Texas Council of Community Centers

Request for Information – Response
October 16, 2020

TO: Texas House Committee on Public Health
PublicHealth@house.texas.gov

FROM: Lee Johnson, MPA
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RE: Request for Information (RFI) Response for Interim Charge 1 – Due October 16th

Related to General Monitoring

***SB 670**, which relates to ensuring reimbursement of telemedicine and telehealth services and expanding which facilities may be reimbursed for those services*

SB 670

On behalf of the Texas Council of Community Centers (Texas Council), thank you for the opportunity to comment on implementation of SB 670 relating to Medicaid telemedicine and telehealth services.

Texas Council represents the 39 Community Mental Health and Intellectual Disability Centers (Centers) throughout Texas statutorily authorized to coordinate, provide, and manage community-based services, as alternatives to institutional care, for persons with intellectual and developmental disabilities (IDD), serious mental illness, and substance addictions. In many areas of the state Centers are known as Local Mental Health Authorities (LMHAs) and Local IDD Authorities (LIDDAs).

We acknowledge SB 670 (86th Legislative Session, 2019) was passed and initially implemented in a pre-pandemic environment, but our comments cannot help but be informed by the experience of our COVID-19 response. We urge the Legislature to continue the pursuit of expanded access to telehealth and telemedicine services and sustain the flexibilities that allow Texans to access care at the right time and place during and after the pandemic subsides.

Using Telehealth and Telemedicine to Increase Access

Prior to the outbreak of COVID-19, many Centers invested in expanded technology infrastructures and telemedicine platforms. These investments were made possible by the state's Delivery System Reform Incentive Payment (DSRIP) program, authorized under Texas' 1115 Transformation Waiver.

Thanks to this expanded availability of telemedicine and other technology through DSRIP projects, in response to the pandemic, Community Centers were able to rapidly implement video and audio-only service to ensure sustained access to outpatient mental health treatment. Psychiatry, medication management, counseling, and case management were integrated into people's lives in new ways, allowing clients to remain in the safety of their own homes, while continuing to benefit from these necessary services. This shift would have been impossible without the leadership of state officials who moved expeditiously to take advantage of regulatory flexibility granted under the federal emergency declaration.

Community Centers achieved a remarkable feat, sustaining continuity of care for people across the full range of adult and children's mental health services. A precipitous drop in total contacts with clients could be expected starting in March 2020, as social distancing measures were implemented; as Figure 1 demonstrates, Community Centers instead fully utilized remote technology and continued to provide services at sustained, and sometimes even increased, levels.

