e-Health Advisory Committee

June 12, 2026

This summary contains supplemental information from reliable sources where that information provides clarity to the issues being discussed. Power Point tables used in the presentations may also be used in this summary. Names of individuals may be misspelled but every attempt has been made to ensure accuracy. Tables and Text have been used from executive and legislative agencies and departments' presentations and publications.

e-Health Advisory Committee advises the HHS executive commissioner and HHS agencies on strategic planning, policy, rules and services related to the use of health information technology, health information exchange systems, telemedicine, telehealth and home telemonitoring services.

The e-Health Advisory Committee (eHAC) was established in July 2016 to advise the Texas Health and Human Services Commission (HHS) and HHS system executive commissioner on strategic planning, policy, rules and services related to the use of health information technology, health information exchange systems, telemedicine, telehealth and home telemonitoring services. eHAC tasks include:

- Advising on the development, implementation and long-range plans for health care information technology and health information exchange (HIE), including the use of:
    - Electronic health records (EHRs).
    - Computerized clinical support systems.
    - HIE systems for clinical and other forms of health information.
    - Other methods of incorporating health information technology (HIT) for the purposes of greater cost-effectiveness and better patient outcomes.
- Advising on the development, use, and long-range plans for telemedicine, telehealth, and home telemonitoring services.
- Advising on incentives for increasing health care provider adoption and use of EHRs and HIEs.
- Making verbal or written recommendations via regularly scheduled meetings, a designated HHSC staff liaison, or both.
- Reporting on committee meetings and recommendations made to HHS.

The eHAC consists of three subcommittees comprised of committee members with expertise in HIE, HIT, interoperability, telehealth, and behavioral health. The three subcommittees are:

- Interoperability Subcommittee
- Telemedicine, Telehealth and Telemonitoring Subcommittee
- Behavioral Health Subcommittee

Members:

Nora Cox (Chair)
Expert on telemonitoring services
(Austin)

John Gachago, DHA
Expert on telemedicine
(Lubbock)

Brett A. Moran, MD (Vice Chair)
Expert on telemedicine
(Dallas)

Waridibo (Wari) E. Allison, MD
Medicaid provider or child health plan program provider
(Fort Worth)

Phil Beckett, PhD
Representative of a local or regional health information exchange
(San Antonio)

Dashiell Ballarta, MSHCT, MPAff, CHCIO
Representative with expertise related to the implementation of electronic health records, computerized clinical support systems, and health information exchange systems for clinical and other types of health information
(Bryan)

Sarah Boyd
Representative of consumers of health services provided through telemedicine
(Austin)

Paul Bradley, MSN, APRN, AGCNS-BC
Representative from the Texas Board of Nursing
(Austin)

Christine Bryan
Representative with expertise related to the implementation of electronic health records, computerized clinical support systems, and health information exchange systems for clinical and other types of health information
(San Antonio)

Mario Garza, MSW, MBA
Expert on telemonitoring services
(Edinburg)

Ken Holland
Representative from the Statewide Health Coordinating Council (SHCC)
(Huntsville)

Katherine Lusk
Representative from the Texas Health Services Authority established under Chapter 182, Texas Health and Safety Code
(Fort Worth)

Sheila M. Magoon, MD
Representative of a local or regional health information exchange
(Harlingen)

Aimee Lusson, Pharm.D., MBA
Representative of the pharmaceutical industry
(San Antonio)

Deanna Naranjo
Ex officio representative from HHSC
(Austin)

Neema Navai, MD
Medicaid provider or child health plan program provider
(Houston)

Christopher M. Palazola
Representative from the Texas Medical Board
(Austin)

Janel Lujan
Representative of a managed care organization
(El Paso)

Steve Eichner
Ex officio representative from Department of State Health Services (DSHS)
(Austin)

Brad Fitzwater, MD
Ex officio representative from HHSC
(Austin)

Mari Robinson, JD
Representative of a health science center in Texas
(Galveston)

Todd Unruh, RPh
Representative from the Texas State Board of Pharmacy
(Austin)

1. Call to order, welcome, and roll call. The meeting was convened by the Chair, Nora Cox. A quorum was present.

2. Advisory committee new member orientation. The links below

Public Information Act and Open Meetings Act overview
eHAC program area overview
HHS ethics overview
Advisory Committee Coordination Office (ACCO) overview

3. Consideration of February 20, 2026, draft meeting minutes. The minutes were approved as drafted

4. eHAC program updates. Update on membership appointments. Jessica Arevalo reported that the solicitation and appointment process for the committee is complete, resulting in 13 new members and two reappointed members. Nominations have been received for representatives from the Texas State Board of Pharmacy, Texas Medical Board, Texas Health Services Authority, Health and Human Services Commission (HHSC), and Department of State Health Services (DSHS). An appointment packet is currently routing to the commissioner, and the process is expected to be finalized before the next scheduled meeting. Chair Nora Cox emphasized the importance of the new member orientation to ensure everyone stays within the rules as the committee moves forward with its work plan.

5. eHAC subcommittee updates: Interoperability; Telemedicine, Telehealth, and Telemonitoring; Behavioral Health. Only the interoperability subcommittee has met.

The Interoperability Subcommittee has remained active, while the Telemedicine, Telehealth, and Telemonitoring (3T) and Behavioral Health subcommittees currently lack members and chairs.

