Teleservices Policy

Rural hospitals are more reliant on Medicare and Medicaid for revenue than are hospitals in urban and suburban population centers. According to data collected through Texas's American Hospital Association Annual Survey, which covers practically all Texas hospitals, Medicare provides the largest share of rural hospitals' net patient revenue, while third-party (commercial) sources are the largest category for urban and suburban hospitals (See Table 2). Moreover, Medicaid also comprises a far greater proportion of rural hospitals' revenue, compared to urban and suburban hospitals (24.5 percent in rural counties versus 17.3 percent in urban and 8.6 percent in suburban counties). Together, Medicare and Medicaid comprise 62.8 percent of Texas rural patient hospitals' net patient revenue. Consequently, Medicare and Medicaid teleservices reimbursement policies are particularly important drivers of teleservice utilization for rural Texas hospitals and likely for other rural providers facing a similar payer mix.

Table 2. Texas Hospital Net Patient Revenue by Payer and County[h], 2019[i]

Payor	Rural	Suburban	Urban	Total
Medicare	38.3%	31.3%	32.2%	32.4%
Medicaid[j]	24.5%	8.6%	17.3%	16.3%
Third Party	31.8%	55.6%	47.7%	48.1%
Self Pay	4.2%	0.7%	0.2%	0.5%
Other	1.3%	3.8%	2.6%	2.8%
Total	100.0%	100.0%	100.0%	100.0%

Data Source: American Hospital Association / Texas Department of State Health Services / Texas Hospital Association. Cooperative Annual Survey of Hospitals. 2019.

Medicare

Existing Policy

Medicare telehealth services are codified in section 1834(m) of the Social Security Act. This statute restricts Medicare coverage of telehealth services to those services provided in certain geographic areas and at certain originating (patient) sites. It also limits Medicare coverage of telehealth services to those rendered by certain types of distant site practitioners and identified on the Medicare Telehealth Services List[k] maintained by CMS as updated through agency notice-and-comment rulemaking.[44] Notably, the statute does not explicitly define "telecommunications system" and instead delegates that authority to CMS. CMS has promulgated

[h] "Urban" includes counties that are home to the largest city, according to population size (as per the 2010 U.S. Census), within a Metropolitan Statistical Area (MSA) designated by the Office of Management and Budget. "Suburban" includes all counties within an MSA that are not home to the largest city in the MSA, with one exception: due to its large population size, Tarrant County, which is part of the Dallas-Fort Worth-Arlington MSA, is classified as an urban county. "Rural" includes all other counties not classified as "urban" or "suburban."

[i] The survey instructions recommend that hospitals report data for the fiscal year they follow. Many hospitals chose to report data for calendar year 2019.

[j] Includes Medicaid supplemental payments.

[k] The Medicare Telehealth Services List is the list of services payable under the Medicare Physician Fee Schedule when furnished via telehealth.

regulations defining "telecommunications system" to mean two-way audio and video communication.[45]

In recent years, Congress authorized exceptions to the section 1834(m) requirements that apply to telehealth in fee-for-service (FFS) Medicare for substance use disorder, end-stage renal disease (ESRD), and stroke care through the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act and Bipartisan Budget Act of 2018, which also allowed additional telehealth benefits in Medicare managed care (Medicare Advantage).[46] In addition, beginning in January 2019, CMS used its regulatory authority to provide for payment for communication technology-based services. These include virtual check-ins (i.e., short patient-initiated communications with a healthcare provider), remote patient monitoring of established patients, e-visits (i.e., non-face-to-face patient-initiated communications through an online patient portal), and tele-consults between professionals.[47,48] The services enabled by the 2019 CMS regulations fall outside of the section 1834(m) definition of Medicare telehealth.

COVID-19 PHE Flexibilities

To increase access to care and help limit community spread of COVID-19 during the PHE, for 1834(m) defined services, CMS temporarily expanded Medicare FFS coverage of telehealth by:

1. Removing geographic and originating site restrictions, allowing for services to be provided to patients in their homes;
2. Removing the restriction on the types of distant site practitioners who could provide telehealth services; including rural health clinics (RHCs);
3. Allowing certain telehealth services to be provided through audio-only communications technology; and
4. Vastly expanding the scope of services that could be provided by telehealth.

Importantly, the HHS Office of Civil Rights (OCR) also indicated that it would not enforce some Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy requirements for video-conferencing during the COVID-19 PHE.[49] Under the notification, healthcare providers are not subject to penalties for violations of HIPPA privacy and security rules that occur in good faith. In its communications, OCR stated that it believes many widely available, non-public facing electronic communication products, such as FaceTime, Skype, and Zoom, include security features to protect patient information.[50] However, providers cannot use public

facing electronic communication platforms (e.g., TikTok, Facebook Live or Twitch) under the notification.

These flexibilities allowed healthcare providers to deliver more services through telehealth. The Medicare telehealth requirements and flexibilities provided during the COVID-19 PHE are summarized in Appendix B.

Several of the Medicare coverage and reimbursement changes that have been implemented during the PHE would require action by the U.S. Congress to become permanent. At the conclusion of the PHE or the end of the calendar year in which the PHE terminates, as applicable, the waivers, interim final rules, and OCR notification will expire, and Medicare coverage and reimbursement for telehealth services will be subject to policies in place prior to the PHE.[51] For example, once the PHE expires, legislative action will be necessary to allow for audio-only communications for Medicare telehealth services and to allow most patients to conveniently receive reimbursable telehealth services in their home rather than at, for instance, a hospital or physician office.[52]

Texas Medicaid

Existing Policy

Teleservices can be delivered through many different modalities, subject to certain conditions.[53] For instance, in telemedicine, a physician-patient relationship must be established prior to providing services through a telemedicine medical service, unless the physician-patient relationship is established pursuant to a call coverage agreement, or established using an audio and visual modality.[54] Additionally, any telemedicine or telehealth services must comply with the same standard of care required for a corresponding in-person healthcare service.[55] Notably, "mental health services" are not subject to either of these conditions and may be provided in a manner that complies with HHSC's and the Texas Medical Board's policies.[56]

Additional terms associated with the reimbursement of teleservices by the Texas Medicaid program are also defined in Texas statute. The location where the health professional rendering the teleservice is referred to as the distant site.[57] The location where the Medicaid client is located while receiving the teleservice is referred to as the patient site.[58]

Texas statute requires HHSC to encourage healthcare providers and healthcare facilities to provide teleservices.[59] In both Texas Medicaid FFS and managed care,

teleservices are benefits for clients of any age. The Medicaid FFS teleservice benefits are specified in the Telecommunication Services Handbook of the Texas Medicaid Provider Procedures Manual (TMPPM).[60] Appendices C and D provide a summary of the existing Medicaid FFS teleservices reimbursement policy.

Services covered under the existing Texas Medicaid FFS policy include, but are not limited to, evaluation and management services, psychiatric diagnostic evaluations, psychotherapy and occupational and speech therapies in school-based settings.[61] A range of places of service are permissible for both the distant site and patient site, including the use of the patient's home as a patient site. All benefit limitations and prior authorization requirements are the same for teleservices as for similar in-person services.

Differences exist between the Medicaid FFS and managed care policies for teleservices. Following the passage of Senate Bill 1107 (85th Legislature, Regular Session, 2017), MCOs were permitted to set their own approval processes before a provider can receive reimbursement for providing teleservices.[62] Building on Senate Bill 1107, the 86th Texas Legislature passed Senate Bill 670 (2019), which allowed Medicaid MCOs to set their own reimbursement policies and gave additional direction in how an MCO should craft their teleservice benefits. Statutory language added by the bill prohibited Medicaid MCOs from denying claims for services covered by Medicaid solely because they were delivered remotely as teleservices or based on the provider's choice of platform.[63] Medicaid MCOs are directed to use clinical and cost-effectiveness, among other factors, in determining which services to cover as teleservices. The Telecommunication Services Handbook of the TMPPM was updated to provide general guidelines to Medicaid MCOs on coverage of teleservices.[64]

COVID-19 PHE Flexibilities

To ensure safety and continuity of care during the COVID-19 PHE, HHSC has expanded Texas Medicaid coverage of teleservices. These flexibilities, listed below, are comprehensive, covering acute care, behavioral health, and long-term services and supports (LTSS) and apply to both MCO functions (such as service coordination) and provider services, so long as they are delivered in accordance with the healthcare provider's licensure:

- The following services may be delivered by telephone (audio-only)[l]:
  - Certain behavioral health services;
  - Medical (physician delivered) evaluation and management services;
  - Early Childhood Intervention (ECI)[m] specialized skills training;
  - Nutritional counseling services;
  - Determination of Intellectual Disability Assessments
  - Supportive employment assistance
  - Community Attendant Services (CAS) case manager visits
- The following services may be delivered by audio-video:
  - School Health and Related Services (SHARS);
  - Physical therapy;
  - Occupational and speech therapy delivered to Medicaid clients who are not also enrolled in ECI outside of a school-based setting[n];
  - Certain components of Texas Health Steps checkups;
  - Rural health clinic (RHC) services; and
  - Federally Qualified Health Center (FQHC) services.[o]

HHSC has encouraged Medicaid MCOs to take advantage of these flexibilities, including the provision of teleservices to members in their homes. HHSC also implemented new telephonic procedure codes for use during the PHE.[p]

Appendices C and D provide a full summary of Medicaid teleservices related reimbursement policy during the COVID-19 PHE for acute care and LTSS.

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[l] These services may also be delivered by audio-video except for the telephonic procedure codes 99441-99443.

[m] Medicaid covers ECI services identified in an Individualized Family Service Plan for children eligible for both ECI and Medicaid.

[n] Under existing FFS Medicaid policy, occupational and speech therapy are covered when provided to clients in a school-based setting or to clients also enrolled in ECI in any setting.

[o] Reimbursement for FQHC telemedicine and telehealth services became permanent Texas Medicaid FFS policy effective December 1, 2020.

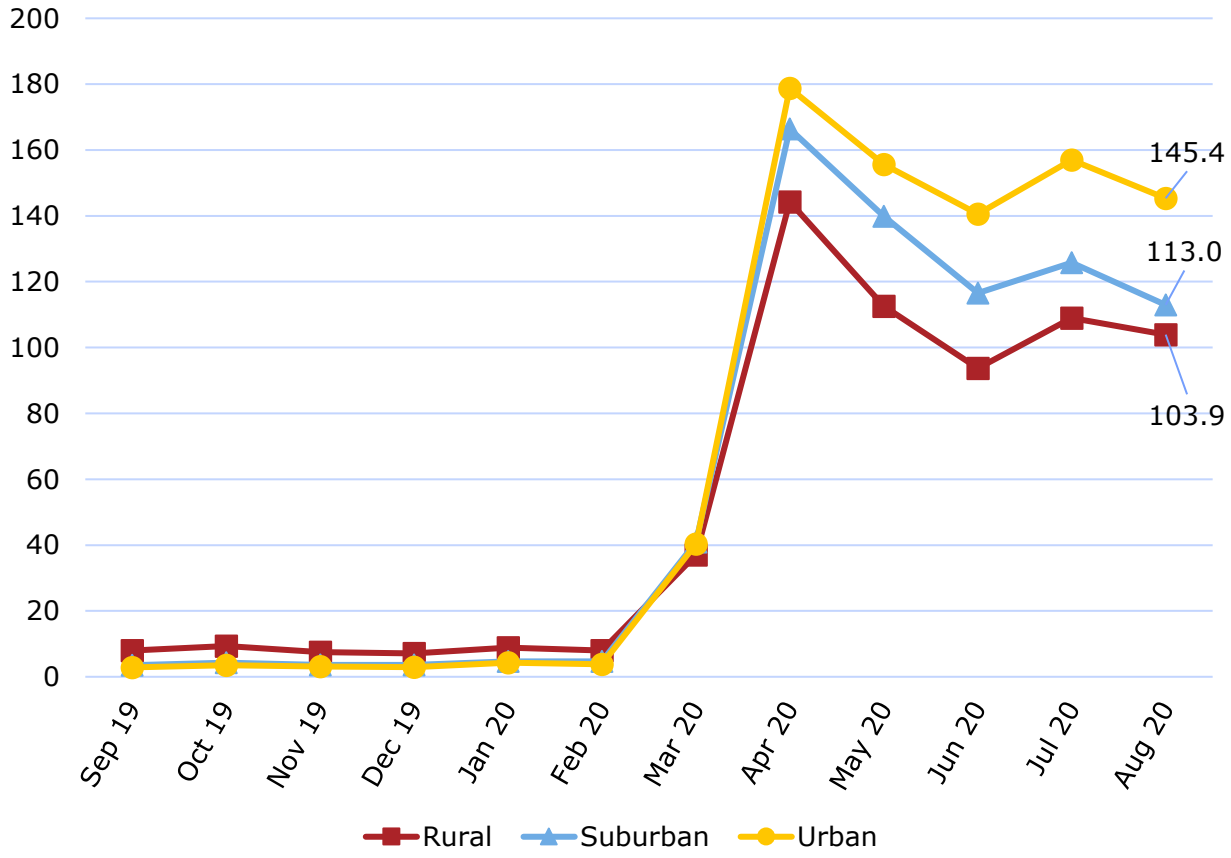
[p] HHSC authorized certain types of providers to bill codes 99201-99205 and 99211-99215 for telephone (audio-only) medical (physician delivered) evaluation and management services. However, providers authorized to bill these codes are not required to bill them; they have the option to use the standard allowable procedure code with a teleservices modifier (95). Therefore, at this time, HHSC cannot always distinguish audio-only from audio-visual services in its claims/encounter data.

4. Recent Trends in Rural Texas Teleservice Utilization

The COVID-19 PHE changed the landscape of teleservices use in Texas and revealed the potential of these technologies to help maintain and enhance patient access to care. Prior to the PHE, state and Medicaid policy and practice primarily focused on connecting patients living in areas with shortages of behavioral health and specialized healthcare resources to qualified providers located in other areas of the state. With the onset of the PHE and associated policy flexibilities, teleservices quickly emerged as a modality for delivering additional types of care and connecting patients to providers both within and outside of their local area. An analysis of Texas Medicaid teleservices data over the past fiscal year, a period split almost exactly in half by the PHE (Pre PHE: September 2019 – February 2020; PHE: March – August 2020) shows the extent of this change in healthcare delivery. Prior to March 2020, utilization rates of teleservices, though somewhat higher in rural areas, remained steady for urban, rural, and suburban regions alike at what now would be considered a very low level. However, with the onset of the PHE, teleservices utilization in Texas rose at an unprecedented rate (see Figure 1). Overall, the total number of teleservices provided to Texas Medicaid clients increased by 3,410 percent in the second half of SFY 2020, after the onset of the PHE.[q]

[q] Note: While this section mainly focuses on trends in acute care healthcare services for which historic teleservices data are available, the PHE also has led to significant increases in teleservices use to support LTSS. For example, between March – August 2020, about half of all assessments for determination of intellectual disability (DID) were performed using audio or audio-visual technology. These technologies were not generally used for DID assessments prior to the PHE. Assessments with components that are not amenable to teleservices continue to be conducted in-person.

Figure 1. Texas Medicaid Teleservices per 1,000 Clients by Month and Client County of Residence in SFY 2020



Data source: Medicaid CHIP Data Analytics (MCDA) Analytical Data Store (ADS), TMHP. Data provided by: MCDA, Center for Analytics and Decision Support, HHSC. (2021, April). Additional analysis conducted by Value-based Initiatives, HHSC. (2021, April).

