SUBJECT: Statewide rural health maintenance organization system

COMMITTEE: Public Health — committee substitute recommended

VOTE: 5 ayes — Berlanga, Hirschi, Davila, Glaze, Maxey

0 nays

3 absent — Coleman, Delisi, Janek

SENATE VOTE: On final passage, April 28 — voice vote

WITNESSES: For — King Hillier, Texas Association of Public and Nonprofit Hospitals; Joe A. DaSilva, Texas Hospital Association; Marc Samuels, Texas Organization of Rural and Community Hospitals/Texas Rural Health Association/Texas Association of Surgical Centers; Troy Alexander, Texas Academy of Family Practice Physicians; Helen K. Davis, Texas Medical Association

Against — None

On — Mike McKinney, M.D., Texas Health and Human Services Commission

BACKGROUND: Health maintenance organizations (HMOs) are governed under chapter 20A of the Insurance Code and are defined as any entity that arranges for or provides a health care plan or a single service health care plan to enrollees on a prepaid basis.

DIGEST: CSSB 1246 would establish a new subchapter 20C in the Insurance Code authorizing the designation of a statewide rural health care system to provide health care services on a prepaid basis to enrollees who reside in rural areas.

The commissioner of insurance would have to designate one organization as the system. The organization would have to meet every requirement under the HMO Act, including reserve requirements that would be established by the commissioner and could be fulfilled by purchase of reinsurance.

The system would have to be a nonprofit corporation composed of a combination of two or more rural hospital providers. The system would have to contract with or otherwise arrange for local health care providers to deliver health care services to rural enrollees and could contract only with local health care provider networks that are composed of not more than 19 counties. The system could accept gifts and grants to use in the provision of services.

The state would have to award to the system at least one Medicaid managed care contract for health care services in rural areas. The system would have to satisfactorily address state contract qualifications, including readiness review and credentialing adequacy, medical management, quality assurance, claims payment, provider network adequacy and inclusion of providers who have furnished a significant amount of Medicaid or charity care. The system would have to be reimbursed at the state-defined capitation rate for each service area.

The system would be considered a unit of local government for purposes of tort claims and payments and entering into interlocal cooperation contracts. The system could enter into contracts or joint ventures to provide administrative services and intergovernmental agreements and could provide technical assistance and management services to local health care providers.

The system would be governed by an 18-member board of directors who would have to reside in the territorial jurisdiction of the system. Twelve members would be appointed by the governor and would have to include two employer representatives, two local government officials, two health care consumers, and six physicians, three of whom being general practitioners. Participating hospital providers would appoint the other six directors.

The board could appoint an executive committee to conduct board business; the executive committee would have to be composed of six members, two representing participating hospital providers, two representing the community, and two physicians. Meetings of the board would be subject to the Texas Open Meetings Act, except for meetings to deliberate pricing or financial planning; new services, product line or marketing proposals; confidential patient care information; and physician credentialing or peer

review.

The board would have to appoint at least one advisory committee composed of representatives from nonprofit and investor-owned hospitals, urban hospital districts, health care teaching facilities, health care specialty facilities, medical residency programs in family practice, and rural health clinics.

A rural area would be defined as a county with a population of 50,000 or less; an area not delineated as an urbanized area by the federal census bureau; or any other area so designated by the commissioner.

The bill would take effect September 1, 1997. The commissioner would have to adopt rules by January 1, 1998, and the system would have to begin offering health care services by March 1, 1998, unless the system determined that it was not prepared to fulfill its regulatory or contractual obligations by that date.

SUPPORTERS SAY:

CSSB 1246 would allow rural communities to maintain their health care infrastructure and to competitively participate in managed care delivery systems. By contracting only with a small number of local providers and referring patients to suburban or urban areas for more extensive care, the expansion of urban-based HMOs and other managed care networks into rural areas threatens the economic viability of existing health care providers, and a rural community's economic base.

CSSB 1246 would authorize the establishment of a statewide system that would be a risk-bearing entity that would contract with locally developed provider networks, such as physician-hospital organizations, or with individual providers to serve a particular rural region. The system would provide centralized administrative, financial and technical support to the local systems. The local providers would retain control over health care delivery, quality assurance, and utilization review.

CSSB 1246 would establish an entity to help rural providers and provider networks assume risk and to allow for intergovernmental fund transfers; it would *not* be creating a unique HMO. The statewide rural health system would have to meet all requirements under the HMO Act. Most rural

hospitals are publicly supported or authorized hospitals, and they are prevented by law from assuming the managed care risk of patients who reside in another county or political subdivision. The bill also would allow rural hospitals to use disproportionate share funds, received from the federal government through the Medicaid program, in a federally authorized manner to establish an HMO.

This bill would help, not hinder, managed care competition in rural areas by helping rural providers participate in an alternative HMO that could match the resources provided by urban, integrated systems. Participation in the system would be totally voluntary and could include contracts with existing HMOs. Solvency and insolvency would be monitored and handled by the Texas Department of Insurance in a fashion similar to its monitoring of all HMO solvency questions.

OPPONENTS SAY:

This bill would grant special, noncompetitive contracting privileges to the rural health care system by requiring the state to grant at least one Medicaid managed care contract to the system. It would not adequately prevent the Medicaid contract from being transferred to a private hospital or managed care system in the event of a sale or dissolution of the rural system. If one purpose of the bill is to foster competition, the rural statewide health care system should have to compete for Medicaid managed care contracts just like every other HMO.

This bill also would be establishing a special type of HMO without clearly specifying legislative intent about how licensing and other regulatory functions would work in circumstances in which the rural system differed from other HMO applications and oversight. Also, carving out special niches for every nuance in health care delivery makes public oversight and the formulation of public policy more difficult than necessary.

NOTES:

The committee substitute added to the Senate-passed version of the bill general and specialty hospitals in the definition of “local health care provider;” redistribution of revenue in the case of system dissolution or sale; limiting system contracting to local health care provider networks that are composed of not more than 19 counties; and limiting mandated state contract provisions to managed care contracts in the Medicaid program.

A related bill, HB 2058 by Delisi, which would have authorized the establishment of a nonprofit, group model HMO called an Integrated Health Plan, or IHP, was placed on the General State Calendar but was not considered by the House.