Katherine Lusk provided an update on the Interoperability Subcommittee, which met on March 4th, April 1st, and May 6th to discuss standards like single sign-on and patient matching. The subcommittee is recommending the adoption of the American Health Information Management Association (AHIMA) naming framework for temporary newborn naming to address misidentification issues.

Statistical evidence presented shows that Texas has approximately 390,000 live births annually, and the American Association of Pediatrics attributes 11% of newborn misadventures to misidentification. A survey of 27 Texas hospitals revealed 23 different naming methods, highlighting the need for a standardized electronic exchange method to prevent delays in care for fragile populations, such as the 45.8% of newborns on Medicaid.

A formal vote on the newborn naming recommendation is scheduled for the September meeting rather than today, as it was not posted for a vote.

Subcommittee Formation Staff will solicit interest via email for members to join the three existing subcommittees: Interoperability, 3T, and Behavioral Health. Members are permitted to serve on multiple subcommittees, provided that no subcommittee reaches a quorum of the full Electronic Health Advisory Committee (EHAC), which would be more than 11 members. Organizational meetings will be held for each subcommittee to select chairs and vice-chairs; Chair Cox noted that while volunteers are preferred, she may "voluntell" members if necessary to fill leadership roles. New subcommittee proposals are welcome and should be submitted to Ms. Arevalo for evaluation and a potential vote by the full body in September.

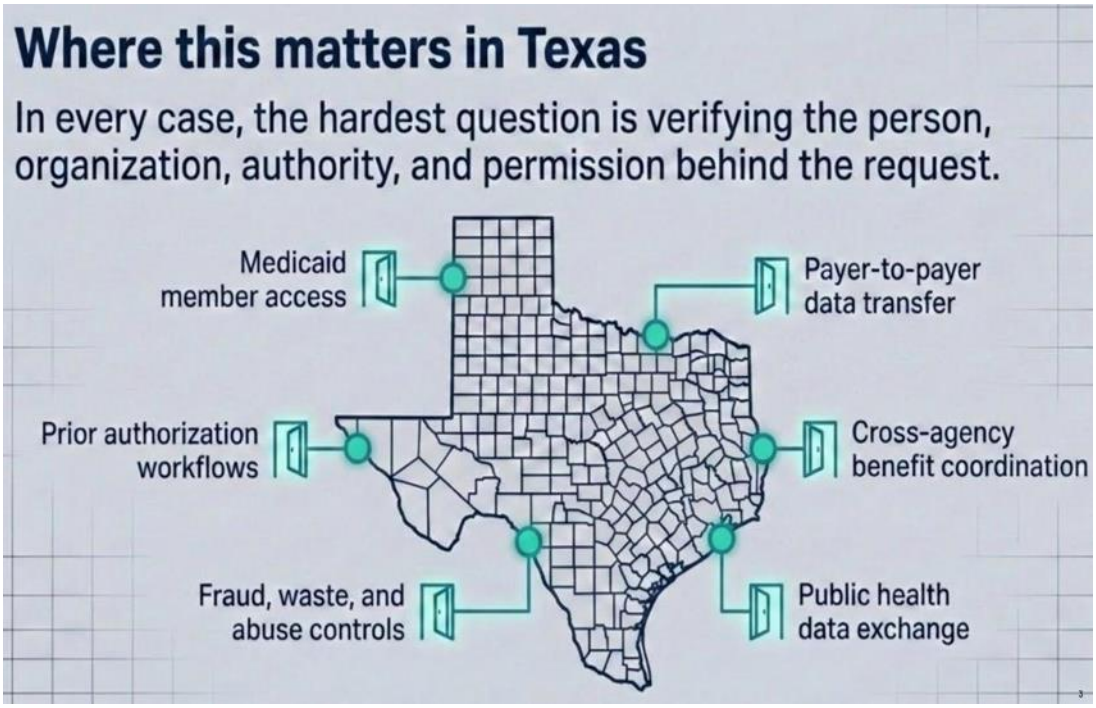
6. Planning of 2026 eHAC biennial report to HHSC and Legislature, as required by Texas Administrative Code, Title 1, Part 15, Section 351.823(d)(1)

The committee is beginning work on the biennial report due to the legislature and HHSC by December 1, 2026. The writing team will consist of subcommittee chairs and vice-

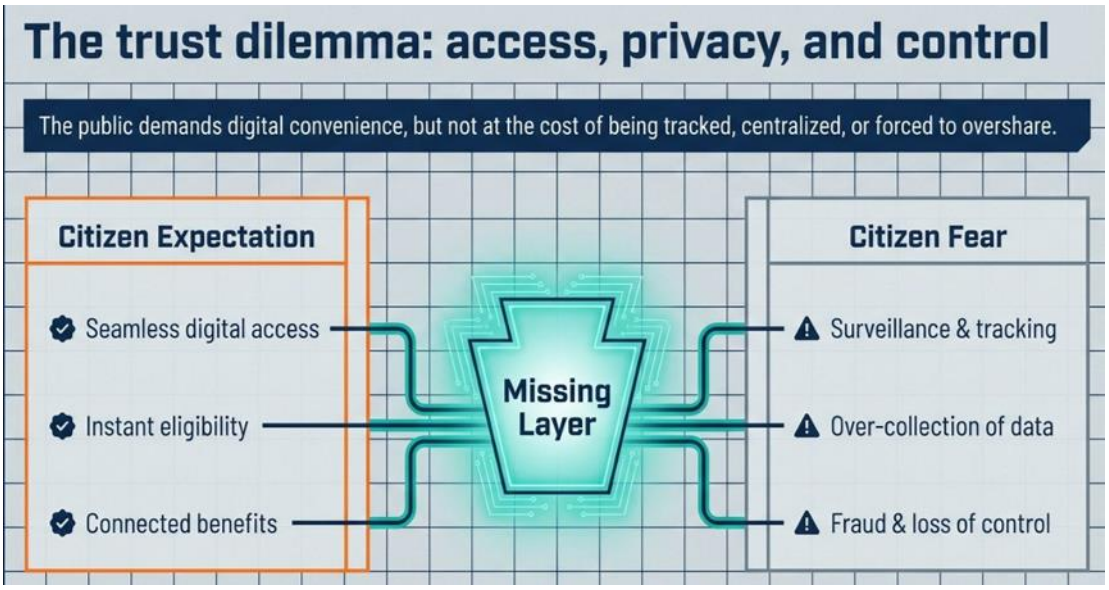
chairs, plus one or two generalist members to assist with administrative editing and proofreading. Chair Nora Cox clarified that while HHSC staff provides templates and accuracy checks, the committee members themselves are responsible for writing the content. The September 18th meeting is the final deadline for voting on any recommendations to be included in the December report. Subcommittees are expected to meet at least monthly through July and August to finalize proposals for the September vote.