Though this expansion was rapid, it was not uniform. As Figure 1 also shows, and as confirmed by an independent study by the Institute for Child Health Policy, the

Texas Medicaid external quality review organization (EQRO), teleservices use peaked in rural areas at a much lower level than in urban areas.[r,65,s,t]

Teleservice Utilization and Broadband Access

One, though not the only, explanation for geographic variation in the use of teleservices during the PHE may be differing levels of broadband access.[u] A key finding in the EQRO's report was that teleservice use varied by MCO and service delivery area (SDA), likely due in part to geographic differences in resources that facilitate teleservices uptake.[66] The EQRO recommended that HHSC investigate SDA-level barriers in access to resources that facilitate teleservices, such as broadband internet.[67]

To follow up on this finding, HHSC analyzed Medicaid utilization data to better understand the impact of broadband availability on access to teleservices. According to the Federal Communications Commission, to meet the standard for broadband, an internet connection should operate with a minimum download speed of 25 Megabits per second (Mbps) with an upload speed of at least three Mbps (25x3 Mbps).[68] Table 3 divides the number of Texas counties into three groups based on the availability of broadband internet access using estimates from Connected Nation Texas in July 2020.[69] The table shows that while a majority of rural Texas enjoys a high level of broadband service, roughly 40 percent of counties still do not have access that is equitable to levels found in nearly all urban and suburban counties.

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[r] The EQRO used a different definition of "Rurality" compared to the previous mention of the term. The use of "rural" by the EQRO refers to counties with a population size of 49,999 or less whereas throughout this report it refers to counties not designated by the Office of Management and Budget (OMB) as metropolitan, or that are not part of a federally delineated metropolitan statistical area (MSA).

[s] This study considered "teleservices" to include telemedicine, telehealth, and telemonitoring.

[t] The study was of adults and children (without dual Medicare eligibility) continuously enrolled in the same Medicaid STAR or STAR+PLUS MCO between October 1, 2019 and July 31, 2020.

[u] Other important explanations include regional differences in COVID-19 infection rates, the availability of physicians and other providers offering teleservices to a region, and other factors related to the "digital divide".

Table 3. Number of Texas Counties by Level of Broadband Access* as of July 2020

	Low	Medium	High	Total
Rural	36	36	100	172
Suburban	4	7	45	56
Urban	0	0	26	26
Total	40	43	171	254

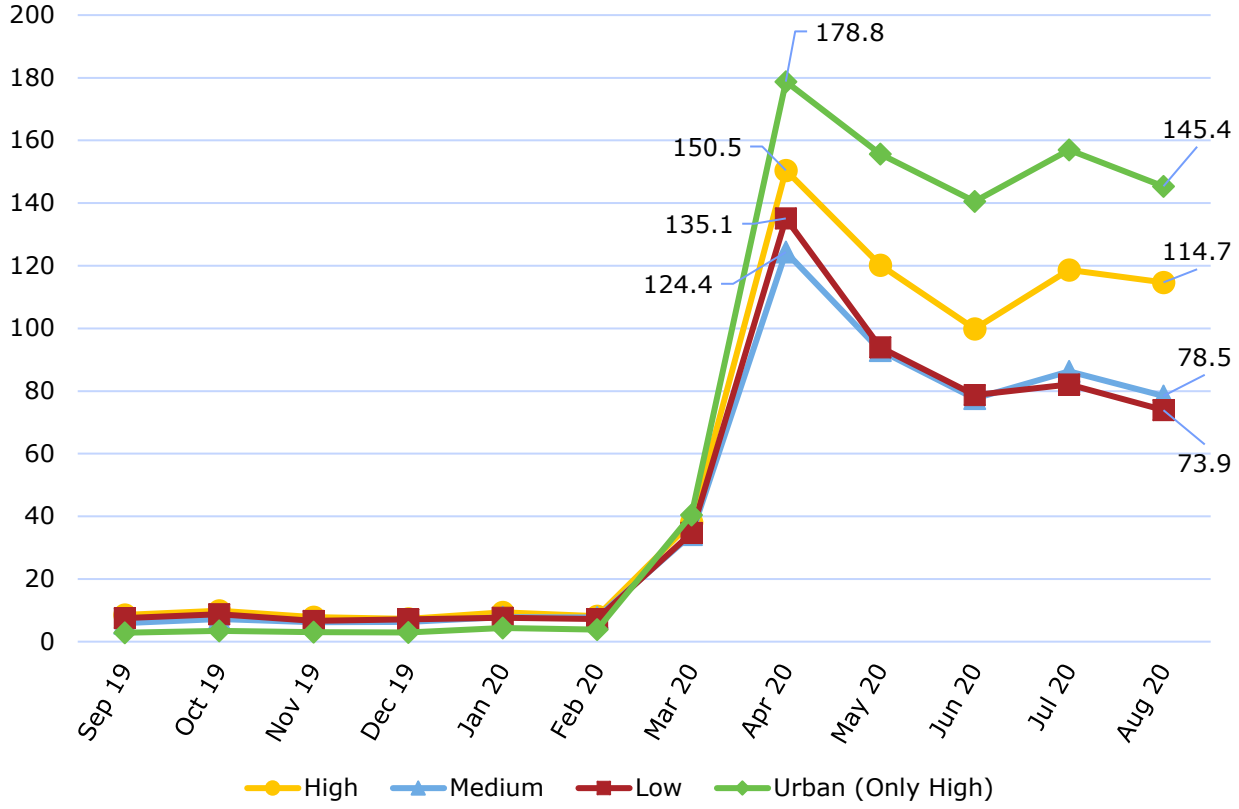
*Broadband access categories are based on the distribution of percentages of households in each Texas county with 25x3 Mbps internet speeds. These percentages are estimated biannually by Connected Nation Texas. This table uses the July 31, 2020 update. For this report, low access is defined as less than 60% of county households having access to 25x3 Mbps internet speeds. Medium access is defined as 60%-79% with access. High access is defined as 80% or higher.

Data source: Connected Nation Texas. (2020, July).

Additional analysis conducted by Value-based Initiatives, HHSC. (2021, April).

As Figure 2 indicates, throughout the PHE, rural counties with higher levels of broadband access also had higher teleservices utilization. Rural areas with better access to broadband achieved levels of teleservices utilization about halfway between urban centers and rural counties. While this utilization pattern suggests a possible relationship between broadband access and the capacity of an area to fully use teleservices, additional study is warranted. As the Governor's Broadband Development Council states in their 2020 report, broadband access and broadband subscription remain two distinct measures. A Medicaid client may have access to broadband internet but might not purchase a subscription.[70] Further, some increase in Medicaid teleservices utilization during the COVID-19 PHE was via telephone only and did not require internet enabled technology. Finally, during COVID-19, the association between access to broadband internet and teleservices use may have been impacted by the availability of providers that historically serve a particular area, especially in the early months of the PHE.

Figure 2. Texas Medicaid Teleservices per 1,000 Clients Living in Rural Counties vs. Urban Counties by Month and Broadband Access Category*



Data sources: Medicaid CHIP Data Analytics (MCDA) Analytical Data Store (ADS), TMHP, and Connected Nation Texas (2020, July).

Data provided by: MCDA, Center for Analytics and Decision Support, HHSC. (2021, April). Additional analysis conducted by: Value-based Initiatives, HHSC. (2021, April).

Teleservice Utilization Across Provider Types

One enduring impact from the COVID-19 PHE will be the sheer number of providers who gained experience incorporating teleservices into their practice. Statewide, compared to the first six months of state fiscal year 2020, during the PHE nearly 11,000 additional providers served Medicaid beneficiaries using teleservices, with about 5,000 of this group providing a teleservice to a rural resident. As Table 4 and Appendix E show, the increase was far-reaching, encompassing providers in many

specialties.[v] This trend was likely due to many reasons, including but not limited to provider and patient preferences during the PHE, new flexibilities enacted at the state and federal level, changes to the enforcement of HIPAA regulations by OCR, and investments in teleservice infrastructure made by MCOs and providers prior to and during the PHE. Though gains were significant for specialty providers, primary care physicians, clinics and group practices saw the biggest increases in teleservices use. Home health agency teleservices use also rose substantially as many in-home therapy services moved to remote delivery. Similarly, the data by service type show robust increases for a wide swath of non-facility services, including office visits for physical and mental health and therapies (see Appendix F).

Table 4. Teleservices Provided by Select Provider Types by Client County of Residence in SFY 2020

Provider Type (PT)	PT Code	Client County	Pre-COVID-19*	During COVID-19**	Difference	Percent Change (%)
Clinic/ Group Practice	22	Rural	22,459	149,611	127,152	566
		Suburban	13,400	250,559	237,159	1,770
		Urban	42,423	1,161,333	1,118,910	2,638
		Total	**78,282**	**1,561,503**	**1,483,221**	**1,895**
Home Health Agency	44	Rural	0	16,533	16,533	-
		Suburban	0	62,889	62,889	-
		Urban	20	313,945	313,925	1,569,625
		Total	**20**	**393,367**	**393,347**	**1,966,735**
FQHC	46	Rural	117	21,529	21,412	18,301
		Suburban	810	45,487	44,677	5,516
		Urban	241	161,607	161,366	66,957
		Total	**1,168**	**228,623**	**227,455**	**19,474**
Physician (PCP)* **	19, 20	Rural	132	5,597	5,465	4,140

[v] Appendix E provides a more detailed breakout of teleservices by provider type during SFY 2020.

Provider Type (PT)	PT Code	Client County	Pre-COVID-19*	During COVID-19**	Difference	Percent Change (%)
		Suburban	143	10,066	9,923	6,939
		Urban	467	60,469	60.002	12,848
		Total	**742**	**76,132**	**75,390**	**10,160**
Physician (Specialist)****	19, 20	Rural	155	5,547	5,392	3,479
		Suburban	732	5,553	4,821	659
		Urban	1,638	27,331	27,331	1,669
		Total	**2,525**	**40,069**	**37,544**	**1,487**
RHC	78, 79	Rural	118	19,119	19,001	16,103
		Suburban	1	5,164	5,163	516,300
		Urban	7	2,227	2,220	31,714
		Total	**126**	**26,510**	**26,384**	**20,940**

*Pre-COVID-19 is defined as September 1, 2019 through February 29, 2020.

**During COVID-19 is defined as March 1, 2020 through August 31, 2020.

***Physician (PCP) includes providers enrolled under PT 19 or 20 and a Specialty Code of 8 (Family Practice/ General Practice), 11 (Internal Medicine), 15 (Obstetrics/ Gynecology), or 37 (Pediatrics).

****Physician (Specialist) includes providers enrolled under PT 19 or 20 and a Specialty Code other than 8, 11, 15, or 37.

Data source: Medicaid CHIP Data Analytics (MCDA) Analytical Data Store (ADS), TMHP.

Data provided by: MCDA, Center for Analytics and Decision Support, HHSC (2021, April).

Additional analysis conducted by: Value-based Initiatives, HHSC. (2021, April).

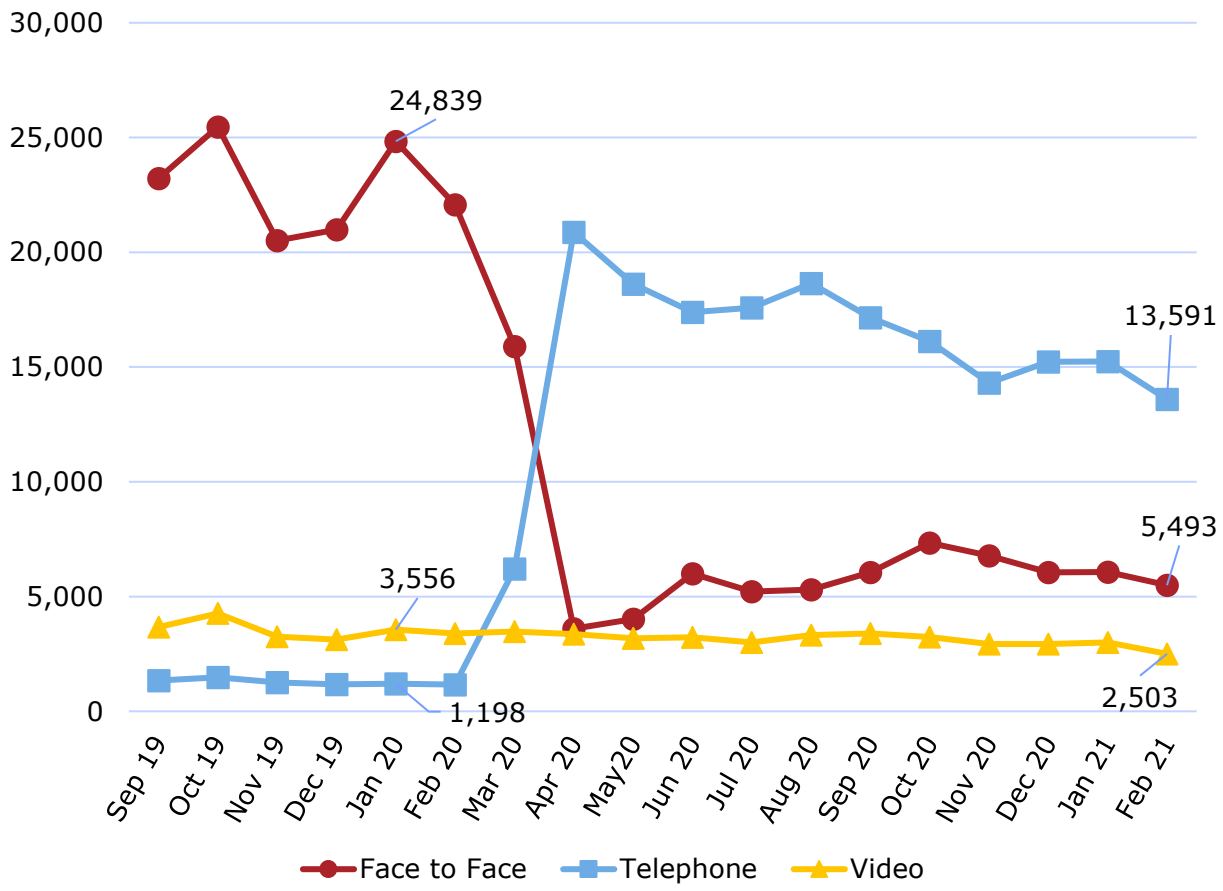
Telephone (Audio-only) Services

Face to face encounters for rural, urban and suburban Medicaid beneficiaries at local mental health authorities (LMHAs) and local behavioral health authorities (LBHAs) dropped by as much as 85 percent at the onset of the COVID-19 PHE. To counter this decline, HHSC began allowing reimbursement for telephonic or audio only services.[w] As a result, in terms of volume, audio only LMHA and LBHA

[w] Note: Unlike some other services, HHSC is able to reliably distinguish audio only from audio-visual services in its LMHA and LBHA data.

encounters filled much of the access gap caused by the PHE, including for rural residents (see Figure 3). During this same time, more traditional audio/visual teleservice encounters remained unchanged. The same pattern of utilization also held for urban and suburban counties. While study is needed to assess the quality of audio only services, access to crucial mental health services for Medicaid and indigent populations could have been severely limited during the PHE without swift adoption of this flexibility.

Figure 3. Total Medicaid Encounters at LMHAs from Clients in Rural Counties by Month and Encounter Type



Data provided by: Office of Decision Support (ODS) Data Services, HHSC. (2021, April).

