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An Update on Telemedicine in Texas and Beyond

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The holding pattern for the telemedicine/telehealth industry (referred to generally in this article as "telemedicine") appears to be lifted with a stay in the Texas Medical Board ("TMB") vs. Teladoc litigation and the convening of the Texas Legislature in January. As published in the September *Health Law Vitals*, regulatory and legislative changes were on the horizon, and the next six months will be critical for telemedicine supporters to convince the Texas Legislature that further utilization of telemedicine will positively impact access to care and workforce shortage issues.

Update on TMB vs. Teladoc

Over the past five years, as the TMB amended various regulations and hindered companies providing medical services via telecommunications, Teladoc—a Dallas-based provider of telemedicine services offering access to physicians by phone and online video consultations—repeatedly clashed with the TMB. In January 2015, the TMB passed an emergency measure to prohibit the prescribing of drugs without an initial in-person visit. Teladoc filed a federal antitrust suit and obtained a preliminary injunction to prevent the measure from taking effect.[1] In turn, the TMB engaged in formal rulemaking and revised the rule to require a face-to-face or in-person evaluation to establish a defined physician-patient relationship.[2] The TMB claimed the rule struck a necessary balance between patient safety and the use of advanced technology, while Teladoc characterized it as limiting access and reducing patient choice. Teladoc filed suit again in April 2015 and obtained a second injunction to prevent the new rule from taking effect.[3]

The district court denied the TMB's motion to dismiss, holding that the TMB's rules are not protected state action because Texas does not actively supervise the Board's conduct.[4] The TMB initially appealed to the Fifth Circuit, but, in the wake of several amicus briefs supporting Teladoc's position (including a joint brief by the Department of Justice and the Federal Trade Commission), voluntarily withdrew its appeal in October 2016. The parties then jointly requested—and received—a stay in the litigation. The timing of the stay happens to occur while the Texas Legislature is meeting, which allows a legislative solution for the dispute. The case is set to resume on April 19, 2017, but the voluntary withdrawal and request for a stay may indicate an impending settlement that allows Teladoc to stay in business. This may be especially true as key critics of Teladoc's services have recently left the Board, and Governor Greg Abbott appointed six new TMB members with terms set to expire in 2021.

Texas Legislative Solution

The Teladoc-TMB conflict and other advances in health care technology spurred a number of stakeholders, including the Texas Medical Association ("TMA"), University of Texas, Texas Association of Health Plans ("TAHP"), Texas Hospital Association, and Texas Academy of Family Physicians, to develop draft legislation prior to the convening of the 85th Texas Legislature.

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[1] *See* Teladoc, Inc. v. Tex. Med. Bd., No. D-1-GN-15-000238 (53rd Dist. Ct., Travis County, Tex. Feb. 6, 2015).

[2] *See* 22 TEX. ADMIN. CODE §§ 174.8(a), 190.8(1)(L).

[3] *See* Teladoc, Inc. v. Tex. Med. Bd., 112 F. Supp. 3d 529 (W.D. Tex. 2015).

[4] *See* Teladoc, Inc. v. Tex. Med. Bd., No. 1-15-CV-343 RP, 2015 U.S. Dist. LEXIS 166754 (W.D. Tex. Dec. 14, 2015).

Some of the stakeholders proposed a bill that redefines telemedicine to mean any health care service requiring "the use of advanced telecommunications technology, other than telephone or facsimile technology," including "video, audio, or data transmission." The proposed bill permits providers to use "store-and-forward" techniques, which would allow electronic transmission of clinical data (such as test results or diagnostic images) to another provider for review at a later time. Perhaps most importantly, the proposed bill would allow physicians to establish relationships with patients using any synchronous audio-visual or asynchronous store-and-forward technology, so long as it did not rely exclusively on audio-only communication, telephone calls, instant messaging, faxes, or internet questionnaires or consultations. This would address the crux of the Teladoc-TMB conflict: under the proposed legislation, Teladoc's online video consultations would constitute the formation of a physician-patient relationship. Details of other legislative fixes and policy changes proposed over the past year can be found here.

Currently, only two telemedicine-related bills have been filed for the 85th Legislative Session:

- H.B. 727: Relating to the use of home telemonitoring services under Medicaid, and
- S.B. 52: Relating to the reimbursement of providers for the provision of certain home telemonitoring services under Medicaid.

Neither bill proposes the sweeping reforms advocated by the stakeholders, but Senator Charles Schwertner recently met with many of them to discuss reform of current telemedicine laws and regulations. Thereafter, TMA and others provided Senator Schwertner with their concerns and recommendations for proposed legislation, including allowing providers to charge for telemedicine services and requiring payers to adopt transparent policies regarding reimbursement for such services. Meanwhile, TAHP has expressed concerns that expanding the current telemedicine coverage mandate would be "a far-reaching action taken without any insight into its actual impact on Texas consumers or the affordability of coverage."[5] Senator Schwertner will likely file a bill that fosters technological innovation to improve access to care without creating costly mandates that interfere with private market competition. The deadline to file bills and joint resolutions for consideration during the current legislative session is March 10, 2017.

Even without accounting for the potential effect of new legislation, the state's Health and Human Services Commission ("HHSC") reports steady growth in both client utilization of, and provider expenditures for, telemedicine, telehealth, and home telemonitoring services. From 2014 to 2015, client utilization increased 31% (from 22,433 to 29,407); provider participation increased 64% (from 280 to 459); and Medicaid spending on those services increased 63% (from $3.7 million to $6.1 million).[6] While the Legislature considers changes to the telemedicine laws and regulations, advocates also will be recommending changes to Medicaid policies.