7. Presentation: healthKERI, Utah's digital identity efforts

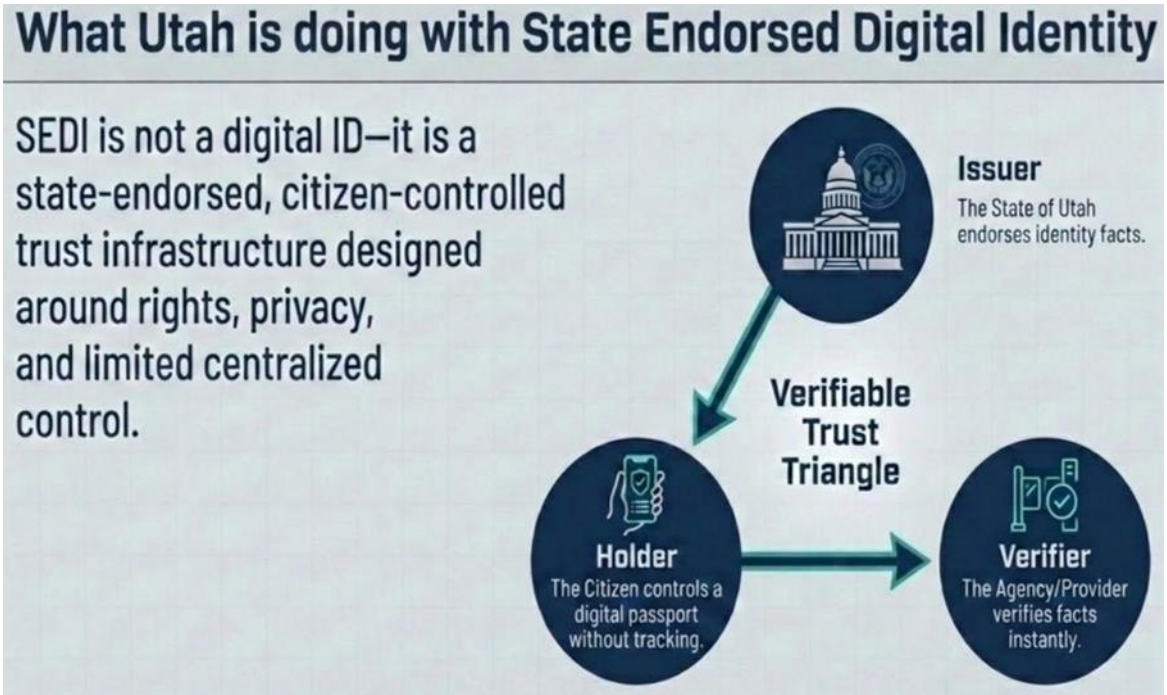
Mitchell Josephson and Jared Jeffrey from HealthKERI, along with Dr. Phil Beckett, presented on Utah's State-Endorsed Digital Identity (SEDI) initiative.