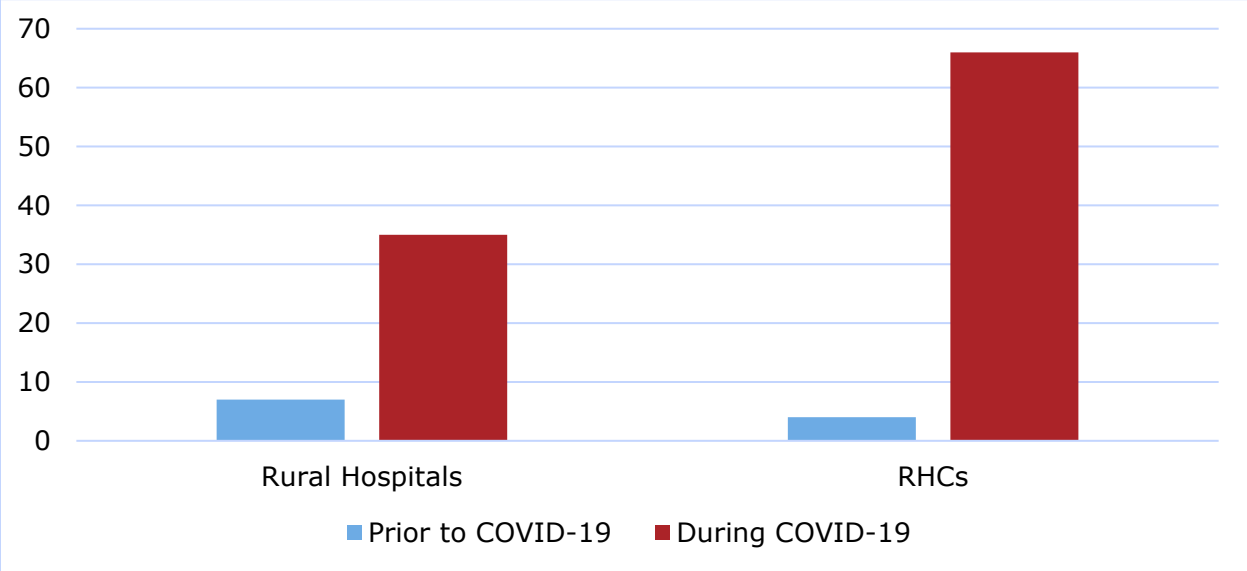
HHSC Rural Hospital and Rural Health Clinic (RHC) Teleservices Survey

In September 2020, HHSC surveyed Texas rural hospitals and RHCs to assess their participation in teleservices both prior to, and during, the COVID-19 PHE, as well as barriers to their participation in these services. For full details on the survey and complete survey results, see Appendix G.

The survey found significant increases in the numbers of rural hospitals and RHCs providing teleservices during the COVID-19 PHE (see Figure 4) compared to the pre PHE time period. These increases are likely due in large part to:

- FFS Medicare allowing for the provision of teleservices to patients in their homes during the COVID-19 PHE.
- FFS Medicare and Texas Medicaid allowing for the provision of certain audio-only services during the COVID-19 PHE.
- FFS Medicare and Texas Medicaid allowing RHCs to provide teleservices during the COVID-19 PHE.

Figure 4. Rural Hospitals and RHCs Providing Teleservices prior to COVID-19 and during COVID-19



Other key findings include:

- *Increased number providing services to patients in their homes/residences.* The number of rural hospitals providing teleservices to patients in their

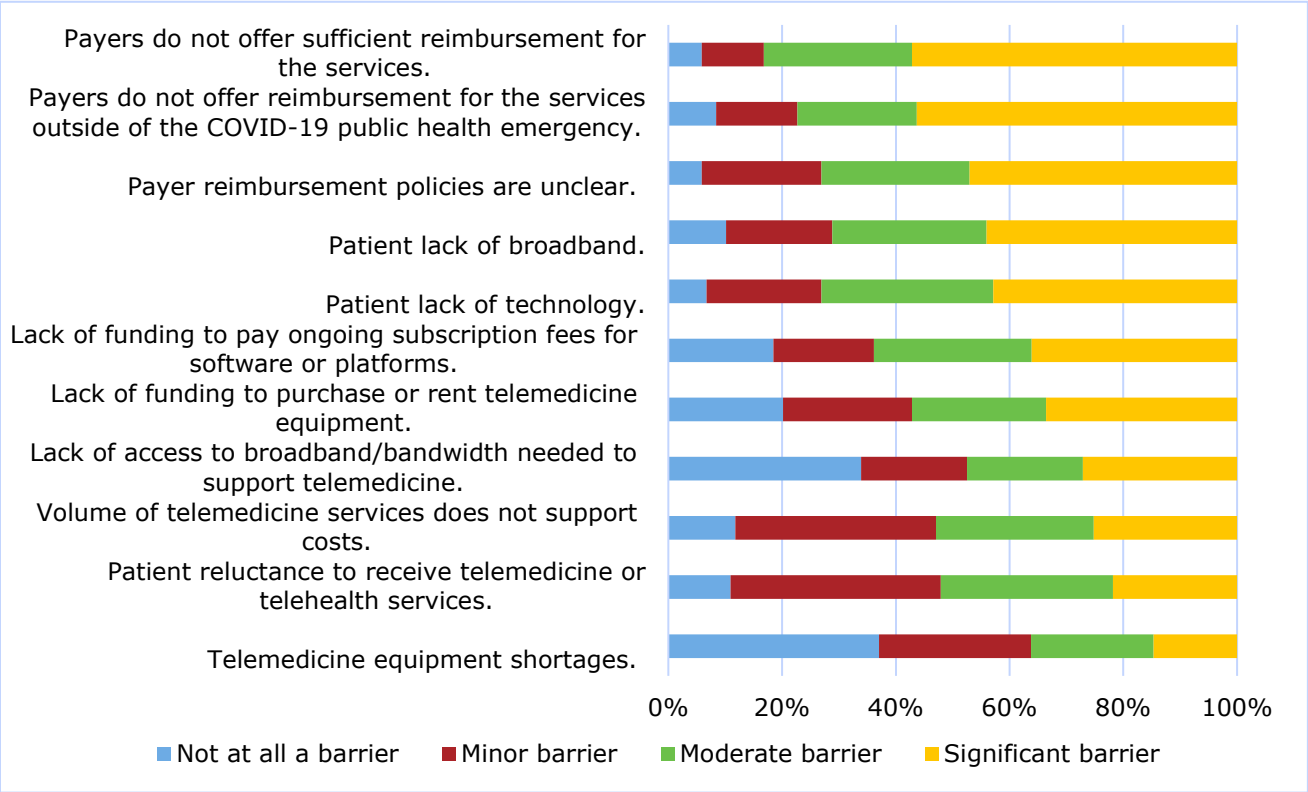
homes increased significantly during the COVID-19 PHE. Similarly, RHCs provided a significant volume of services to patients in their homes and at nursing facilities. These increases were enabled by federal and state flexibilities that allowed RHCs to provide teleservices and that facilitated the provision of teleservices in the patient's home.

- *Modalities used.* Audio-visual technology has been the dominant teleservice modality used by rural hospitals and RHCs during the PHE, though high use of audio-only technology was also reported.
- *Types of services provided.* Rural hospitals and RHCs are primarily using teleservices during the COVID-19 PHE to provide primary and mental healthcare. The most common types of teleservices in which rural hospitals are participating during COVID-19 are family medicine and psychiatry. The most common types of teleservices in which RHCs are participating are family medicine, pediatrics, and geriatrics.

Barriers and Flexibilities Influencing Rural Hospital and RHC Participation in Teleservices

Figure 5 shows that the most significant barriers reported by rural hospitals and RHCs regarding participation in teleservices generally involve issues related to provider reimbursement and patients' lack of broadband and other technology.

Figure 5. Most Significant Barriers to Rural Hospitals' and RHCs' Participation in Teleservices



The survey also assessed which COVID-19 Medicare FFS and Texas Medicaid medical policy flexibilities rural hospitals and RHCs found to be most helpful during the COVID-19 pandemic. While a significant percentage of survey respondents reported that all of the flexibilities had been helpful, the leading categories reported as most helpful include:

- FFS Medicare allowing patients to receive teleservices in their home/residence.
- FFS Medicare allowing teleservice videoconference visits to be delivered via smartphone.
- FFS Medicare and Texas Medicaid allowing RHCs to provide teleservices.

5. Strategies for Facilitating Teleservices in Rural Texas

Texas is moving forward on opportunities to improve teleservices, some previously planned and others becoming apparent through the state's COVID-19 PHE response. Generally, these statutory and regulatory changes and other initiatives will support telehealth practitioners and users across the entire state, including rural areas. This assessment identifies the key initiatives to promote appropriate and enhanced use of teleservices.

Making Certain Texas Medicaid COVID-19 Teleservice Flexibilities Permanent

Building on a succession of previous legislation that provided the foundation for the expansion of teleservices in the Texas Medicaid program, H.B. 4, passed by the 87th Legislature in 2021 directs HHSC to make permanent many COVID-19 Texas Medicaid teleservice policy flexibilities, including, but not limited to, recognizing RHCs as a reimbursable distant site provider, expanding the types of services Medicaid MCOs may provide through teleservices, allowing MCOs to conduct certain assessment and care coordination activities via teleservices, and allowing for the provision of telephone (audio-only) behavioral health services.[71]

HHSC is already assessing options for continuing COVID-19 Texas Medicaid teleservice policy flexibilities. The agency's evidence-based medical benefit review process includes consideration of clinical literature; practice recommendations from academies, colleges, and professional associations; coverage determinations by other State Medicaid Agencies, and state licensure requirements. The process will incorporate direction from the 87th Legislature.

Making Certain Medicare COVID-19 Telehealth Flexibilities Permanent

Supportive federal action also has played a key role facilitating states to expand teleservices during the PHE. For example, over 80 percent of rural hospital and RHC survey respondents rated FFS Medicare's decision to allow patients to receive teleservices in their homes as significantly helpful for their participation in

teleservices. A high percentage of survey respondents also indicated that FFS Medicare permitting some services to be delivered via telephone was helpful. After the PHE, CMS may have the authority to make permanent some of the flexibilities that rural hospitals and RHCs indicated have been helpful to their participation in telemedicine and telehealth services, such as CMS guidance interpreting "telecommunications system" to include an audio-only telephone call (after an initial face-to-face visit or in other circumstances) for some services provided as a telehealth service.

Modifying Audio-Only Medicaid Teleservice Billing Requirements to Capture Data on Audio-Only Service Provision

To respond quickly to the need for audio-only services during the COVID-19 PHE, HHSC authorized providers to bill Texas Medicaid for the provision of audio-only services the same way they bill for the provision of services via televideo—by using the established procedure code with the appropriate (95) modifier. HHSC also gave certain types of providers the option to bill telephonic procedure codes directly. To follow up on actions by the 87th Legislature, HHSC plans to revise Texas Medicaid billing requirements, develop medical policy for the appropriate use of audio-only services, and ensure that adequate data is collected on audio-only services to inform future policymaking.

Implementing Directed Payment Programs with a Teleservice Component

Directed payment programs are authorized under 42 CFR 438.6(c)(1)(i) through (iii), which details ways states may set parameters for Medicaid managed care spending to achieve goals for delivery system and payment reform, as well as improved performance. Specifically, it allows Medicaid MCOs to make payments to healthcare providers at the direction of the Medicaid agency when the payments support specific Medicaid program goals and objectives.

HHSC has recently requested CMS approval to implement directed payment programs as part of the DSRIP transition. Some of these programs have a teleservice component. These programs and their teleservice components are described below.

Rural Access to Primary and Preventive Services (RAPPS)

The RAPPS program is a directed payment program for RHCs that incentivizes primary and preventive services for persons in rural areas of the state enrolled in the STAR, STAR+PLUS and STAR Kids Medicaid managed care programs. RAPPS focuses on the management of chronic conditions and is comprised of two payment components:

- Component 1 is a monthly prospective uniform dollar increase paid to all participating RHCs to promote improvement activities with a focus on access to primary and preventive care services. Providers report semi-annually on certain structure measures, including telemedicine/telehealth capabilities.
- Component 2 is a uniform percent rate increase for certain services. Providers report their progress on process measures for preventive care and screening and management of chronic conditions.

Component 1 requires participating RHCs to report twice per year on the status of, or progress on, certain structure measures. One of these structure measures is "Telehealth to provide virtual medical appointments with a primary care or specialty care provider."

Directed Payment Program for Behavioral Health Services (DPP BHS)

The DPP BHS incentivizes the Certified Community Behavioral Health Clinic (CCBHC) model of care for persons enrolled in the STAR, STAR+PLUS and STAR Kids Medicaid managed care programs. Eligible providers include community mental health centers (CMHCs).

The CCBHC model provides a comprehensive range of evidence-based mental health and substance use disorder services with an emphasis on offering 24-hour crisis care, care coordination with local primary care and hospital providers, and integration with physical healthcare. DPP BHS is comprised of two payment components:

- Component 1 pays a monthly uniform dollar increase paid to all participating CMHCs. CMHCs must report their progress towards gaining or maintaining certification for the CCBHC model and other activities foundational to quality improvement, such as telehealth services.

- Component 2 is a uniform percent increase applied to certain CCBHC services based on achieving quality metrics that align with the model's measures and goals.

Component 1 requires participating CMHCs to report twice per year on the status of, or progress on, certain structure measures. One of these structure measures is "Provide patients with services by using remote technology including audio/video, client portals and apps for the provision of services such as telehealth, assessment collection and remote health monitoring/screening."

Texas Incentives for Physicians and Professional Services (TIPPS)

TIPPS is a value-based directed payment program for certain physician groups providing healthcare services to persons enrolled in the STAR, STAR+PLUS, and STAR Kids Medicaid programs. Eligible physician groups include health-related institution physician groups, physician groups affiliated with hospitals that receive indirect medical education funding and other physician groups. These classifications allow HHSC to direct reimbursement increases where they are most needed and to align with the quality goals of the program.

TIPPS payments are paid to MCOs through three components in their capitation rates and distributed to eligible physician groups based on each physician group meeting performance requirements:

- Component 1 is a monthly performance incentive payment based upon the implementation of quality improvement activities, including telemedicine/ telehealth.
- Component 2 is a semi-annual performance incentive payment based on the achievement of quality metrics focused on primary care and chronic care. Health-related institutions and indirect medical education physician groups are the only classes eligible for Components 1 and 2.
- Component 3 is a uniform rate increase on paid claims for certain outpatient services based on the achievement of quality metrics that measure aspects of maternal health, chronic care, behavioral health, and social determinants of health. All participating physician groups are eligible for Component 3.

Component 1 requires participating physician practices to report twice per year on the status of, or progress on, certain structure measures. One of these structure measures is "Telehealth to provide virtual medical appointments and/or consultations for specialty services, including both physical health and behavioral health services."

Applying for Federal Community Health Access and Rural Transformation (CHART) Model Funding

In August 2020, CMS announced a cooperative agreement funding opportunity called the CHART Model.[72] The CHART Model is a voluntary payment model for rural communities to test healthcare transformation supported by payment reform. It includes two tracks: Community Transformation Track and Accountable Care Organization Transformation Track. The CHART Model Community Transformation Track will test whether aligned financial incentives, increased operational flexibility, and robust technical support can assist rural providers to implement an effective redesign of their health care delivery system. The CMS Innovation Center will evaluate the impact of the CHART Model on Medicare and Medicaid expenditures, access to care, quality of care, and health outcomes.

Under the Community Transformation Track, CMS will award funding of up to $5 million to a maximum of 15 lead organizations that will represent a group of rural hospitals in a single county or census tract or a set of contiguous or non-contiguous counties or census tracts. The lead organizations will be responsible for ensuring compliance with CHART Model requirements and driving delivery system redesign with participant rural hospitals. Fourteen potential participant hospitals in 13 rural Texas counties and federal census tracts have submitted a nonbinding letter of intent in support of HHSC's application.

Of the $5 million cooperative agreement funding to be awarded, up to $2 million may be made available upfront.[73] Participant hospitals will receive a monthly Medicare capitated payment amount in the form of a prospectively set annual payment that will provide rural hospitals with a stable revenue stream and create incentives to reduce both fixed costs and avoidable utilization.[74] If awarded the funding, HHSC plans to pass through some of the cooperative agreement funding to participating hospitals for a telemedicine/telehealth project

HHSC submitted its application to CMS as the Texas lead organization in May 2021. Additional information about HHSC's CHART Model application can be found on the HHSC website.

Improving Broadband Access in Rural Texas Communities

H.B. 5, 87th Legislature, Regular Session, 2021 will help to close the digital divide in Texas by increasing access to affordable broadband service. The new legislation establishes a broadband development office in Texas to:

- Serve as a resource for information regarding broadband service in Texas.
- Engage in outreach to communities regarding the expansion, adoption, and affordability of broadband service and the programs administered by the broadband office.
- Serve as an information clearinghouse to help local entities engage with federal programs that provide assistance and resources for broadband service.

