SUBJECT: Administration and duties of the Texas Health Services Authority

COMMITTEE: Public Health — committee substitute recommended

VOTE: 9 ayes — Kolkhorst, Naishtat, Gonzales, Hopson, S. King, Laubenberg, McReynolds, Truitt, Zerwas

0 nays

2 absent — Coleman, J. Davis

SENATE VOTE: On final passage, May 12 — 31-0

WITNESSES: For — Starr West, Texas Hospital Association

Against — None

On — Archie Alexander; John Holcomb, Texas Medical Association, Texas Pediatric Society, Texas Academy of Family Physicians; Ted Melina Raab, Texas American Federation of Teachers; Manfred Sternberg, Texas Health Services Authority

BACKGROUND: In 2007, the 80th Legislature enacted HB 1066 by Delisi, which added Health and Safety Code, ch. 182 to establish the Texas Health Services Authority, a public nonprofit corporation intended to facilitate the electronic exchange of health information to improve patient safety and quality of care.

DIGEST: CSSB 8 would expand the purpose of the Texas Health Services Authority to include making recommendations to improve the quality of health care funded by both public and private payors and to increase accountability and transparency.

The bill would add to the reasons for which the authority was established that the authority would research, develop, support, and promote recommended strategies to improve health care quality and to increase accountability and transparency through voluntary implementation of the

recommendations by health care practitioners, health care facilities, and payors, including recommendations for:

- evidence-based best practice standards for health care facilities and practitioners as well as performance measures for health care practitioners identified by the evidence-based best practices and quality of care advisory committee;
- improved payment methodologies to reward adoption of clinical best practices and improved outcomes;
- streamlined administrative processes, including standardized claims;
- verification and authentication of the source data used in performance measures; and
- development and distribution of electronic applications for use by health care practitioners in self-evaluation of their performance compared to their peers.

The authority would be administratively attached to the Health and Human Services Commission (HHSC). The commission would:

- seek and administer funds, including applying for grants, paying salaries, and reimbursing board expenses;
- provide administrative assistance, services and materials to the corporation, including budget planning and purchasing; and
- provide computer equipment and support and adequate office space.

If a chief executive officer or any staff were hired, they would be employees of the authority and not HHSC. The authority would be considered to be a state agency and its employees would be considered state employees.

The bill would amend the authority's board to include 15 directors, including five members appointed by the governor, five members appointed by the governor from a list of candidates prepared by the speaker of the House, and five members appointed by the lieutenant governor. The chief officers of several agencies, including HHSC, the Department of State Health Services, the Employees Retirement System, the Teacher Retirement System, and the Department of Insurance, would be nonvoting members of the board as well as the state Medicaid director. The board would meet at least quarterly and would hold public meetings.

The board could employ or contract with a medical advisor who was a licensed Texas physician with direct patient care experience and expertise in health care quality improvement and performance measures. The chief executive officer could employ a technology director who had education, training, and experience in planning, developing, and implementing health information exchange initiatives.

The board would establish an advisory committee on technology and an advisory committee on evidence-based best practices and quality of care. The board could establish additional advisory committees that it found necessary to assist the board in performing its functions. Advisory committee members would be required to have significant expertise in the relevant areas, with at least one member of each committee having practical experience and would represent both the private and public sectors and stakeholders. Advisory committees could receive reimbursement for travel expenses.

The bill would add to the requirements of the statewide health information exchange that it would be capable of enabling patients to access their own medical records through the Internet. The authority no longer would be allowed to seek funding to identify standards for streamlining health care administrative functions across payors and providers, including electronic patient registration, communication of enrollment in health plans, and information at the point of care regarding services covered by health plans.

The authority would research, develop, support, and promote objectives related to evidence-based best practice standards, performance measures that could be used to evaluate quality of care, technology that could collect medical information or exchange health care information, integration and collaboration of health care practitioners to control cost and improve quality, alternative payment methodologies for health care payments that met certain outcomes, standards and recommendations for streamlining health care administrative functions, and standards for verification and authentication of source data.