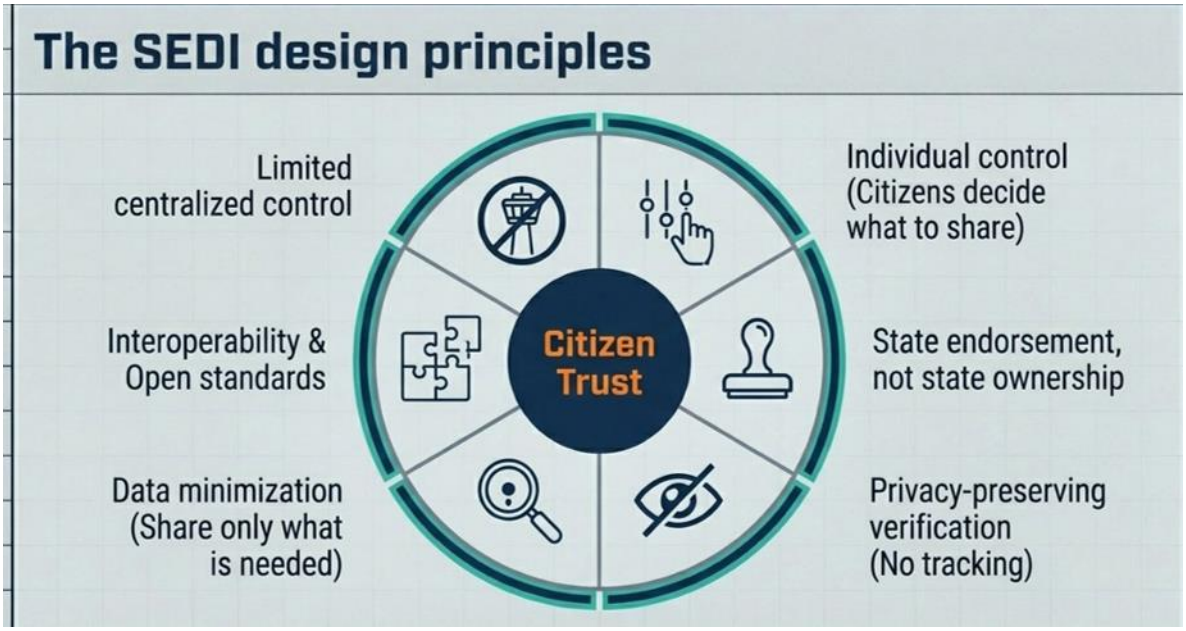


The presentation highlighted the "Zero Trust" concept, where machine-to-machine authentication replaces risky manual password systems and provides cryptographic audit logging.

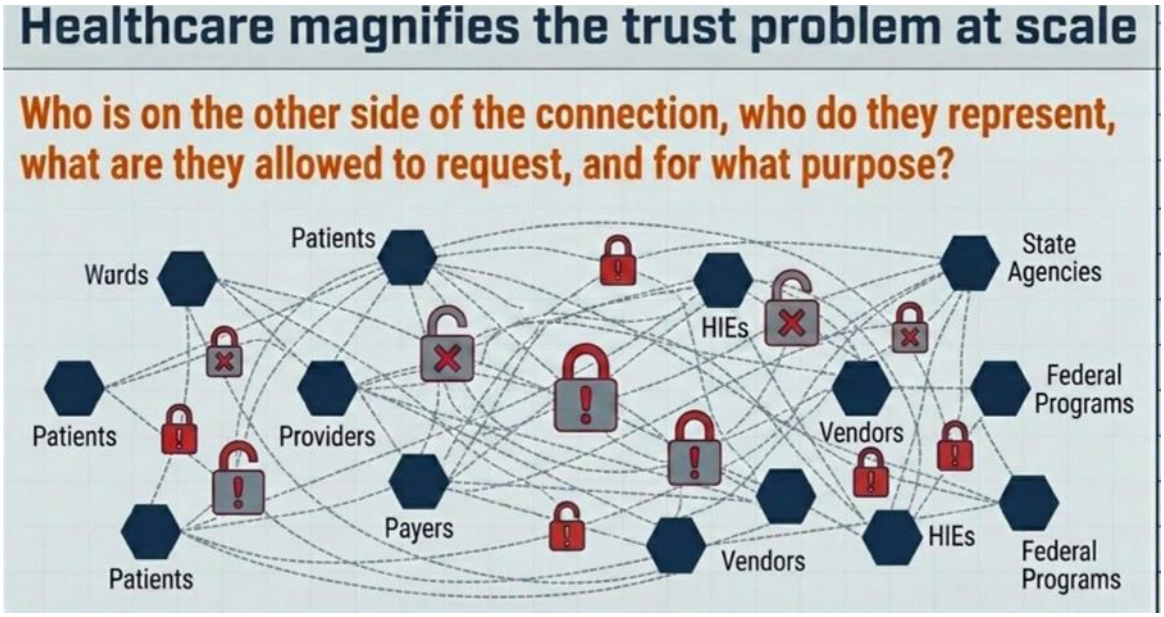


The SEDI model operates on the principle of individual sovereignty, where the citizen owns their identity and the state provides endorsements (e.g., driver's or hunting licenses) without tracking usage at the point of verification.