H.B. 5 also requires the broadband office to establish a program to award grants, low-interest loans, and other financial incentives to applicants for the purpose of expanding access to and adoption of broadband service in designated areas determined to be eligible. In addition, it would require the broadband office to prepare, update and publish a state broadband plan that establishes long-term goals for greater access to and adoption of affordable broadband service in Texas.

Developing Evidence on Teleservices' Value

Further analysis of Medicaid teleservices data generated during the COVID-19 PHE is warranted. This recent utilization has had a fundamentally different character than in the past. Some of the largest expansion involves the extension of teleservices into new service areas, such as primary care, in-home therapies and assessments for LTSS. The PHE also brought an increase in the use of paid audio-only services to support core behavioral and some physical healthcare services. To date, related analyses, like those included in this report, have looked mainly at access and disparities in access to these services. For the future, the state has an opportunity to leverage the considerable amount of data from this period to better understand the impact of teleservices on the value (quality and cost) of healthcare. These analyses will need to account for many confounding factors linked to the PHE, but Texas has developed advanced analytical capabilities within its HHS

agencies as well as strong relationships with its EQRO and other academic research institutions in Texas and across the nation from which to draw expertise.[x]

[x] For an example of a recent academic partnership to study teleservices, see Appendix E (conducted by Texas A&M) of HHSC's biennial report to the Texas Legislature, "Telemedicine, Telehealth, and Home Telemonitoring Services in Texas Medicaid," (December 2020): https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/sb-789-telemedicine-telehealth-hts-medicaid-dec-2020.pdf.

6. Conclusion

Teleservices have proved an invaluable tool for sustaining access to healthcare during the COVID-19 PHE. When the pandemic began, Medicaid MCOs, providers, and policymakers affected a rapid transformation of prevailing models of care to accommodate remote service delivery. These swift actions helped avert an even deeper public health crisis and served to protect the health of many Texans. With the passage of H.B. 4, state policymakers have taken another step to ensure that the benefits from the expansion of teleservices endure long after the PHE subsides.

Rural areas have benefited from this expansion of teleservices. During the PHE, rural county residents have used remote services to receive care from primary, specialty, rural health clinics, therapy, and other providers. Evidence available through this report and other analyses suggests that many rural counties enjoy relatively good levels of access to teleservices. However, meaningful pockets of rural Texas still lack connectivity to broadband internet and face other challenges to the full utilization of digital technologies. Texas policymakers have taken proactive steps to address this digital divide through H.B. 5 and the creation of a new state broadband development office and broadband development program.

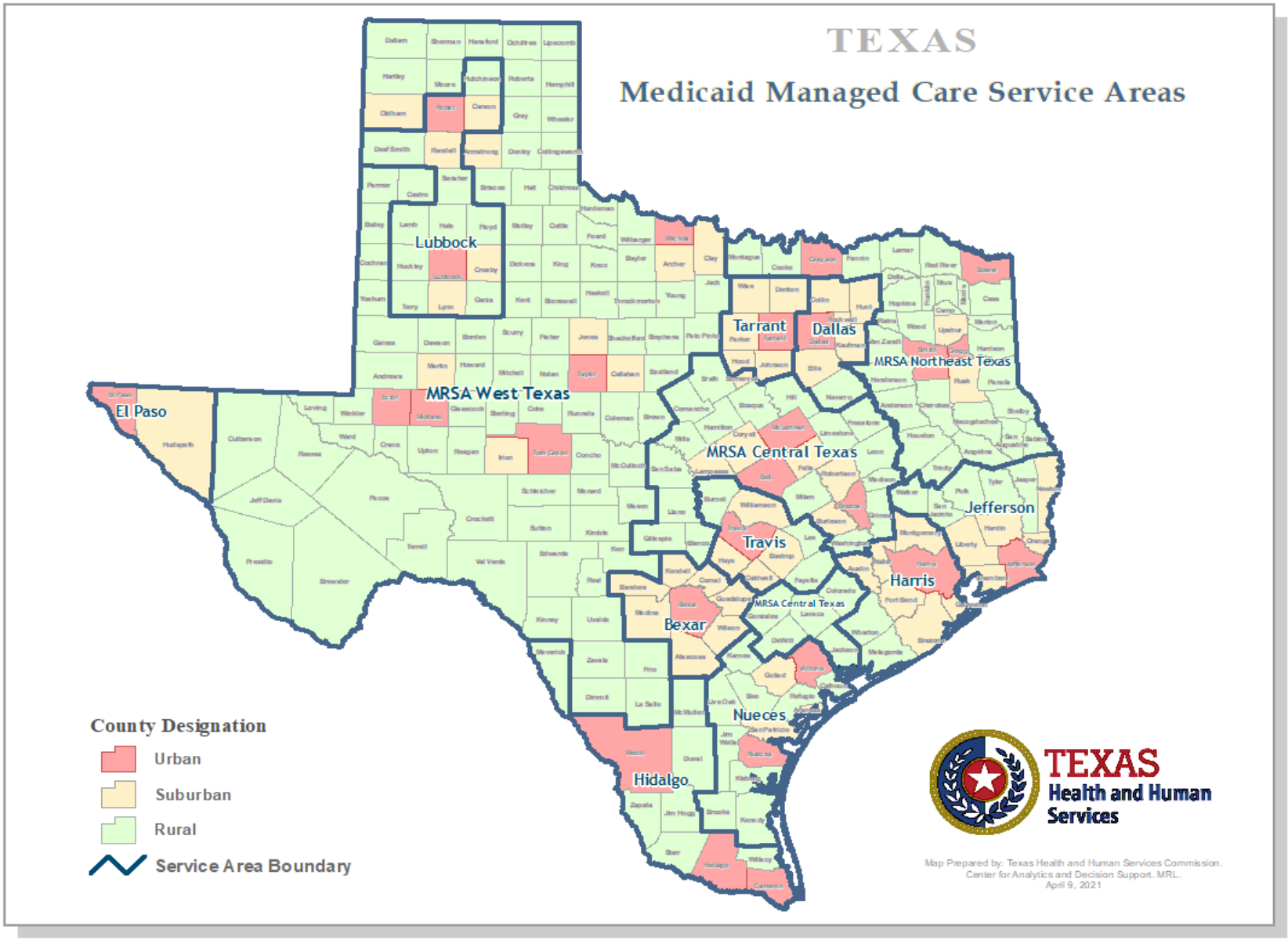
The experience gained during the PHE will likely help to catalyze continued adoption of teleservices by providers and patients in the future. As a permanent feature of the healthcare landscape, enhanced use of teleservices offers some advantages over traditional practice. As discussed previously, in some circumstances, compared to office-based visits, teleservices may enhance a provider's ability to assess a patient's living environment and how it contributes to health outcomes. Patients facing challenges with transportation or travel distance have a more convenient option for engaging with the healthcare system. Some evidence suggests, other things being equal, that teleservices lead to fewer missed appointments and less delayed care. More study is warranted to evaluate the value of care delivered through teleservices during the PHE, in particular for more novel aspects of utilization. Most importantly, as Medicaid teleservices' policy evolves in Texas, it should do so in alignment with the program's emerging value-based principles and initiatives and with a strong connection to payment for outcomes rather than for volume.

List of Acronyms

Acronym	Full Name
APM	Alternative Payment Model
CAH	Critical Access Hospital
CAS	Community Attendant Services
CCBHC	Certified Community Behavioral Health Clinic
CCP	Comprehensive Care Program
CHART	Community Health Access and Rural Transformation
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
COVID-19	Coronavirus Disease 2019
DPP BHS	Directed Payment Program for Behavioral Health Services
DSRIP	Delivery System Reform Incentive Payment
ECI	Early Childhood Intervention
EQRO	External Quality Review Organization
ESRD	End-stage renal disease
FFS	Fee-for-service
FQHC	Federally Qualified Health Center
HB	House Bill

HCBS	Home and Community-Based Services
HHA	Home Health Agency
HHSC	Health and Human Services Commission
HIPAA	Health Insurance Portability and Accountability Act of 1996
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
LBHA	Local Behavioral Health Authority
LMHA	Local Mental Health Authority
LTSS	Long Term Services and Supports
MCO	Manage Care Organization
MRSA	Medicaid Rural Service Area
MSA	Metropolitan Statistical Area
OCR	Office of Civil Rights
PHE	Public Health Emergency
RAPPS	Rural Access to Primary and Preventive Services
RHC	Rural Health Clinic
SDOH	Social Determinants of Health
SHARS	School Health and Related Services
TIPPS	Texas Incentives for Physicians and Professional Services
TMPPM	Texas Medicaid Provider Procedures Manual

Appendix A. Texas Counties by Designation and Managed Care Service Area



Appendix B. Medicare Telehealth Policies

Table 5. Existing Medicare Telehealth Fee-for-Service (FFS) Policy as compared to FFS Policy during the COVID-19 PHE

	Existing FFS Policy	FFS Policy during COVID-19 PHE
Reimbursable distant site providers	• Physicians • Nurse practitioners • Physician assistants • Nurse-midwives • Clinical nurse specialists • Certified registered nurse anesthetists • Clinical psychologists • Clinical social workers • Registered dietitians or nutrition professionals	Removes all restrictions on distant site provider type

Allowable originating (patient) sites/ Reimbursable patient site providers	The following sites located in a rural HPSA or county outside of an MSA[y]:
	• Physician and practitioner offices
	• Hospitals
	• Critical Access Hospitals (CAHs)
	• RHCs
	• FQHCs
	• Skilled nursing facilities
	• CMHCs
	• Hospital-based or CAH-based renal dialysis centers
		• Removes rural restrictions – expands telehealth to urban areas
		• Adds the following as allowable originating sites:
		  ○ Beneficiary's home
		  ○ Temporary hospitals

[y] In 2019, some exceptions were made from both the geographic and originating site requirements for ESRD services, treatment of acute stroke and treatment of substance use disorder and co-occurring mental health conditions.

	Existing FFS Policy	FFS Policy during COVID-19 PHE
Reimbursable services	A limited set of services were reimbursable (until January 1, 2021, when more than 60 additional services were made permanently reimbursable).[75,76z]	106 services were made reimbursable only during the PHE.[77]
Allowable modalities	Interactive two-way, audio/video telecommunications technology	• Audio/video • Audio-only for certain services Suspended HIPAA privacy requirements – allows Facetime, Skype, Zoom, etc.
Reimbursement Rate[78aa]	PFS rate for facility-based services (less than the non-facility rate)	PFS rate is the same as if the service was furnished in person (facility or non-facility rate, depending on the clinician's location). Same for audio-only visits.

[z] As of April 16, 2021, 109 services are permanently reimbursable, and 56 services are reimbursable up through the year in which the PHE ends.

[aa] Under the PFS, clinicians who provide services in facilities such as hospitals receive a lower payment rate (the facility rate) than clinicians who provide services in offices (the nonfacility rate).

Appendix C. Texas Medicaid Acute Care Teleservices Policies

Table 6. Existing Texas Medicaid Acute Care Teleservices Fee-for-Service (FFS) Policy as compared to Policy during the COVID-19 PHE[28]

	Existing FFS Policy	FFS Policy during COVID-19 PHE
Reimbursable distant site providers[29,30]	Telemedicine • Physicians • Physician groups • Physician assistants • Nurse practitioners • Clinical nurse specialists • Clinics and group practices • LMHAs • County Indigent Health Care Program (CIHCP) providers • FQHCs[31] • Hospitals Telehealth • Psychologists • Psychology groups • LPCs • LMFTs	Telemedicine Same as under existing FFS policy, plus: • RHCs • School districts participating in SHARS • Private providers of mental health services • THSteps medical providers Telehealth Same as under existing FFS policy, plus: • RHCs • School districts participating in SHARS

[28] This table includes Texas Medicaid FFS policy only because each Medicaid MCO has their own policy.

[29] Distant site providers must be licensed in Texas. An out-of-state physician who is a distant site provider may provide episodic telemedicine medical services without a Texas medical license as outlined in Texas Occupations Code §151.056 and Title 22 Texas Administrative Code (TAC) §172.2(g)(4) and 172.12(f).

[30] H.B. 4 requires HHSC to make RHCs a reimbursable telemedicine or telehealth distant site provider only if the Texas Legislature appropriates money specifically for this purpose. If the Texas Legislature does not appropriate money specifically for this purpose, HHSC may, but is not required to, make RHCs a reimbursable telemedicine or telehealth distant site provider using other money available to HHSC for this purpose.

[31] FQHCs because a reimbursable distant site provider type effective December 1, 2020.

	Existing FFS Policy	FFS Policy during COVID-19 PHE
	• LCSWs • LMHAs • RNs • Nurse midwives • ECI providers[32] • HHAs • FQHCs • OTs • SLPs • Dietitians	• PTs
Reimbursable patient site providers[33]	Telemedicine • Physicians • Physician groups • Physician assistants • Nurse practitioners • Clinical nurse specialists • Clinics and group practices • CIHCPs • FQHCs Telehealth • FQHCs	Telemedicine Same as under existing FFS policy Telehealth Same as under existing FFS policy
Allowable patient sites	Telemedicine Any	Telemedicine Same as under existing FFS policy

[32] ECI providers became a reimbursable distant site provide type effective March 1, 2020. See https://www.tmhp.com/news/2020-01-06-telehealth-services-will-become-benefit-early-childhood-intervention-providers

[33] H.B. 4, 87th Legislature, Regular Session, 2021 requires HHSC to make RHCs a reimbursable telemedicine or telehealth patient site provider only if the Texas Legislature appropriates money specifically for this purpose. If the Texas Legislature does not appropriate money specifically for this purpose, HHSC may, but is not required to, make RHCs a reimbursable telemedicine or telehealth patient site provider using other money available to HHSC for this purpose.

	Existing FFS Policy	FFS Policy during COVID-19 PHE
	Telehealth Any, except that allowable therapies are restricted to school-based settings	Telehealth Same as under existing FFS policy except that allowable therapies are no longer restricted to school-based settings
Reimbursable services provided via televideo[34]	Telemedicine • Evaluation and management services • Psychiatric diagnostic evaluations • Psychotherapy • Inpatient consultations • ESRD services • FQHC encounters Telehealth • Evaluation and management services • Psychiatric diagnostic evaluations • Psychotherapy • Inpatient consultations • ESRD services • FQHC encounters • OT and ST[35] • Medical nutritional counseling • ECI specialized skills training	Telemedicine Same as under existing FFS policy, plus: • RHC encounters • THSteps medical checkups • SHARS • Healthy Texas Women's services Telehealth Same as under existing FFS policy, plus: • Targeted case management • Peer specialist services • Screening, Brief Intervention, and Referral to Treatment (SBIRT) • Substance use disorder (SUD) counseling • Mental health rehabilitation • SHARS • PT

[34] H.B. 4, 87th Legislature, Regular Session, 2021 , requires HHSC to provide Medicaid reimbursement for the following telemedicine and telehealth services: RHC encounters, ECI, SHARS, PT, OT, ST, targeted case management, nutritional counseling, THSteps checkups, Medicaid 1915(c)waiver programs, including the Community Living and Support Services waiver, and any other service HHSC determines to be cost effective and clinically effective.

[35] When provided to clients in a school-based setting or to clients also enrolled in ECI in any setting.

	Existing FFS Policy	FFS Policy during COVID-19 PHE
Reimbursable services provided via telephone (audio-only)	None	<u>Telemedicine</u>[36] Existing procedure codes with 95 modifier for: • Evaluation and management services • Psychiatric diagnostic evaluations • Psychotherapy • THSteps medical checkups • Women's health services Telephonic procedure codes[37] for services provided by: • Physicians • Physician groups • Physician assistants • Nurse practitioners • Clinical nurse specialists • Clinics and group practices • LMHAs • CIHCPs • FQHCs <u>Telehealth</u> Existing procedure codes with 95 modifier for:

[36] H.B. 4, 87th Legislature, Regular Session, 2021, requires HHSC to implement audio-only delivery of behavioral health services and allow audio-only delivery in any other program under HHSC jurisdiction, in accordance with federal and state law, that HHSC determines cost-effective and clinically effective.