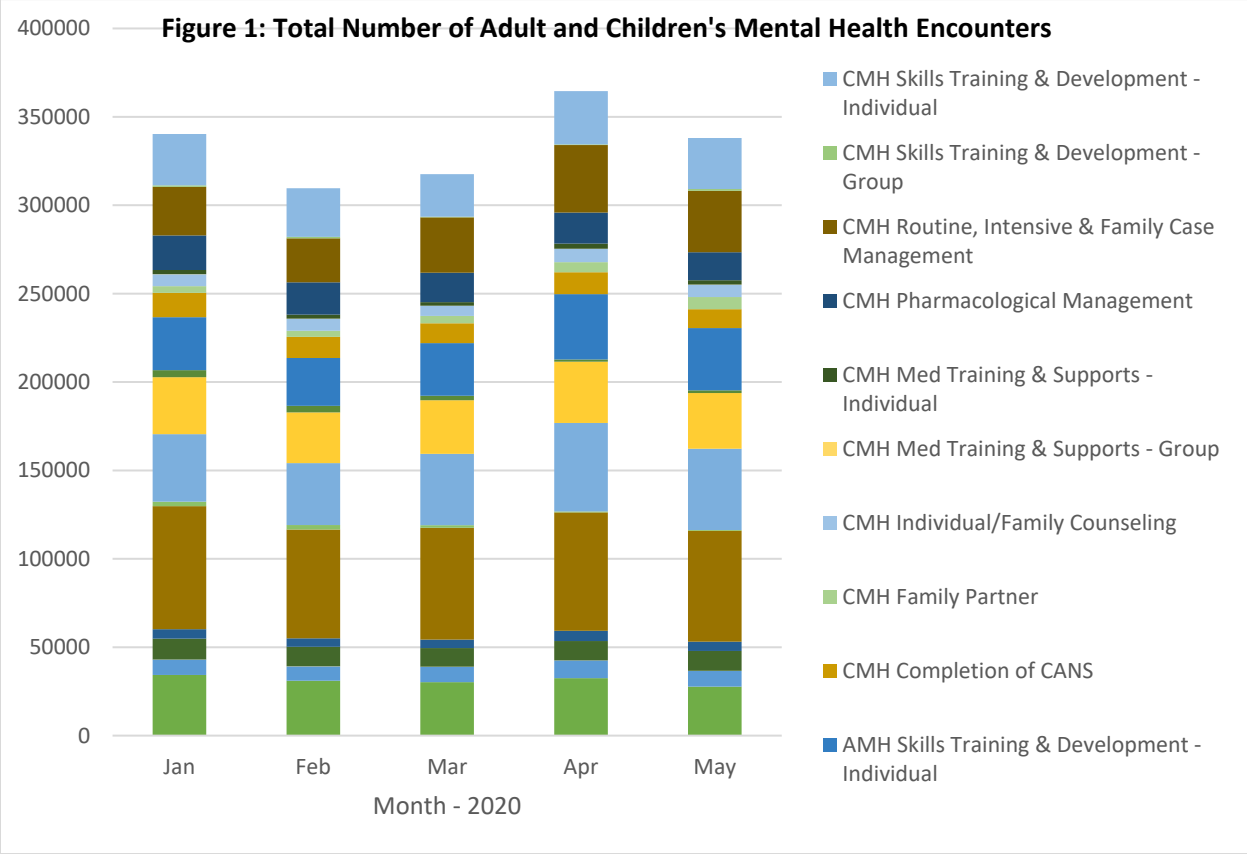
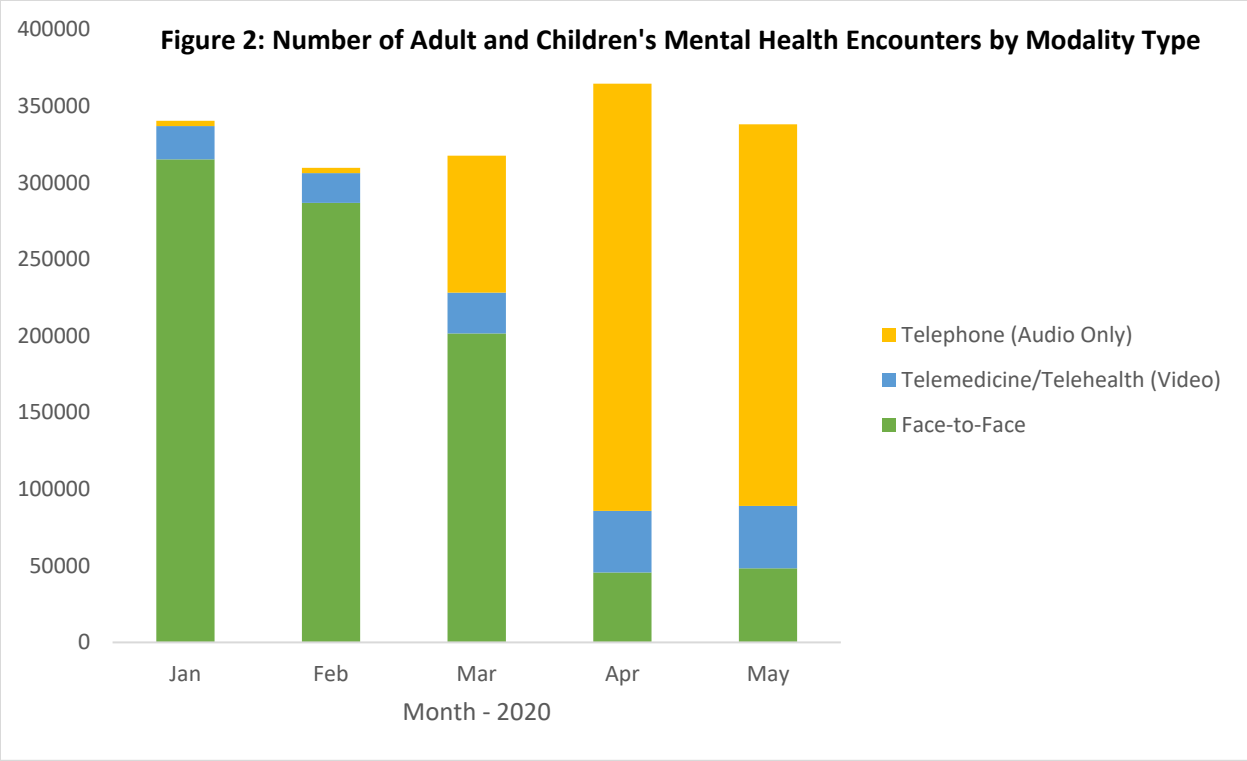