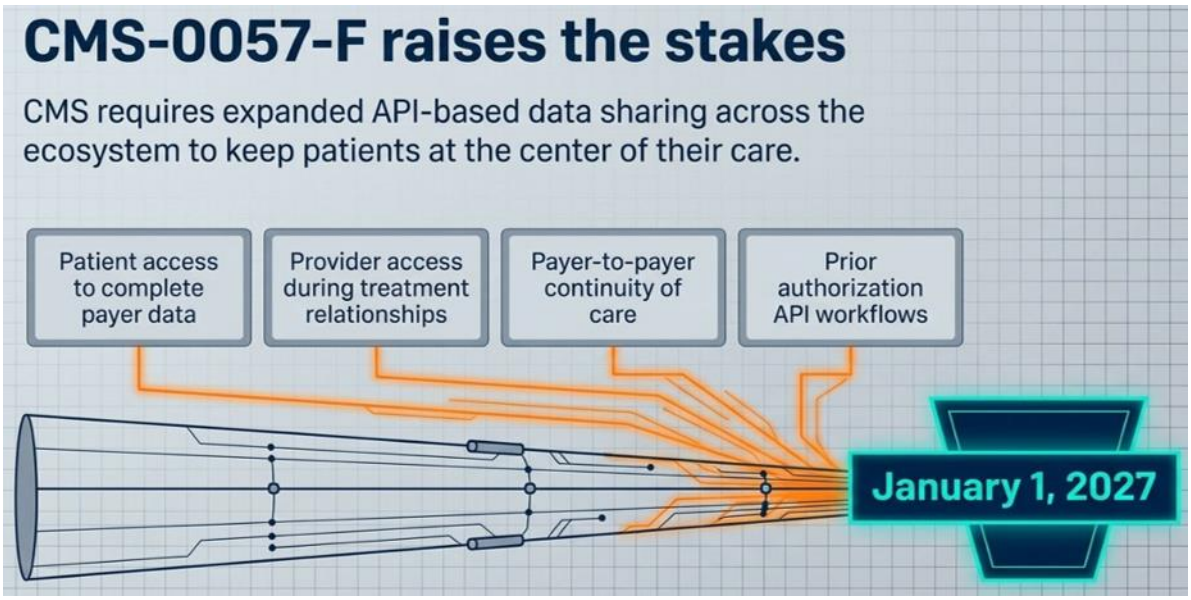


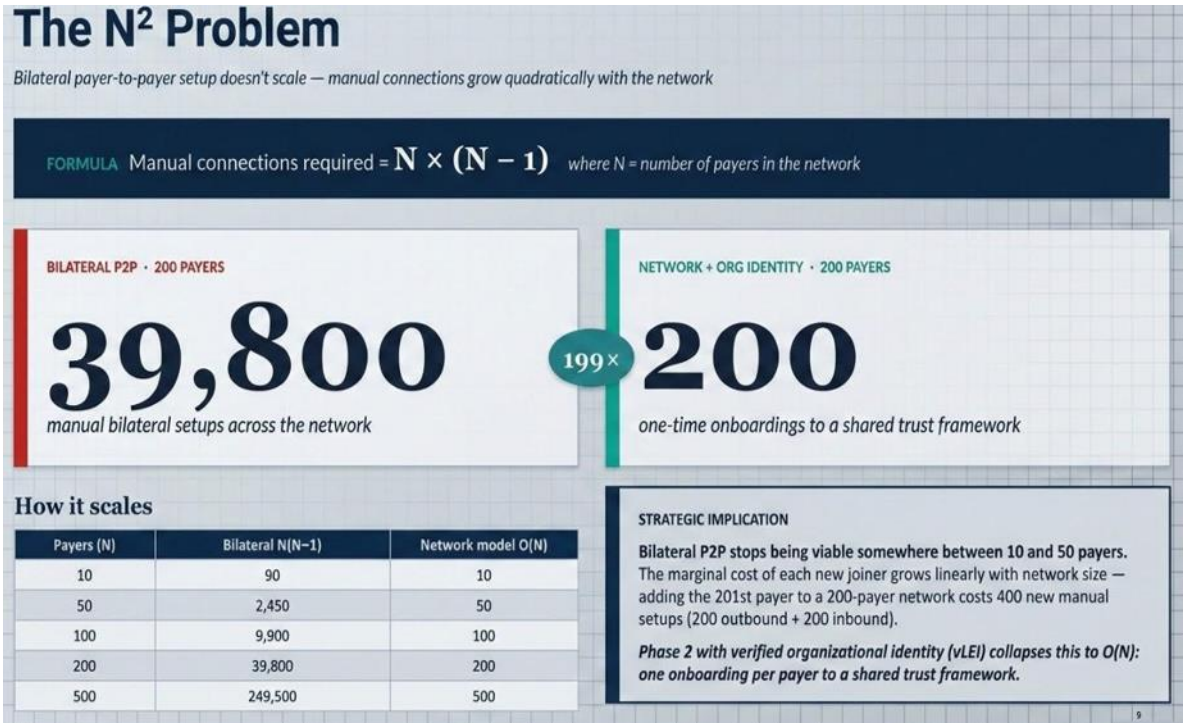


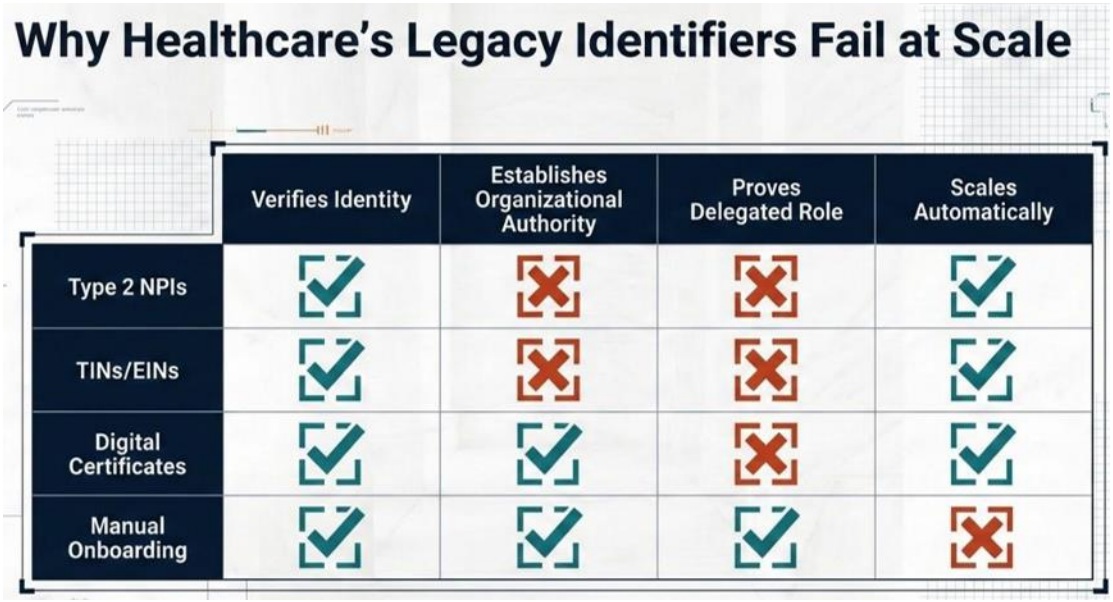
Jared Jeffrey shared a personal anecdote regarding his medical records being compromised three times following cancer treatment to illustrate the fragility and fraud risks inherent in current healthcare data systems.