[37] On March 30, 2020, CMS approved Texas's Section 1135 waiver request for Coronavirus Disease 2019, which included suspension of State Plan Amendment (SPA) public notice requirements for changes to Medicaid payment rates. Through this flexibility, HHSC used an expedited rate setting process to adopt procedure codes 99441, 99442, and 99443, effective March 1, 2020 through the end of the COVID-19 PHE, to reimburse providers for telephonic services.

	Existing FFS Policy	FFS Policy during COVID-19 PHE
		• Evaluation and management services • Psychiatric diagnostic evaluations • Psychotherapy • Targeted case management • Peer specialist services • SBIRT • SUD counseling • Mental health rehabilitation • Women's health services • Medical nutritional counseling • ECI specialized skills training Telephonic procedure codes[38] for services provided by: • Optometrists • Optometric groups • Podiatrists • Podiatry groups • Audiologists • Family planning clinics • Dentists • Dental groups
Reimbursement rate	Same as for in-person service	No change[39]

[38] Procedure codes 99441, 99442, and 99443 are also reimbursed to providers of telehealth services effective March 1, 2020 through the end of the COVID-19 PHE.

[39] Procedure codes 99441, 99442, and 99443 are reimbursed at different rates than procedure codes used to reimburse for both remotely delivered and in-person services.

Appendix D. Texas Medicaid Long-term Services and Supports Teleservices COVID-19 PHE Flexibilities

Community Living Assistance & Supports Services (CLASS)

- Allow the following CLASS therapies to be delivered via teleservices to recipients in their homes:
  - Occupational therapy;
  - Physical therapy;
  - Speech therapy;
  - Recreational therapy;
  - Music therapy;
  - Dietary;
  - Behavior supports; and
  - Cognitive rehabilitation therapy.
- Allow billable activities for supported employment assistance through teleservices (including telephonic).
- Allow nursing assessments and comprehensive nursing assessments to be delivered through teleservices.

Deaf Blind with Multiple Disabilities (DBMD)

- Allow billable activities for supported employment assistance through teleservices (including telephonic).
- Allow nursing assessments and comprehensive nursing assessments to be delivered through teleservices.

Home and Community-based Services (HCS)

- Allow billable activities for supported employment assistance through teleservices (including telephonic).
- Allow nursing assessments and comprehensive nursing assessments to be delivered through teleservices.

Texas Home Living (TxHmL)

- Allow billable activities for supported employment assistance through teleservices (including telephonic).
- Allow nursing assessments and comprehensive nursing assessments to be delivered through teleservices.

State Plan LTSS

Community Attendant Services (CAS)

- Waive the requirement for CAS case managers to visit individuals in the home or care setting at least every 90 days and allow case managers to conduct visits via teleservices (including telephonic) and document the reason it was not completed in the home.

Hospice

- Permit hospice reassessment to be conducted via teleservices on a case-by-case basis.

Service Planning

- Allow the use of teleservices to develop service plans for members receiving waiver and state plan LTSS.

Case Management

- Suspend case management requirements for face-to-face visits, offering telephonic case management for a mix of state plan LTSS and acute care services.

Appendix E. Texas Medicaid Teleservices by Provider Type, Month and Client County for SFY 2020

Table 7. Teleservices[nn] by Provider Type, Month and Client County of Residence for SFY 2020[oo]

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
CLINIC/ GROUP PRACTICE[pp]	22	September 2019	3,829	2,047	6,586	51	12,513
		October 2019	4,420	2,426	7,614	42	14,502
		November 2019	3,463	1,990	6,640	30	12,123
		December 2019	3,221	1,992	6,124	36	11,373
		January 2020	3,904	2,570	7,951	39	14,464
		February 2020	3,622	2,375	7,508	44	13,549
		March 2020	10,088	16,231	66,890	222	93,431
		April 2020	34,669	57,742	250,828	729	343,968
		May 2020	26,979	47,063	206,443	546	281,031

[nn] "Teleservices" include telemedicine and telehealth services but not telemonitoring.

[oo] This table includes data for the provider types that provided more than 500 teleservices during SFY 2020.

[pp] Physician-led groups and behavioral health provider groups can enroll in Texas Medicaid as a clinic/ group practice (PT 22).

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
		June 2020	23,963	40,980	196,973	566	262,482
		July 2020	28,168	46,881	232,656	675	308,380
		August 2020	25,744	41,662	207,543	565	275,514
HOME HEALTH AGENCY	44	September 2019	0	0	1	0	1
		October 2019	0	0	2	0	2
		November 2019	0	0	2	0	2
		December 2019	0	0	0	0	0
		January 2020	0	0	4	0	4
		February 2020	0	0	11	0	11
		March 2020	453	1,416	4,227	10	6,106
		April 2020	3,666	13,822	60,576	109	78,173
		May 2020	3,566	13,795	66,989	105	84,455
		June 2020	2,914	12,024	59,291	43	74,272
		July 2020	3,087	11,642	63,152	75	77,956
		August 2020	2,847	10,190	59,710	57	72,804

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
EARLY CHILDHOOD INTERVENTION[qq]	11	September 2019	107	45	892	2	1,046
		October 2019	126	49	944	2	1,121
		November 2019	90	38	866	3	997
		December 2019	114	38	800	2	954
		January 2020	117	64	990	2	1,173
		February 2020	112	62	944	3	1,121
		March 2020	1,087	1,437	9,463	6	11,993
		April 2020	5,624	7,696	40,274	8	53,602
		May 2020	5,498	7,623	42,795	10	55,926
		June 2020	5,210	7,644	42,808	11	55,673
		July 2020	5,090	7,138	41,519	14	53,761
		August 2020	4,845	6,734	40,234	7	51,820
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	46	September 2019	16	105	35	0	156

[qq] Providers contracted with HHSC's Early Childhood Intervention (ECI) Program may enroll as ECI providers (PT 11). ECI services are rendered by early intervention specialists, speech-language pathologists, physical and occupational therapists, psychologists, registered nurses, dieticians, social workers, and counselors.

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
		October 2019	19	145	38	0	202
		November 2019	17	127	38	0	182
		December 2019	26	117	41	0	184
		January 2020	32	142	37	0	211
		February 2020	7	174	52	0	233
		March 2020	862	1,577	4,718	7	7,164
		April 2020	5,813	8,573	32,497	119	47,002
		May 2020	3,957	8,290	29,086	98	41,431
		June 2020	3,092	8,477	30,751	78	42,398
		July 2020	4,039	9,723	34,036	60	47,858
		August 2020	3,766	8,847	30,519	62	43,194
REHABILITATION CENTER[rr]	65	September 2019	0	0	0	0	0
		October 2019	0	0	0	0	0
		November 2019	0	0	0	0	0
		December 2019	0	0	1	0	1

[rr] Licensed hospitals can enroll in Texas Medicaid as rehabilitation centers (PT 65).

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
		January 2020	0	0	7	0	7
		February 2020	0	0	25	0	25
		March 2020	208	331	3,731	1	4,271
		April 2020	1,531	3,408	36,507	66	41,512
		May 2020	1,165	2,951	32,220	55	36,391
		June 2020	632	2,142	25,675	29	28,478
		July 2020	839	2,613	30,849	31	34,332
		August 2020	710	2,149	27,922	23	30,804
MENTAL HEALTH REHABILITATIVE SERVICES[ss]	12	September 2019	2	3	25	0	30
		October 2019	5	3	17	0	25
		November 2019	4	1	23	0	28
		December 2019	4	1	12	1	18
		January 2020	7	2	19	0	28

[ss] Local mental health authorities (LMHAs) can enroll in Texas Medicaid as a mental health rehabilitative services provider (PT 12). In addition, non-LMHA providers of mental health targeted case management and mental health rehabilitation services can also enroll in this provider type.

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
		February 2020	2	1	16	0	19
		March 2020	1,812	1,225	6,347	11	9,395
		April 2020	7,410	6,297	20,364	67	34,138
		May 2020	6,131	5,574	20,883	58	32,646
		June 2020	3,900	4,765	19,040	49	27,754
		July 2020	5,335	5,443	19,783	55	30,616
		August 2020	5,990	5,414	18,206	69	29,679
TEXAS HEALTH STEPS - MEDICAL[tt]	66	September 2019	6	13	64	0	83
		October 2019	5	16	163	1	185
		November 2019	14	27	238	3	282
		December 2019	7	27	218	1	253
		January 2020	13	22	374	1	410

[tt] Physicians, physician assistants, and advanced practice registered nurses, including clinical nurse specialists, nurse practitioners, and certified nurse midwives, FQHCs, and other public or private healthcare facilities, such as local health departments, family planning clinics, migrant health clinics, community-based hospitals and clinics, maternity services clinics, RHCs, home health agencies, and school-based health centers, can enroll in Texas Medicaid as Texas Health Steps – Medical provider (PT 66).

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
		February 2020	10	30	275	1	316
		March 2020	750	2,209	6,493	12	9,464
		April 2020	2,813	6,655	24,854	46	34,368
		May 2020	1,714	5,162	18,980	40	25,896
		June 2020	1,422	4,016	18,890	35	24,363
		July 2020	2,067	4,394	25,368	39	31,868
		August 2020	1,865	3,369	20,879	26	26,139
LICENSED PROFESSIONAL COUNSELOR	16	September 2019	56	81	351	30	518
		October 2019	61	105	416	10	592
		November 2019	69	68	383	3	523
		December 2019	51	95	436	12	594
		January 2020	54	130	606	9	799
		February 2020	194	263	873	5	1,335
		March 2020	1,297	1,712	6,389	33	9,431
		April 2020	4,345	6,088	23,095	38	33,566
		May 2020	3,406	4,777	20,647	29	28,859
		June 2020	2,590	3,931	18,468	28	25,017

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
		July 2020	2,699	4,667	20,292	49	27,707
		August 2020	2,267	4,122	17,979	21	24,389
CCP PROVIDER[uu]	50	September 2019	0	0	0	0	0
		October 2019	0	0	1	0	1
		November 2019	0	0	2	0	2
		December 2019	1	0	1	0	2
		January 2020	0	2	66	0	68
		February 2020	0	1	84	0	85
		March 2020	170	689	1,918	1	2,778
		April 2020	2,164	3,566	17,337	15	23,082
		May 2020	2,037	3,310	16,122	25	21,494
		June 2020	1,964	2,630	13,834	33	18,461
		July 2020	2,228	2,757	14,707	25	19,717

[uu] Dietitians, nurses, occupational therapists, and speech therapists can enroll in Texas Medicaid as a Comprehensive Care Program (CCP) provider (PT 50).

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
		August 2020	2,372	2,226	13,731	28	18,357
CASE MANAGEMENT/ HCBS PROVIDER[vv]	7	September 2019	22	10	136	2	170
		October 2019	23	21	173	0	217
		November 2019	10	15	136	1	162
		December 2019	5	2	97	0	104
		January 2020	12	10	121	1	144
		February 2020	10	6	122	0	138
		March 2020	1,116	1,026	3,892	16	6,050
		April 2020	3,424	3,308	11,683	29	18,444
		May 2020	3,031	2,707	11,758	33	17,529
		June 2020	2,329	2,420	12,340	19	17,108
		July 2020	2,778	2,677	11,855	30	17,340
		August 2020	3,083	2,592	12,236	33	17,944

[vv] Physicians, nurses, and behavioral health providers can enroll in Texas Medicaid as individual case management providers. LMHAs, LIDDAs, and Licensed Home and Community Based Services - Adult Mental Health Providers can enroll as case management provider entities.

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
PHYSICIAN (M.D.) PCP[ww]	20	September 2019	11	8	24	0	43
		October 2019	8	17	38	0	63
		November 2019	12	21	85	0	118
		December 2019	15	19	75	0	109
		January 2020	31	20	114	0	165
		February 2020	41	12	72	2	127
		March 2020	318	877	3,052	6	4,253
		April 2020	1,155	2,579	12,860	21	16,615
		May 2020	851	1,625	8,516	12	11,004
		June 2020	789	1,286	8,957	12	11,044
		July 2020	1,234	1,767	14,399	19	17,419
		August 2020	969	1,492	11,166	19	13,646

[ww] Physician (M.D.) PCP includes M.D.s enrolled under PT 20 and Specialty Code 8 (Family Practice/ General Practice), 11 (Internal Medicine), 15 (Obstetrics/ Gynecology), or 37 (Pediatrics).

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
SHARS - INDIVIDUAL[xx]	13	September 2019	0	2	0	6	8
		October 2019	28	69	474	30	601
		November 2019	61	33	243	17	354
		December 2019	121	57	377	14	569
		January 2020	267	144	1,895	91	2,397
		February 2020	282	393	1,552	31	2,258
		March 2020	451	451	2,330	33	3,265
		April 2020	1,231	3,439	15,497	49	20,216
		May 2020	799	3,488	12,538	12	16,837
		June 2020	32	127	1,001	0	1,160
		July 2020	6	54	364	0	424
		August 2020	1,373	2,610	18,946	52	22,981

[xx] Schools, including charter schools, co-ops, and school districts can enroll in Texas Medicaid as School Health and Related Services (SHARS) providers.

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
PHYSICIAN (M.D.) Specialist[yy]	20	September 2019	16	100	206	0	322
		October 2019	24	119	281	0	424
		November 2019	26	126	242	0	394
		December 2019	23	123	227	0	373
		January 2020	39	152	342	0	533
		February 2020	20	112	281	0	413
		March 2020	201	378	1,449	2	2,030
		April 2020	767	928	5,768	22	7,485
		May 2020	614	880	4,896	19	6,409
		June 2020	557	719	4,725	10	6,011
		July 2020	644	756	5,445	23	6,868
		August 2020	790	747	4,606	17	6,160

[yy] Physician (M.D.) Specialist includes M.D.s enrolled under PT 20 and a Specialty Code other than 8 (Family Practice/ General Practice), 11 (Internal Medicine), 15 (Obstetrics/ Gynecology), or 37 (Pediatrics).

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
CHEMICAL DEPENDENCY TREATMENT FACILITY (TCADA APPROVED)	8	September 2019	23	25	3	0	51
		October 2019	12	39	1	0	52
		November 2019	24	26	0	0	50
		December 2019	20	2	1	0	23
		January 2020	24	3	3	0	30
		February 2020	15	3	2	0	20
		March 2020	240	188	1,764	4	2,196
		April 2020	628	790	6,730	7	8,155
		May 2020	486	749	5,277	6	6,518
		June 2020	554	698	3,801	11	5,064
		July 2020	425	700	4,170	8	5,303
		August 2020	543	761	3,957	7	5,268
HOSPITAL - LONG TERM, LIMITED, OR SPECIALIZED CARE	60	September 2019	0	0	2	0	2
		October 2019	1	0	1	0	2
		November 2019	1	2	0	0	3

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
		December 2019	0	3	3	0	6
		January 2020	0	4	4	0	8
		February 2020	0	4	12	0	16
		March 2020	34	83	267	0	384
		April 2020	303	1,330	4,305	3	5,941
		May 2020	252	1,079	3,575	1	4,907
		June 2020	221	762	2,877	0	3,860
		July 2020	266	688	2,487	2	3,443
		August 2020	195	555	2,184	1	2,935
PHYSICIAN ASSISTANT/ NURSE PRACTITIONER/ CLINICAL NURSE SPECIALIST	10	September 2019	23	14	32	0	69
		October 2019	37	12	21	0	70
		November 2019	28	15	28	0	71
		December 2019	23	14	28	0	65
		January 2020	42	28	51	0	121
		February 2020	41	32	39	0	112
		March 2020	123	233	837	0	1,193

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
		April 2020	595	821	3,317	13	4,746
		May 2020	412	655	2,613	11	3,691
		June 2020	378	523	2,543	14	3,458
		July 2020	369	544	2,935	8	3,856
		August 2020	386	499	2,617	7	3,509
YES WAIVER/MENTAL RETARDATION DIAGNOSTIC SERVICES (MRDA)[zz]	9	September 2019	13	18	33	0	64
		October 2019	28	31	42	0	101
		November 2019	11	21	37	0	69
		December 2019	17	26	41	0	84
		January 2020	16	28	57	0	101
		February 2020	18	28	55	0	101
		March 2020	132	129	949	2	1,212
		April 2020	345	355	3,198	7	3,905

[zz] LMHAs can enroll in Texas Medicaid as Yes Waiver/ MRDA providers.