In performing these duties, the board would examine existing standards, guidelines, strategies, and methodologies created by nationally recognized organizations and used in the federal Medicare program and review them to ensure they were safe, effective, timely, efficient, equitable, and patient-centered. The board would develop recommendations on achieving maximum participation of health care practitioners, health care facilities,

and payors in using these standards, guidelines, strategies, and methodologies.

The authority would conduct or contract for a study to develop payment incentives to increase access to primary care. The study would evaluate proposals for changes to payment methodologies for implementation by multiple public and private payors. In evaluating the proposals, the study would consider the six aims of quality care identified by the Institute of Medicine and would be required to consider payment methodologies that rewarded primary health care practitioners for patient retention, monitoring, adequacy of access to care, and other measures.

The authority would conduct or contract for a second study to develop payment methodologies based on risk-adjusted episodes of care, including global payments, that created incentives for a higher quality of services and a reduction in unnecessary services. The study would be required to evaluate payment methodologies that aligned incentives for health care practitioners and facilities, bundled payments based on episodes of care, allowed for the adjustment of payments based on the risk factors of the patient, and could be adopted by private and public payors. The study also would identify high-cost, frequently performed procedures for which the cost would be most affected by a change in payment methodologies.

The studies would examine certain payment methodologies, review them for certain quality care measures, and include recommendations on achieving maximum participation of health care practitioners, health care facilities, and payors in using the payment methodologies evaluated under those studies. By January 1, 2011, the authority would submit to the Legislature a summary of the results of the studies and recommendations for legislation regarding the studies' findings, including methods to require or encourage as many payors as possible to use the payment methodologies recommended by the studies. Authorization for the pilot programs would expire September 1, 2011.

The bill would take effect September 1, 2009.

SUPPORTERS SAY:

CSSB 8 would expand the role of the Texas Health Services Authority to improve the quality, safety, and efficiency of health care delivery in Texas. The bill would integrate the authority’s existing emphasis on health technology in the development of evidence-based best practices. Health care providers, facilities, patients, and various payors, including Medicaid

and state retirement systems, could weigh in on the impacts of health care proposals to aid in the development of better health care approaches and share effective practices.

The current health care model emphasizes fee-for-service approaches that incentivize providers to perform unnecessary procedures to obtain higher reimbursements. One of the major benefits of this bill would be to incorporate recommendations from nationally recognized organizations that would reward health care providers and facilities for providing the services that would most benefit patient welfare, not only at the time of treatment but through ongoing follow-up and encouraging access to primary care. Such practices would reduce costs to the health system because patients would stay healthier and doctors would not be rewarded for unnecessary treatments.

All of the recommendations of this bill would be implemented on a voluntary basis. The bill would allow for the hiring of an expert medical director and the formation of advisory committees that could include medical experts to provide the insight and practical experience that would inform the authority on health matters. Even if funds were not immediately available to implement some of the more ambitious proposals, the authority as would be revised under CSSB 8 would ensure the state anticipated and had an established plan to address any barriers to the implementation of quality and efficiency processes when resources became available.

OPPONENTS SAY:

CSSB 8 would undertake too many expansive goals with inadequate resources and expertise to ensure that the bill would be beneficial rather than harmful. Focusing on quality of care is extremely important, yet without proper implementation, performance incentive programs can be abused or unintentionally could have inappropriately punitive consequences for health care providers.

The Texas Health Services Authority was never funded to achieve its initial goals, and CSSB 8 would expand the authority's goals further without the guarantee of any funding and certainly not adequate funding to undertake thorough research. The bill also would not establish safeguards to ensure input from medical experts in the appropriate roles. There would be no criteria requiring health care practitioners to be members of the board, and hiring of a medical director would be optional. Use of the advisory committees, which would be the only sure source of medical

expertise, could be limited to the few circumstances under which their input specifically was required.

NOTES:

The fiscal note indicates the bill could have a fiscal impact depending on the scope of the Texas Health Authority, but not enough data was available to anticipate this impact.