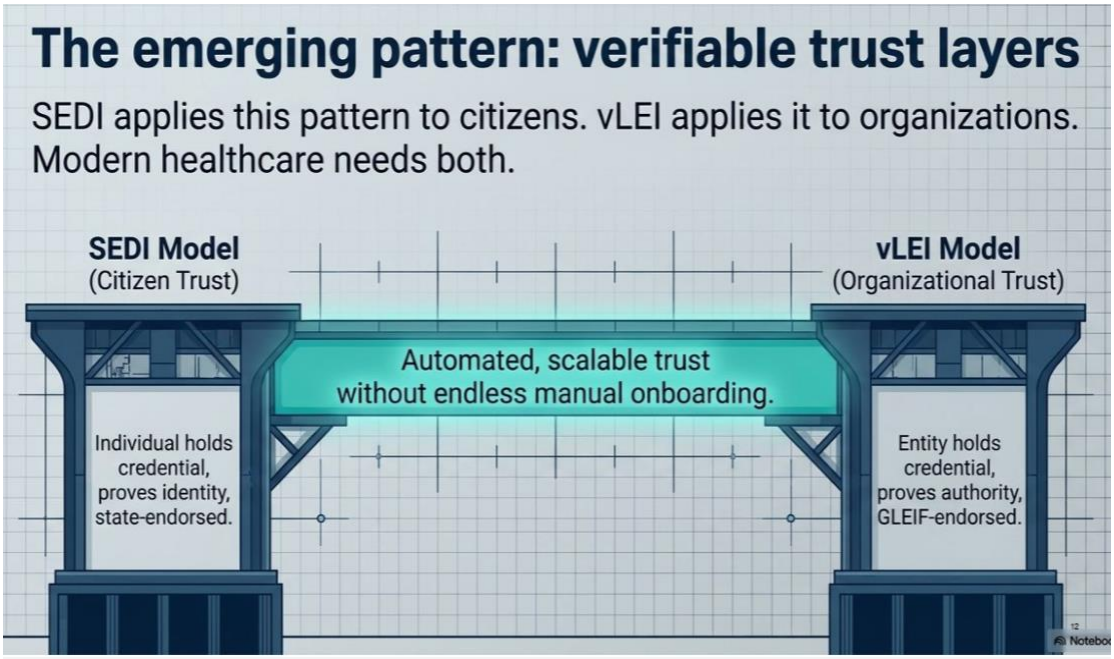
CMS mandates for 2027 will require payers to open data APIs, potentially creating 39,000 new connections across 200 payers at a maintenance cost of $2,000 per connection.