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
		May 2020	308	283	2,956	9	3,556
		June 2020	264	267	3,161	19	3,711
		July 2020	302	265	2,799	2	3,368
		August 2020	330	230	2,649	5	3,214
RURAL HEALTH CLINIC - FREESTANDING/ INDEPENDENT	78	September 2019	0	0	0	0	0
		October 2019	0	1	0	0	1
		November 2019	0	0	0	0	0
		December 2019	0	0	0	0	0
		January 2020	1	0	0	0	1
		February 2020	1	0	1	0	2
		March 2020	501	167	38	3	709
		April 2020	2,635	819	239	9	3,702
		May 2020	2,023	574	180	6	2,783
		June 2020	2,676	468	232	5	3,381
		July 2020	3,569	748	319	9	4,645
		August 2020	2,982	680	296	8	3,966

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
LICENSED CLINICAL SOCIAL WORKER (LCSW)	18	September 2019	0	1	0	0	1
		October 2019	0	3	3	0	6
		November 2019	1	0	8	0	9
		December 2019	0	0	1	0	1
		January 2020	0	8	21	0	29
		February 2020	8	5	44	0	57
		March 2020	155	298	791	0	1,244
		April 2020	496	1,140	2,376	1	4,013
		May 2020	391	804	1,890	2	3,087
		June 2020	349	863	1,874	2	3,088
		July 2020	301	770	1,907	0	2,978
		August 2020	241	742	1,779	1	2,763
PHYSICAL THERAPIST	34	September 2019	0	0	0		0
		October 2019	0	0	0		0
		November 2019	0	0	0		0
		December 2019	0	0	0		0
		January 2020	0	0	0		0

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
		February 2020	0	0	0		0
		March 2020	11	92	195		298
		April 2020	223	563	1,451		2,237
		May 2020	228	568	1,319		2,115
		June 2020	204	576	1,019		1,799
		July 2020	150	693	1,187		2,030
		August 2020	182	558	1,089		1,829
PSYCHOLOGIST	31	September 2019	14	0	2	0	16
		October 2019	17	1	1	0	19
		November 2019	0	0	0	0	0
		December 2019	2	0	0	0	2
		January 2020	30	1	4	0	35
		February 2020	15	25	5	0	45
		March 2020	53	138	348	3	542
		April 2020	170	329	1,000	9	1,508
		May 2020	181	343	1,013	12	1,549
		June 2020	126	338	957	8	1,429
		July 2020	130	359	1,046	8	1,543

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
		August 2020	129	349	892	11	1,381
RURAL HEALTH CLINIC – HOSPITAL-BASED	79	September 2019	28	0	1	0	29
		October 2019	25	0	1	0	26
		November 2019	18	0	2	0	20
		December 2019	18	0	1	0	19
		January 2020	22	0	1	0	23
		February 2020	5	0	0	0	5
		March 2020	385	102	49	1	537
		April 2020	1,403	526	388	12	2,329
		May 2020	736	299	143	5	1,183
		June 2020	531	227	98	5	861
		July 2020	852	298	147	6	1,303
		August 2020	826	256	98	5	1,185
PHYSICIAN (D.O.) Specialist	19	September 2019	0	0	1	0	1
		October 2019	0	0	0	0	0
		November 2019	3	0	29	0	32
		December 2019	0	0	0	0	0

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
		January 2020	0	0	0	0	0
		February 2020	4	0	29	0	33
		March 2020	13	10	18	0	41
		April 2020	413	207	379	1	1,000
		May 2020	400	209	458	0	1,067
		June 2020	381	224	376	0	981
		July 2020	389	280	421	0	1,090
		August 2020	378	215	428	0	1,021
FAMILY PLANNING CLINIC	71	September 2019	0	0	0	0	0
		October 2019	2	2	1	0	5
		November 2019	0	0	0	0	0
		December 2019	1	0	4	0	5
		January 2020	4	2	9	0	15
		February 2020	1	1	3	0	5
		March 2020	20	74	97	0	191
		April 2020	103	200	519	6	828
		May 2020	60	133	554	3	750
		June 2020	37	87	541	1	666

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
		July 2020	112	118	985	0	1,215
		August 2020	119	95	814	2	1,030
TEXAS HEALTH STEPS DENTAL - GROUP	92	September 2019	0	0	0	0	0
		October 2019	0	0	0	0	0
		November 2019	0	0	0	0	0
		December 2019	0	0	0	0	0
		January 2020	0	0	0	0	0
		February 2020	0	0	1	0	1
		March 2020	8	54	110	0	172
		April 2020	25	164	551	1	741
		May 2020	32	136	521	0	689
		June 2020	24	157	489	0	670
		July 2020	17	165	535	1	718
		August 2020	17	179	497	1	694
PHYSICIAN (D.O.) PCP	19	September 2019	4	5	18	0	27
		October 2019	1	3	9	0	13
		November 2019	4	6	5	0	15

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
		December 2019	1	12	11	0	24
		January 2020	2	9	6	0	17
		February 2020	2	11	10	0	23
		March 2020	4	34	94	0	132
		April 2020	27	122	330	1	480
		May 2020	34	81	253	1	369
		June 2020	38	94	211	1	344
		July 2020	74	69	352	1	496
		August 2020	104	40	279	1	424
HOSPITAL - PSYCHIATRIC	64	September 2019	0	0	0	0	0
		October 2019	0	0	0	0	0
		November 2019	0	0	0	0	0
		December 2019	0	0	0	0	0
		January 2020	0	0	0	0	0
		February 2020	0	0	0	0	0
		March 2020	0	50	88	0	138
		April 2020	37	160	438	0	635
		May 2020	22	166	232	0	420

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
		June 2020	20	87	175	13	295
		July 2020	37	173	295	0	505
		August 2020	16	108	180	0	304
PHYSICAL THERAPY GROUP	98	September 2019	0	0	0		0
		October 2019	0	0	0		0
		November 2019	0	0	0		0
		December 2019	0	0	0		0
		January 2020	0	0	0		0
		February 2020	0	0	0		0
		March 2020	4	34	47		85
		April 2020	35	225	352		612
		May 2020	24	180	291		495
		June 2020	23	62	115		200
		July 2020	34	39	135		208
		August 2020	19	26	176		221
HOSPITAL - PRIVATE FULL CARE	61	September 2019	0	0	0		0
		October 2019	0	1	1		2

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
		November 2019	0	0	0		0
		December 2019	0	0	0		0
		January 2020	1	0	0		1
		February 2020	3	0	0		3
		March 2020	4	28	42		74
		April 2020	73	116	204		393
		May 2020	47	78	192		317
		June 2020	53	97	222		372
		July 2020	41	62	231		334
		August 2020	20	64	233		317
UNKNOWN		September 2019	0	0	0	0	0
		October 2019	0	0	0	0	0
		November 2019	0	0	0	0	0
		December 2019	0	0	0	0	0
		January 2020	0	0	0	0	0
		February 2020	0	0	0	0	0
		March 2020	0	9	73	0	82
		April 2020	13	27	231	0	271

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
		May 2020	8	25	297	0	330
		June 2020	9	9	231	0	249
		July 2020	4	7	292	0	303
		August 2020	4	3	331	4	342
NURSING HOME	47	September 2019	0	0	0		0
		October 2019	0	0	0		0
		November 2019	0	0	0		0
		December 2019	0	0	0		0
		January 2020	0	0	0		0
		February 2020	0	0	0		0
		March 2020	0	0	0		0
		April 2020	0	0	0		0
		May 2020	2	0	1		3
		June 2020	70	40	71		181
		July 2020	115	44	171		330
		August 2020	156	55	262		473
PSYCHOLOGY GROUP	97	September 2019	0	2	4		6
		October 2019	0	0	2		2

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
		November 2019	0	0	1		1
		December 2019	0	1	2		3
		January 2020	1	0	3		4
		February 2020	1	4	1		6
		March 2020	17	4	29		50
		April 2020	54	43	128		225
		May 2020	14	45	119		178
		June 2020	26	45	85		156
		July 2020	24	50	67		141
		August 2020	35	53	74		162
GENETICS	68	September 2019	0	3	2	0	5
		October 2019	2	1	3	0	6
		November 2019	0	0	1	0	1
		December 2019	0	0	3	0	3
		January 2020	2	1	4	0	7
		February 2020	0	1	5	0	6
		March 2020	3	9	24	0	36
		April 2020	17	12	61	0	90

	Provider Type (PT) Code	Month	Rural	Suburban	Urban	Unknown	Total
		May 2020	9	20	77	0	106
		June 2020	16	18	86	0	120
		July 2020	12	13	63	1	89
		August 2020	19	16	85	0	120

Data source: Medicaid CHIP Data Analytics (MCDA) Analytical Data Store (ADS), TMHP.
Data provided by: MCDA, Center for Analytics and Decision Support, HHSC, (2021, April).
Additional analysis conducted by: Value-based Initiatives, HHSC. (2021, April).

Appendix F. Texas Medicaid Teleservices by Service Type and Client County of Residence, State Fiscal Year 2020

Table 8. Number of Teleservices Provided by Service Type* and Client County of Residence, SFY 2020

Service Type[aaa]	Client County Designation	Pre-COVID-19**	During COVID-19***	Difference	Percent Change (%)
Office/Outpatient Visit – Established Client	Rural	17,855	114,682	96,827	542
	Suburban	12,006	196,588	184,582	1,537
	Urban	41,180	922,922	881,742	2,141
	Total	**71,041**	**1,234,192**	**1,163,151**	**1,637**
Speech-Language Pathology Services	Rural	465	32,461	31,996	6,881
	Suburban	632	76,706	76,074	12,037
	Urban	4,512	473,529	469,017	10,395
	Total	**5,609**	**582,696**	**577,087**	**10,289**
Psychotherapy	Rural	1,350	29,347	27,997	2,074
	Suburban	1,591	59,846	58,255	3,662
	Urban	3,495	256,106	252,611	7,228

[aaa] Service Types are based on procedure codes. Table 9 below provides the procedure codes included in each Service Type. Facility fee billings are excluded.

Service Type[aaa]	Client County Designation	Pre-COVID-19**	During COVID-19***	Difference	Percent Change (%)
	Total	**6,436**	**345,299**	**338,863**	**5,265**
Mental Health Rehabilitation	Rural	0	36,352	36,352	-
	Suburban	0	44,664	44,664	-
	Urban	0	236,573	236,573	-
	Total	**0**	**317,589**	**317,589**	**-**
Physical or Occupational Therapy Services	Rural	230	17,138	16,908	7,351
	Suburban	60	44,066	44,006	73,343
	Urban	149	219,335	219,186	147,105
	Total	**439**	**280,539**	**280,100**	**63,804**
Targeted Case Management	Rural	0	30,685	30,685	-
	Suburban	0	33,571	33,571	-
	Urban	0	133,351	133,351	-
	Total	**0**	**197,607**	**197,607**	**-**
FQHC and RHC Encounter	Rural	0	28,338	28,338	-
	Suburban	0	23,865	23,865	-
	Urban	0	72,273	72,273	-
	Total	**0**	**124,476**	**124,476**	**-**

Service Type[aaa]	Client County Designation	Pre-COVID-19**	During COVID-19***	Difference	Percent Change (%)
Early Childhood Intervention (ECI) Specialized Skills Training	Rural	0	10,756	10,756	-
	Suburban	0	14,123	14,123	-
	Urban	0	70,276	70,276	-
	Total	**0**	**95,155**	**95,155**	**-**
Telephonic Evaluation and Management Service – Established Client	Rural	0	7,651	7,651	-
	Suburban	0	9,353	9,353	-
	Urban	0	58,348	58,348	-
	Total	**0**	**75,352**	**75,352**	**-**
Clinician-directed Care Coordination for Clients in Nursing Facilities	Rural	0	11,101	11,101	-
	Suburban	0	19,876	19,876	-
	Urban	0	41,395	41,395	-
	Total	**0**	**72,372**	**72,372**	**-**
Psychiatric Diagnostic Evaluation	Rural	2,798	6,473	3,675	131
	Suburban	2,175	9,804	7,629	351

Service Type[aaa]	Client County Designation	Pre-COVID-19**	During COVID-19***	Difference	Percent Change (%)
	Urban	7,042	37,979	30,937	439
	Total	**12,015**	**54,256**	**42,241**	**352**
Office/Outpatient Visit – New Client	Rural	343	3,038	2,695	786
	Suburban	328	6,311	5,983	1,824
	Urban	1,347	22,045	20,698	1,537
	Total	**2,018**	**31,394**	**29,376**	**1,456**

*Service types are groupings of procedure codes consisting of the 30 individually billed procedure codes with the highest total volume of telemedicine and telehealth services in SFY 2020. Therefore, many other procedures codes that were billed during this time could belong to these groups but are not represented in this table. Table 9 provides the individual procedure codes in each service type.

**Pre-COVID-19 is defined as September 1, 2019 through February 29, 2020.

***During COVID-19 is defined as March 1, 2020 through August 31, 2020.Data source: Medicaid CHIP Data Analytics (MCDA) Analytical Data Store (ADS), TMHP.

Data provided by: MCDA, Center for Analytics and Decision Support, HHSC, (2021, April).

Additional analysis conducted by: Value-based Initiatives, HHSC. (2021, April).

Table 9. Procedure Codes for Service Types

Service Type	Procedure Codes
Office/Outpatient Visit – Established Client	99212, 99213, 99214, 99215
Office/Outpatient Visit – New Client	99203, 99204
Physical or Occupational Therapy Services	97110, 97112, 97530
Speech-Language Pathology Services	92507, 92508, 92526
Mental Health Rehabilitation	H0034, H2014, H2017,
Psychotherapy	90832, 90833, 90834, 90837, 90847
Psychiatric Diagnostic Evaluation	90791, 90792
Targeted Case Management	T1017**
Clinician-directed Care Coordination for Clients in Nursing Facilities	99308, 99309
Telephonic Evaluation and Management Service – Established Client	99441, 99442, 99443
FQHC and RHC Encounter	T1015
Early Childhood Intervention (ECI) Specialized Skills Training	T1027

*Includes the 30 procedure codes with the highest volume of teleservices.
**T1017 can be used in Texas Medicaid to bill for mental health and ECI targeted case management.

Appendix G. HHSC Rural Hospital and Rural Health Clinic (RHC) Teleservices Survey

In mid-2020, HHSC worked with the Texas Organization of Rural & Community Hospitals (TORCH), the Texas Association of Rural Health Clinics (TARHC), and the e-Health Advisory Committee to develop a survey to assess the participation of Texas rural hospitals and RHCs in teleservices both prior to, and during, the COVID-19 pandemic, as well as barriers to their participation in these services. This survey was not specific to Texas Medicaid teleservices – it asked respondents to provide information on teleservices provided to all patients regardless of payer type.

TORCH distributed the survey to their member hospitals, and TARHC disseminated the survey to their member RHCs. The survey was open from August 31, 2020 through September 23, 2020. Table 10 below provides the number of rural hospitals and RHCs in Texas, the number in each provider organization, and the number that responded to the survey.