Texas is not the only state with a shifting telemedicine landscape. In 2016, 44 states introduced over 150 telemedicine-related pieces of legislation addressing issues ranging from licensing and reimbursement to delivery standards. As Texas and other states continue to respond to the growing utilization of technology in the delivery of health care, lawmakers will almost certainly continue to adopt and amend state laws and regulations with an eye towards telemedicine.

Recently Enacted Federal Laws Promote Telemedicine

While Texas courts continue to tackle foundational issues, such as whether a video or telephone consultation establishes a physician-patient relationship, recently enacted federal laws further embrace the

[5] Letter from Jamie Dudensing, CEO, Texas Association of Health Plans, to Charles Schwertner, Chair, Senate Health and Human Services (Jan. 19, 2017).

[6] Report, Health and Human Servs. Comm'n, Telemedicine, Telehealth, and Home Telemonitoring Services in Texas Medicaid (Dec. 2016)

use of technology for the delivery of medical care. For example, the 21st Century Cures Act directs the Centers for Medicare & Medicaid Services ("CMS") to identify:

1) The populations of Medicare beneficiaries whose care may be improved by the expansion of telehealth services currently reimbursed by CMS;
2) Demonstration projects, models, and initiatives being conducted by the Center for Medicare and Medicaid Innovation that examine the use of telehealth services;
3) The types of high-volume services and diagnoses that may be furnished using telehealth; and
4) The possible barriers that prevent the expansion of telehealth services.[7]

Similarly, the Expanding Capacity for Health Outcomes ("ECHO") Act mandates research into the role technology can play in promoting the sharing of knowledge and collaboration between rural and urban centers.[8] The ECHO Act is intended to both increase access to patients in underserved areas and link specialists with primary care providers in those areas via interactive videoconferencing. There are over 6,000 primary care Health Professional Shortage Areas ("HPSAs")—populations or geographic areas with population-to-provider ratios of less than 3,500-to-1 (or 3,000-to-1 if there are unusually high needs in the community)—with a combined population of over 60 million people.[9] Alleviating shortages in all HPSAs would require more than 8,000 additional primary care physicians.[10] Increasing access to, and expanding the use of, telemedicine services may be the only tenable solution to addressing the shortage.

The Joint Commission Flip-Flops on Texting Ban

In 2011, The Joint Commission, a non-profit health care accreditation organization that accredits over 4,000 hospitals, stated that safety and security concerns bar providers from texting orders for patient care, treatment, or services. Then in May 2016, the Commission concluded that texting platforms had evolved enough to address safety, security, and retention concerns, even though the health care industry remains one of the most common targets of cyber-attacks. So, providers could transmit medical orders by text message provided that a secure text messaging platform was implemented that included a secure sign-on process, message encryption, delivery and read receipts, date and time stamps, customized message retention time frames, and specified contact lists for individuals authorized to receive and record orders.[11] The Commission's position was supported by studies that showed communication via secure text messaging could improve patient outcomes, reduce hospital stay lengths, and enhance care team efficiency.[12]

Yet only two months after The Joint Commission lifted its ban on text messaging, the organization placed a hold on its May 2016 decision. It decided to collaborate with CMS to produce guidelines to facilitate the implementation of secure texting of medical orders.[13] The Joint Commission reversed course entirely in

[7] Pub. L. No. 114-255, 130 Stat. 1033 (Dec. 13, 2016).

[8] Pub. L. No. 114-270, 130 Stat. 1395 (Dec. 14, 2016).

[9] Mark. W. Friedberg et al., Evaluation of Policy Options for Increasing the Availability of Primary Care Services in Rural Washington State 3 (2016)

[10] U.S. Dep't of Health & Human Servs., Health Resources & Servs. Admin. Data Warehouse

[11] The Joint Comm'n, Update: Texting Orders, 36 JT. COMM. PERSPECT. 1, 15 (May 2016).

[12] *See, e.g.*, Mitesh S. Patel et al., *Change In Length of Stay and Readmissions among Hospitalized Medical Patients after Inpatient Medicine Service Adoption of Mobile Secure Text Messaging*, 31 J. GEN. INTERN. MED. 863 (2016).

[13] The Joint Comm'n, Delayed Implementation of Removing Ban on Secure Text Orders Until September 2016, 36 JT. COMM. PERSPECT. 1, 7 (July 2016).

December 2016 and again banned the use of secure text orders. Further, the Commission and CMS released the following recommendations:

- All health care organizations should have policies prohibiting the use of unsecured text messaging—that is, short message service ("SMS") text messaging from a personal mobile device—for communicating protected health information.
- Computerized provider order entry ("CPOE") should be the preferred method for submitting orders as it allows providers to directly enter orders into the electronic health record.
- In the event that a CPOE or written order cannot be submitted, a verbal order is acceptable; the use of secure text orders is not permitted at this time.[14]

In particular, The Joint Commission expressed concern that orders conveyed via text message could not be entered into patients' medical records in real time. Instead, an additional mechanism to transmit orders could lead to an increased burden on providers to manually transcribe text orders into the record or to contact the ordering clinician for any necessary discussion prior to order entry. So, while the advancement of communications technology might have addressed data privacy and security issues, there remain concerns that the delayed receipt of clinically urgent or time-sensitive texted health information could harm patients.

[14] The Joint Comm'n, Clarification: Use of Secure Text Messaging for Patient Care Orders Is Not Acceptable, 36 JT. COMM. PERSPECT. 1, 9 (Dec. 2016).