Figure 2 below demonstrates the shift from a primarily in-person model of care, as reflected in January and February 2020, to a model increasingly utilizing remote technology beginning in March 2020, at the outset of the pandemic.



Delivering Quality Care

Many regard the rapid expansion of remote healthcare technology as both a solution to barriers posed by the current pandemic and a natural step toward increased access to care. Others point out inherent limitations of remote service delivery and question whether telehealth can deliver comparable quality to in-person services.

Fortunately, a large volume of research demonstrates that clinical outcomes with telehealth are as good or better than outcomes from typical care, with benefits concentrated in specific uses and for specific populations.[i] A comprehensive review of over 950 studies of telehealth supports the use of telehealth for communicating and counseling patients with chronic conditions and providing psychotherapy as part of behavioral health.[ii]

Today, individuals and families participate in a wide range of services through a remote modality, whether video-conferencing, phone calls, or some combination. Generally, both the recipients engaging in virtual services and professional staff indicate they experienced immediate value in the remote service delivery and hope this flexibility would remain as an option post-COVID-19.[iii]

Individuals receiving services and professionals describe that remote service delivery:

- increases convenience of services by alleviating need for childcare and cost of travel;
- enhances positive outcomes by allowing for support at just the right moment and more frequently throughout the week;
- encourages people to feel comfortable opening up because they are in their own home environment;

- increases consistency in participation by reducing no-shows, especially for people with physical mobility limitations or transportation issues;
- increases intimacy of group sessions because interactive platforms allow connecting visually with people in their own space, with pets, artwork, and other meaningful objects becoming topics of conversation; and
- supports sharing resources readily at hand.

Recommendations

We urge the Legislature, in collaboration with state agency officials and stakeholders, to consider ways in which we can enhance access to care through lessons learned from the COVID-19 response, including flexible use of technology to provide services beyond the COVID-19 pandemic. In fact, the COVID-19 experience creates an opportunity to consider the full range of options that practitioners and individuals accessing care may choose in deciding the mode of service delivery that is most clinically effective and responsive to individual choice.

We offer the following recommendations:

1. **Continue parity.** Continue reimbursement parity for all modes of remote service delivery for at least a period sufficient to determine whether substantial differences in cost exist
2. **Sustain flexibilities.** Sustain provider flexibilities to deliver services via remote technology, including audio-only options, when clinically appropriate and consistent with client choice during and after pandemic response
3. **Establish uniform standards**. Support state agency efforts to establish uniform standards for (a) determining cost-effectiveness and clinical effectiveness of services and procedures delivered through remote technology and (b) consistency in billing codes and modifiers across Medicaid Managed Care Organizations to reduce administrative burden on providers, expedite reimbursements, and work toward administrative simplification for the system as a whole
4. **Increase access to broadband**. Increase access to remote service delivery by increasing access to broadband, especially in rural areas.

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[i] Annette M. Totten, Marian S. McDonagh, and Jesse H. Wagner. The Evidence Base for Telehealth: Reassurance in the Face of Rapid Expansion During the COVID-19 Pandemic. White Paper Commentary. (Pacific Northwest Evidence-based Practice Center, Oregon Health & Science University under Contract No. 290-2015-00009-I). AHRQ Publication No. 20-EHC015. Rockville, MD: Agency for Healthcare Research and Quality. May 2020.

[ii] *Id.*

[iii] Texas Council of Community Centers. Transcript of Peer Support Call. June 4, 2020.