Table 10. Number of Rural Hospitals and RHCs in Texas, in their Provider Organization, and that Responded to the Survey

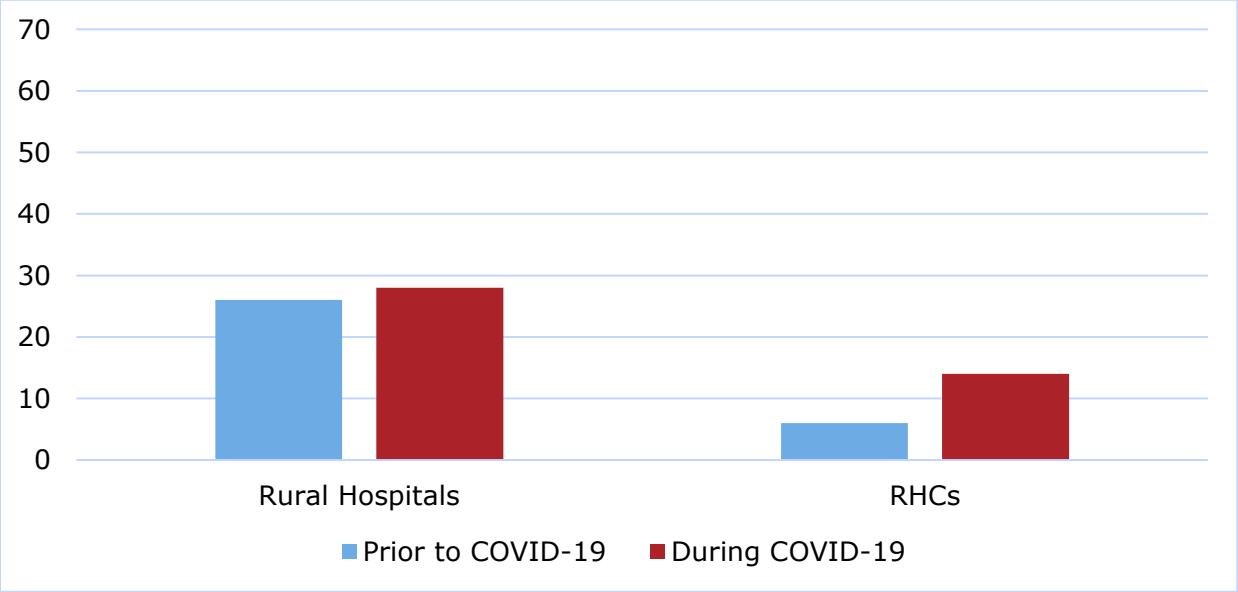
Provider Type	# in Texas	# in Provider Organization (TORCH or TARHC)	# Responded to Survey
Rural hospitals	157	148	52
RHCs	312	120	67

There are two main types of RHCs: hospital-based RHCs and freestanding RHCs. Because TARHC members are primarily hospital-based RHCs, the survey results may not be representative of all RHCs.

Rural Hospitals and RHCs Participating in Teleservices

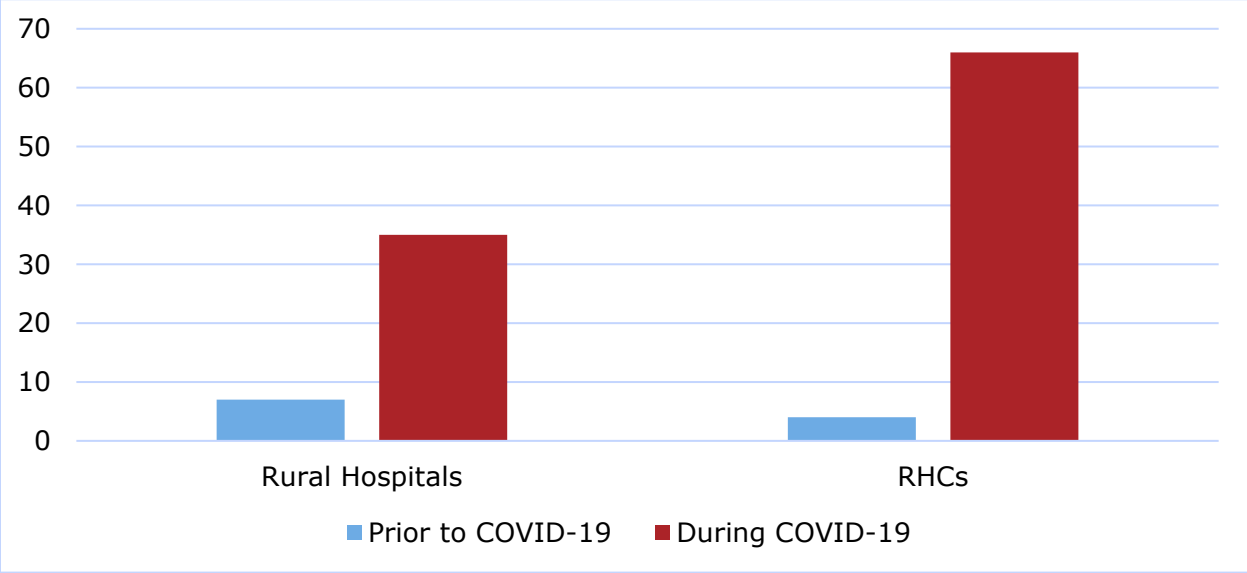
As shown in Figure 6, survey results demonstrated that the number of rural hospitals and RHCs at which patients received teleservices from providers at another site increased during the COVID-19 PHE.

Figure 6. Rural Hospitals and RHCs Receiving Teleservices from Providers at Another Site Prior to COVID-19 and during COVID-19



The number of rural hospitals and RHCs providing teleservices also increased during the COVID-19 PHE, though much more dramatically, as shown in Figure 7.

Figure 7. Rural Hospitals and RHCs Providing Teleservices prior to COVID-19 and during COVID-19



These increases are likely due in large part to:

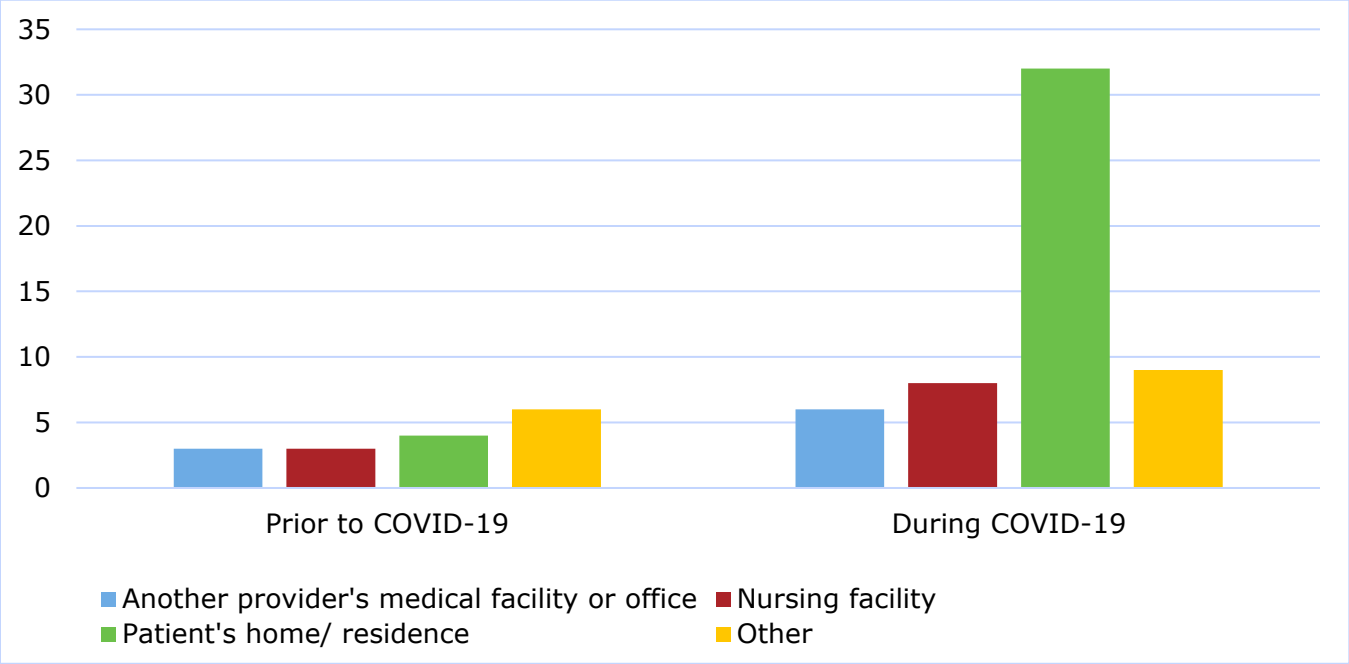
- FFS Medicare allowing for the provision of teleservices to patients in their homes during the COVID-19 PHE.
- FFS Medicare and Texas Medicaid allowing for the provision of certain audio-only services during the COVID-19 PHE.
- FFS Medicare and Texas Medicaid allowing RHCs to provide teleservices during the COVID-19 PHE.

Location of Patients Receiving Teleservices from Rural Hospitals and RHCs

Existing Texas Medicaid FFS policy allows for the provision of teleservices to patients in their homes, except that occupational and speech therapy provided to clients who are not also enrolled in ECI must be provided in a school-based setting. Existing Medicare FFS policy does not allow for telehealth services to be provided to patients in their homes.

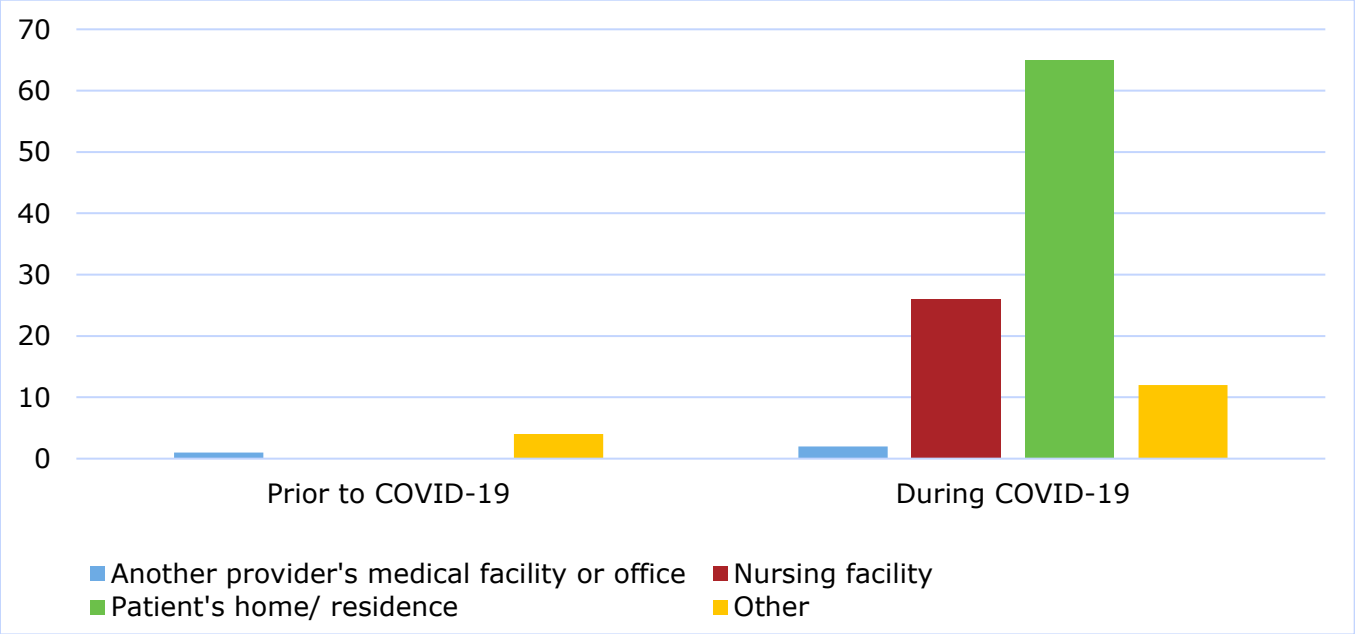
However, during the COVID-19 PHE, Texas Medicaid FFS policy and Medicare FFS policy allows for the provision of teleservices to patients in their homes. As shown in Figure 8, the number of rural hospitals providing teleservices to patients in their homes increased significantly during the COVID-19 PHE. This increase is likely due in large part to the Medicare FFS flexibility allowing for the provision of telehealth services in the patient's home during the COVID-19 PHE.

Figure 8. Rural Hospitals Providing Teleservices to Patients at Each Type of Patient Site prior to COVID-19 and during COVID-19



Similarly, Figure 9 shows the number of RHCs providing teleservices to patients in their homes or at a nursing facility increased significantly during the COVID-19 PHE. These increases are likely due in large part to the Medicare and Texas Medicaid FFS flexibilities allowing RHCs to provide teleservices, and the Medicare FFS flexibility allowing for the provision of teleservices in the patient's home.

Figure 9. RHCs Providing Teleservices to Patients at Each Type of Patient Site prior to COVID-19 and during COVID-19

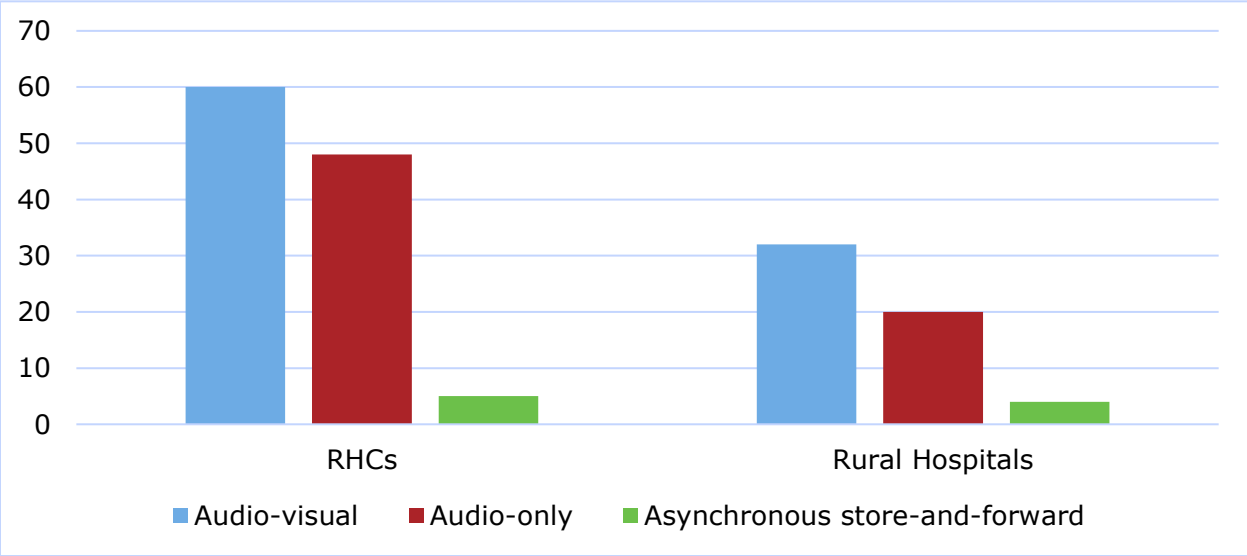


Teleservice Modalities Used by Rural Hospitals and RHCs

Different teleservice modalities can be used to allow healthcare providers at rural hospitals and RHCs to connect with patients. Results from the survey shown in Figure 10 demonstrate that for rural hospitals and RHCs, teleservices were

delivered most commonly using audio-visual followed by audio only modalities during the COVID-19 PHE.