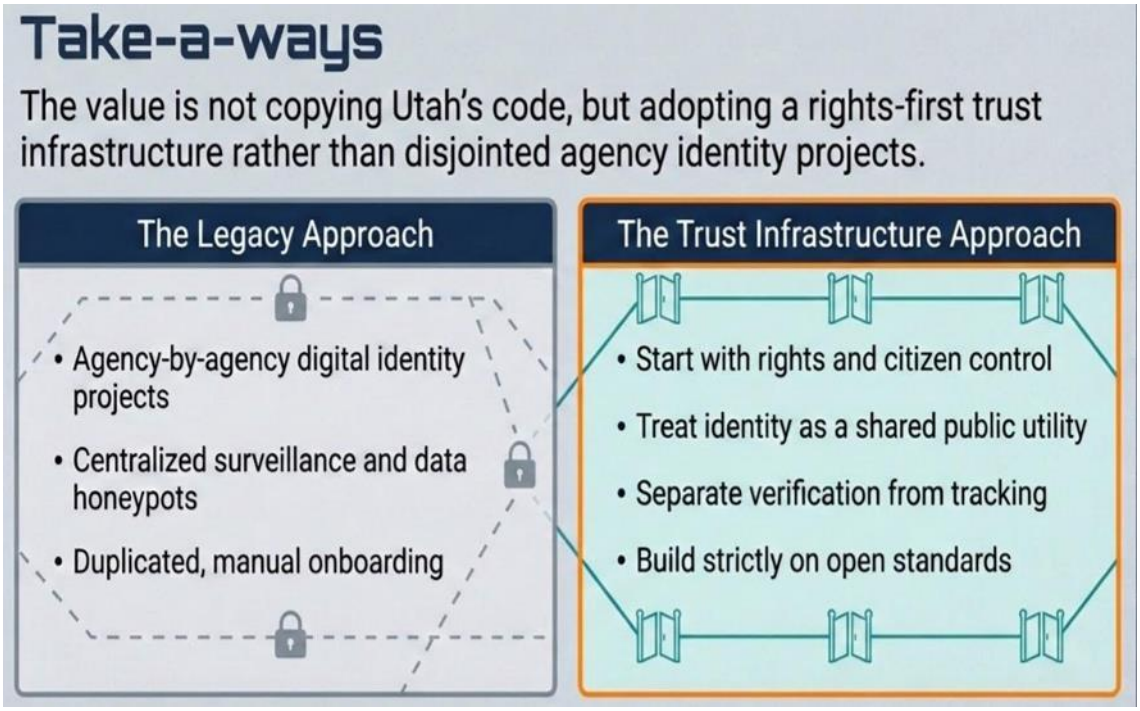

The N² Problem
Bilateral payer-to-payer setup doesn't scale — manual connections grow quadratically with the network
FORMULA Manual connections required = N × (N − 1) where N = number of payers in the network
BILATERAL P2P · 200 PAYERS
39,800
manual bilateral setups across the network
199×
NETWORK + ORG IDENTITY · 200 PAYERS
200
one-time onboardings to a shared trust framework
How it scales
Payers (N) | Bilateral N(N−1) | Network model O(N)
10 | 90 | 10
50 | 2,450 | 50
100 | 9,900 | 100
200 | 39,800 | 200
500 | 249,500 | 500
STRATEGIC IMPLICATION
Bilateral P2P stops being viable somewhere between 10 and 50 payers. The marginal cost of each new joiner grows linearly with network size — adding the 201st payer to a 200-payer network costs 400 new manual setups (200 outbound + 200 inbound).
Phase 2 with verified organizational identity (vLEI) collapses this to O(N): one onboarding per payer to a shared trust framework.


Why Healthcare's Legacy Identifiers Fail at Scale
Verifies Identity
Establishes Organizational Authority
Proves Delegated Role
Scales Automatically
Type 2 NPIs
TINs/EINs
Digital Certificates
Manual Onboarding


Enter the LEI and vLEI
LEI
ISO Standard Organizational ID.
Identifies a legal entity.
GLEIF
Enabling global identity
Protecting digital trust
vLEI
Cryptographically Bound, Delegable Authority.
Proves who the organization is, who represents it, and what they are authorized to do.
vLEI is the organizational equivalent of Utah's SEDI. Backed by the G20, it enables dynamic client registration and automated governance.


The emerging pattern: verifiable trust layers
SEDI applies this pattern to citizens. vLEI applies it to organizations. Modern healthcare needs both.
SEDI Model
(Citizen Trust)
vLEI Model
(Organizational Trust)
Automated, scalable trust without endless manual onboarding.
Individual holds credential, proves identity, state-endorsed.
Entity holds credential, proves authority, GLEIF-endorsed.

Utah's SB 275 requires organizations standing up new portals to support SETI credentials and establishes a "Duty of Loyalty," giving companies a fiduciary responsibility to act in the best interest of the citizens whose data they hold.



8. HHSC interoperability activities update. Health Information Exchange Connectivity Project.

Lacey Mathis from HHSC provided updates on the 2026 interoperability report, which is being developed in collaboration with DSHS. EHAC members are scheduled to review the draft at the end of July, with the final report due to the Legislative Budget Board and the Governor on December 1, 2026.

- Strategy 1 of the HIE connectivity project involves three local HIEs currently onboarding Medicaid providers. An open enrollment period was posted in May to encourage all five Texas regional HIEs to participate, with applications due in July.

- Strategy 2 focuses on HIE infrastructure. Since July 2025, the Texas Medicaid data repository has received nearly 455,000 Consolidated Clinical Document Architecture (CCDA) documents.
- Strategy 3 involves the Emergency Department Encounter Notification (EDEN) system. Since July 2025, the system has processed over 7.5 million Admission, Discharge, and Transfer (ADT) alerts. C3 HIE and HealthConnect Texas are active participants in this strategy.

The Patient Unified Lookup System for Emergencies (PULSE) is currently ready for hurricane season. Training for end users is ongoing to ensure readiness for any declared disasters.

Eliel Oliveira requested specific details regarding the subscribers and destinations for EDEN alerts and utilization volume for PULSE. Lacey Mathis committed to following up with the Texas Health Services Authority (THSA) to provide this information.

9. House Bill 2727, 88th Legislature, Regular Session, 2023 - home telemonitoring implementation.

Jasmine Patel from HHSC Medical and Dental Benefits Policy discussed the implementation of House Bill 2727, which adds Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) as providers for home telemonitoring.

House Bill (HB) 2727 amends Government Code, Chapter 531, and directs HHSC to: The bill adds Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) as providers of telemonitoring services in Medicaid, including the Medicaid managed care programs and requires home telemonitoring providers to establish a plan of care with outcome measures for each patient, and to share the plan and outcome measures with the patient's physician.

The bill further requires:

- Update risk factors and criteria for eligibility.
- Clarify 'home telemonitoring service' is synonymous with 'remote patient monitoring' (RPM).

- Provide home telemonitoring services to persons diagnosed with conditions for which the commission determines the provision of home telemonitoring services would be cost-effective and clinically effective.
- Determine whether high risk pregnancy is a condition for which the provision of home telemonitoring services is cost effective and clinically effective

Key policy changes include requiring only one risk factor for eligibility (down from two) and clarifying that home telemonitoring is synonymous with Remote Patient Monitoring (RPM).

Project Implementation
Texas Medicaid Provider Procedures Manual (TMPPM) Policy Update -- Became effective September 1, 2024 following a comprehensive Policy Review

Texas Administrative Code Rule Amendment -- Became effective February 27, 2025 ; Title 1, Part 15, Chapter 354
§354.1430 – Definitions
§354.1434 – Home Telemonitoring Benefits and Limitations

While policy and rule changes became effective between September 2024 and February 2025, the reimbursement rates for these services are still being finalized with CMS.