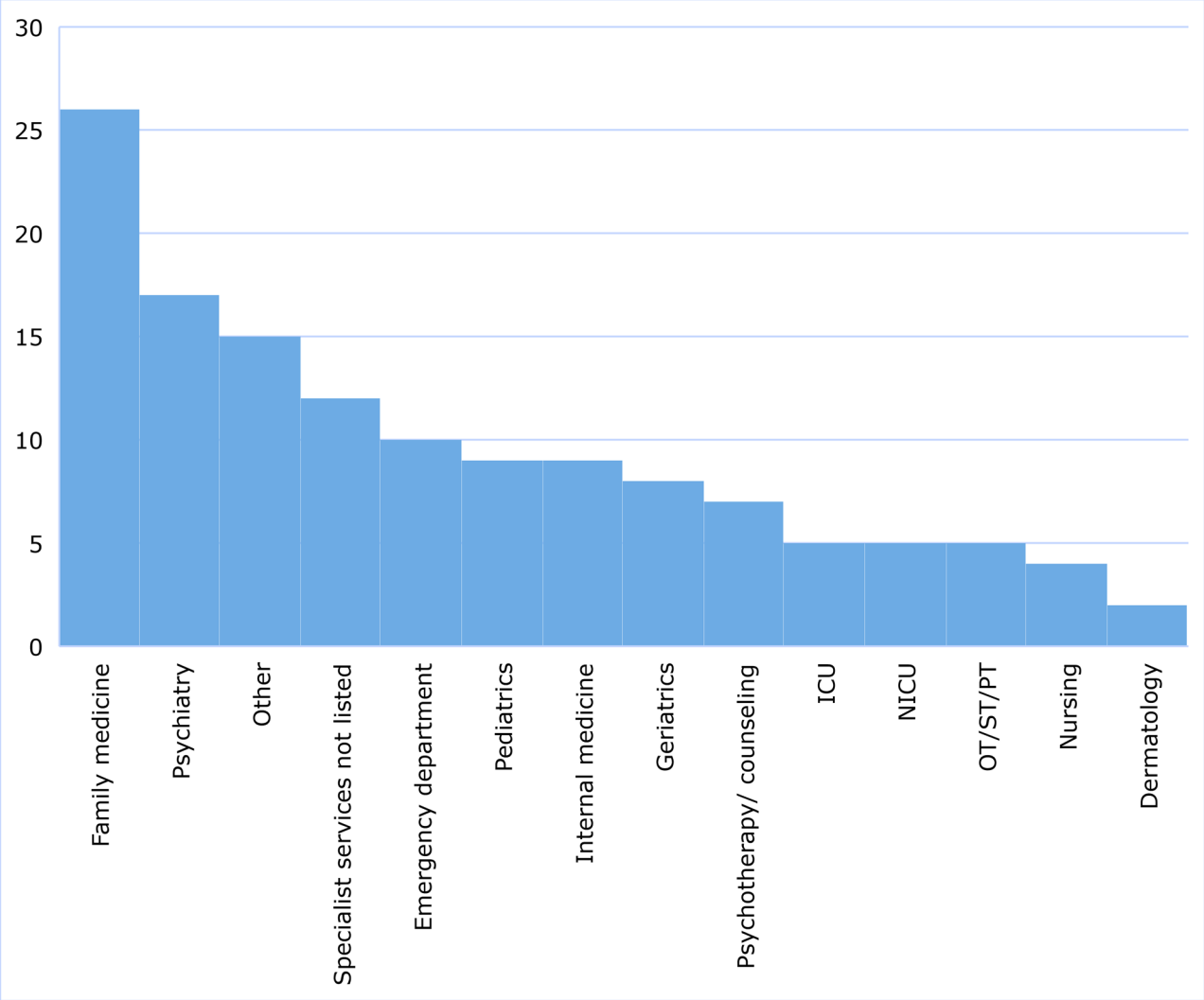
Figure 10. Rural Hospitals and RHCs Providing Teleservices via Each Modality during COVID-19



Types of Teleservices in which Rural Hospitals and RHCs are Participating during the COVID-19 PHE

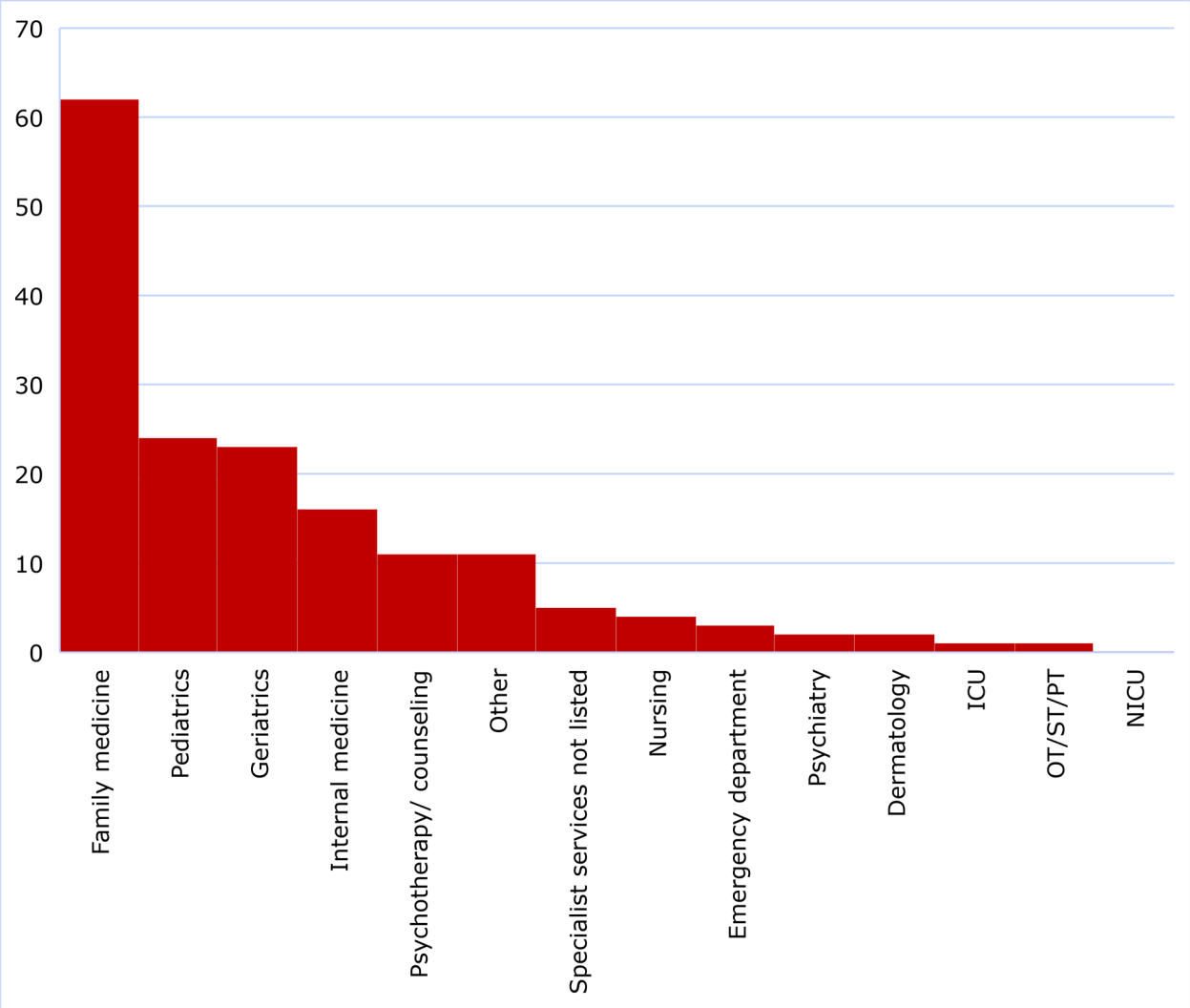
Figure 11 shows the number of rural hospitals participating in each type of teleservice during the COVID-19 PHE. Family medicine is the type of teleservice in which the greatest number of rural hospitals are participating, followed by psychiatry.

Figure 11. Rural Hospitals Participating in Each Type of Teleservice during COVID-19



Similarly, Figure 12 shows the number of RHCs participating in each type of teleservice during the COVID-19 PHE. As with rural hospitals, family medicine is the type of service in which the greatest number of RHCs are participating, followed by pediatrics and geriatrics.

Figure 12. RHCs Participating in Each Type of Teleservice during COVID-19

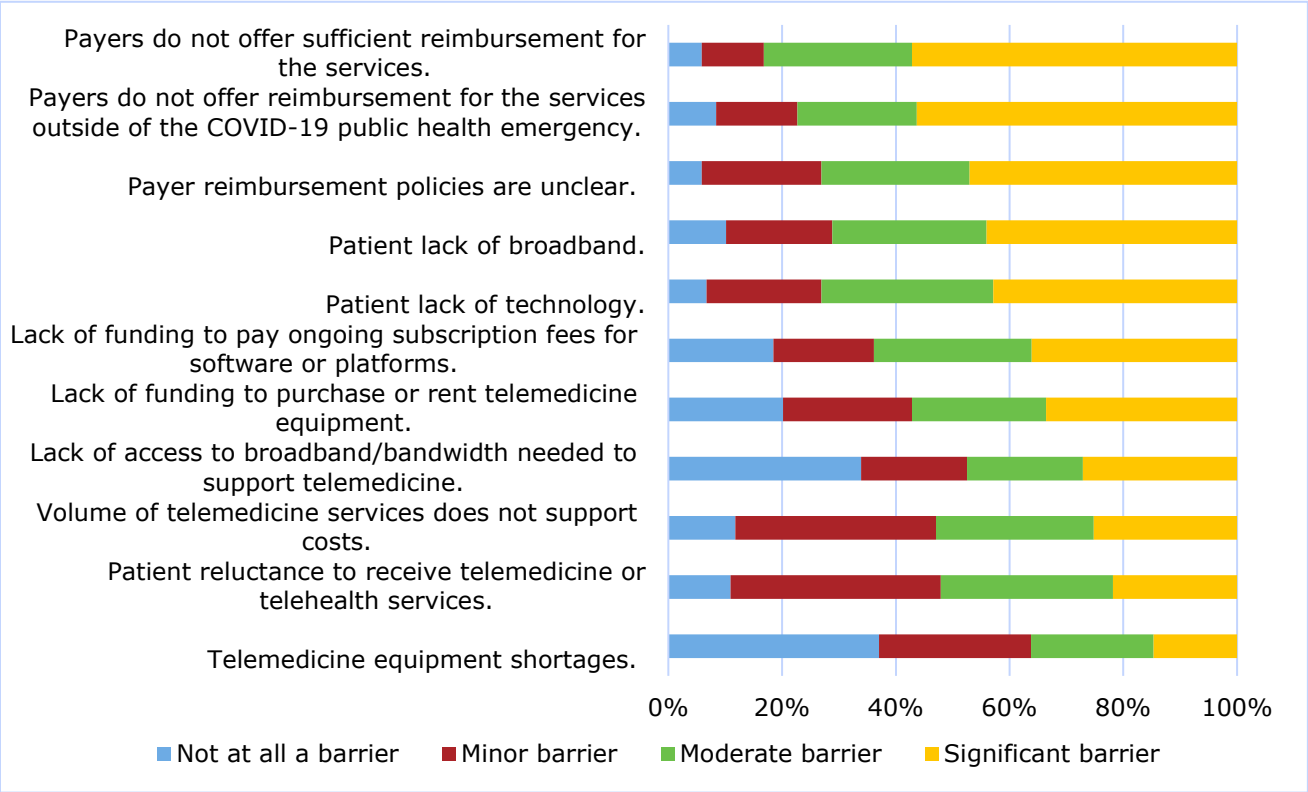


This data indicates that rural hospitals and RHCs are primarily using teleservices during the COVID-19 PHE to provide primary care.

Barriers and Flexibilities Influencing Rural Hospital and RHC Participation in Teleservices

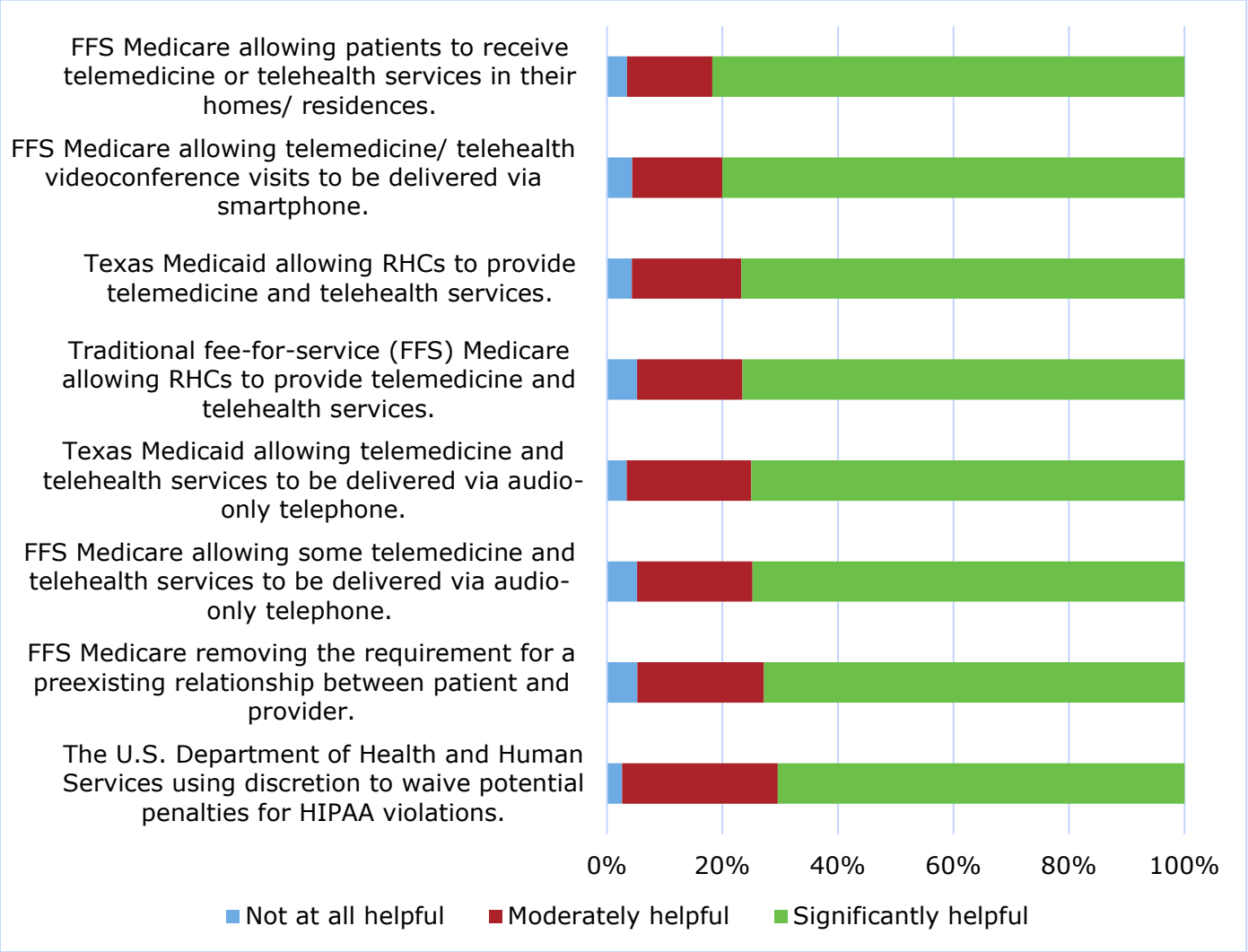
Figure 13 shows the most significant barriers to rural hospitals' and RHCs' participation in teleservices relate to reimbursement - that payers do not offer sufficient reimbursement for the services and that payer reimbursement policies are unclear. Other significant barriers relate to patients' lack of broadband and technology.

Figure 13. Most Significant Barriers to Rural Hospitals' and RHCs' Participation in Teleservices



The survey also assessed which COVID-19 Medicare FFS and Texas Medicaid medical policy flexibilities rural hospitals and RHCs found to be most helpful during the COVID-19 pandemic. Results in Figure 14 indicate that while a high percentage of survey respondents found all of these flexibilities to be significantly helpful, the highest percentage of respondents found FFS Medicare allowing patients to receive teleservices in their homes/residences to be significantly helpful. Other helpful flexibilities included FFS Medicare allowing teleservice videoconference visits to be delivered via smartphone and Texas Medicaid allowing RHCs to provide teleservices.

Figure 14. COVID-19 Flexibilities Most Helpful for Rural Hospital and RHC Participation in Teleservices



7. References

[1] Texas Health and Human Services Commission. (2020, August 27). *Delivery System Reform Incentive Payment (DSRIP) Transition Plan*. https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/dsrip-transition.

[2] Texas Health and Human Services Commission. (2020, August 27). *Delivery System Reform Incentive Payment (DSRIP) Transition Plan*. https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/dsrip-transition.

[3] Texas Occupations Code, Section 111.001(4).

[4] Texas Occupations Code, Section 111.001(3).

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