Federal Approval A state plan amendment (SPA) was submitted to Centers for Medicare and Medicaid Services (CMS). The State Plan Benefit SPA was Approved on 1/16/25 and retroactively effective to 9/1/24. The Reimbursement Rate SPA is still in progress.

Coverage for high-risk pregnancies is currently in the policy research phase, with a targeted implementation date of Spring 2027, pending leadership approval.

The Proposed High Risk Pregnancy
- Medical Policy Governance approved on December 11, 2024
- Currently in policy analysis phase
- Target implementation – Spring 2027

- Requires final approvals
- Comprehensive policy review
- Texas Administrative Code rule update
- State Plan Amendment, requires federal approval

Nora Cox expressed significant disappointment regarding the 2027 timeline for high-risk pregnancy coverage, noting that stakeholders expected a 2026 rollout and that delays put mothers and babies at risk during the Rural Health Transformation program implementation.

Margaret Scott inquired if these topics would be discussed in the "Three Ts" (Telehealth, Telemedicine, and Telemonitoring) subcommittee; Nora Cox confirmed they would be a primary focus.

10. Remote patient monitoring services update.

Diane Salisbury and Erika Johnson from the Office of Inspector General (OIG) clarified that their role focuses on the prevention and detection of fraud, waste, and abuse (FWA), rather than quality of care or policy oversight.

A 2025 data review of RPM services from September 2021 to August 2024 found that procedure code 99091 was the most utilized, accounting for $11.5 million in expenditures, primarily within the STAR+ population. The OIG identified 10 providers who received 35% of all reimbursements. Seven cases were opened, with five remaining ongoing, representing approximately $100,000 in potential funds at risk.

Common observations in these cases included a lack of physician orders or plans of care, missing qualifying diagnoses on claims, and a lack of proof that data was collected or interpreted by a qualified professional every 30 days.

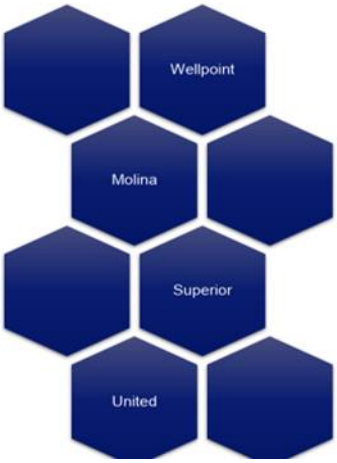
Future OIG analysis will look for "clinical interpretation" billing gaps, where clients receive equipment, but no clinical data review is recorded.

Federal Coordination and Scaling Analytics

The collection and interpretation of patient-generated physiologic data (e.g., ECG, blood pressure, glucose monitoring) transmitted by the patient/caregiver to a physician or

qualified healthcare professional. This requires a minimum of 30 minutes of provider time, can be billed once per 30-day period, and cannot be reported with a concurrent office visit.

MCO Utilization Aligned with STAR+PLUS Plans



There are 5 MCOs that serve STAR+PLUS:

- Wellpoint - $4M
- Molina - $3.5M
- Superior - $2.4M
- United - $1M United
- Community Health Choice - $27K

Provider Utilization – 99091

> 35% of reimbursements were paid to 10 providers, with proportional amounts of clients and claims.	Highest paid provider: $1M, 5,600 claims, 530 clients Of the Top 10, provider types included: 7 Multi-Specialty Groups (Family Medicine, Nurse Practitioners), > 35% of reimbursements were paid to 10 providers, with proportional amounts of clients and claims.

	3 Single Specialty Groups (Internal Medicine). One was also enrolled as a Texas HealthSteps provider.

Potential Fraud, Waste, or Abuse ReportTexasFraud.com--OIG Initiated Cases on 7 of the Top 10 Providers.

2 Closed without sufficient evidence of findings.

5 Ongoing, with potential dollars at risk of ≈ $100K in total.

Diane Salisbury detailed the OIG's coordination with federal partners, including monthly meetings with the Unified Program Integrity Contractor (UPIC) and participation in CMS Technical Advisory Groups (TAGs).

The OIG has recommended that federal partners provide access to non-public data sources to better track provider ownership and improve the accuracy of the T-MSIS database. To scale oversight as RPM usage grows, the OIG is developing predictive and proactive analytics using machine learning models to monitor the data landscape for anomalies automatically.

Notable Observations ReportTexasFraud.com

- Lack of physician's orders or Plan of Care (PoC) with data parameters for telemonitoring.
- Missing diagnostic protocols on telemonitoring referral forms or missing qualifying diagnoses (diabetes, hypertension).
- Lack of proof that a physician or other qualified health care professional collected and interpreted the client's data once every 30 days.
- Missing daily record of blood pressure and/or glucose as per the PoC.
- Documentation not sufficient to support that services were rendered for dates of service billed.
- Documentation of blood pressure readings does not support required minimum of 30-minute review from provider.
- Incorrect performing provider submitted on the claim.
- Failure to submit medical records.

OIG is currently conducting additional analyses of telemonitoring (specifically 99091) – examining whether clients included on claims for the receipt of equipment or recording

devices are also included on claims for the clinical interpretation of results from those devices.

11. Public comment No public comment was offered

12. Next meeting planning

Future Meetings: Friday, September 18, 2026; Friday, December 4, 2026; Friday, March 5, 2027

13. Adjourn. There being no further business, the meeting was adjourned.