SUBJECT: Health care collaboratives and other quality and efficiency measures

COMMITTEE: Public Health — favorable, without amendment

VOTE: 7 ayes — Kolkhorst, Naishtat, Coleman, S. Davis, V. Gonzales, Truitt, Zerwas

0 nays

2 present not voting — S. King, Schwertner

2 absent — Alvarado, Laubenberg

SENATE VOTE: On final passage, April 19 — 31-0

WITNESSES: For — Sue Bornstein, Texas Medical Home Initiative; Asa Lockhart, Texas Medical Association; Jared Wolfe, Texas Association of Health Plans; (*Registered, but did not testify*: Tom Banning, Texas Academy of Family Physicians; Michael Gutierrez; Eliza Vielma, Americans for Prosperity)

Against — None

On — Charles Bailey, Texas Hospital Association; Douglas Danzeiser, Texas Department of Insurance; Anne Dunkelberg, Center for Public Policy Priorities; Carl Isett, Robyn Jacobson, Texas Association of Benefit Administrators; Lisa McGiffert, Consumers Union Safe Patient Project; Tommy Prudhomme, Office of the Attorney General (*Registered, but did not testify:* Ramdas Menon, Melanie Williams, Department of State Health Services)

BACKGROUND: The Health Care Policy Council comprises state agency administrators and was established by the 79th Legislature in 2001 to identify and study gaps, inefficiencies, or problems in the health care system, including health-related issues referred by the governor, and identify possible solutions.

Public use data are collected by the Department of State Health Services (DSHS) and disclosed to researchers and other users and contain patient-

level data relating to individual hospitalizations that have not been summarized or analyzed, have had patient identifying information removed, identify physicians only by use of uniform physician identifiers, and are severity and risk adjusted, edited, and verified for accuracy and consistency.

DIGEST:

SB 8 would establish the Texas Institute of Health Care Quality and Efficiency, abolish the Health Care Policy Council, establish a statutory framework for the regulation and operation of health care collaboratives, establish a statewide patient risk identification requirement, establish a recognition program for certain health care providers, and amend requirements related to health care provider reporting and the disclosure of data that are not public use data.

Texas Institute of Health Care Quality and Efficiency. The purpose of the Institute would be to make recommendations to the Legislature to improve health care quality, efficiency, and health care data reporting and to support innovative health care collaborative payment and delivery systems. The Health and Human Services Commission (HHSC) would be responsible for the institute's administrative operations. The institute would be required to submit its findings and recommendations in a report by December 1, 2012, to the governor, the lieutenant governor, the speaker, and the chairs of appropriate standing committees. The institute would subject to the Sunset Act and would be abolished by September 1, 2017.

The Institute would have a board composed of nonvoting ex officio members, including the state Medicaid director and the heads of the following state agencies: HHSC, DSHS, Texas Department of Insurance (TDI), Employees Retirement System of Texas (ERS), Teacher Retirement System of Texas (TRS), and the Texas Medical Board (TMB), and each state agency or system of higher education that purchased or provided health care services. The governor would appoint an additional 15 voting directors with expertise in health care, which could include providers, payors, or other entities to serve two-year terms. The institute would be funded by each state agency represented on the board and could request and accept gifts and grants.

The specific duties of the institute would include providing research and a forum for regulators, providers, and payors to make recommendations on:

- outcome measures for quality of care and efficiency (the institute's recommendations would cover all teacher and state employee and retiree benefit plans, Medicaid, and the Children's Health Insurance Program [CHIP]);
- reducing the incidence of potentially preventable events;
- improving reporting and transparency of health care information and conducting a complete assessment of all health-related state-collected data;
- study the feasibility of establishing a centralized all-payor health care claims database; and
- innovative alternative health care payment and delivery systems.

Health care collaboratives. SB 8 would define a health care collaborative as an organization that consisted of physicians and other health care providers that was organized within a formal legal structure to provide health care services and capable of receiving and distributing payments to the participating physicians or health care providers.

A health care collaborative would have to be certified by TDI as provided by rules, unless it already held a certificate of authority under another chapter of the Insurance Code. TDI also would have to set application fees and annual assessments in amounts sufficient to pay the reasonable expenses of TDI and the Office of the Attorney General (OAG) in regulating health care cooperatives. The bill would state that the intent of the Legislature would be to exempt and provide immunity from federal antitrust laws through the state action doctrine for certified health care collaboratives.

For approval of a certificate of authority, applicants would have to:

- identify the service area covered by the collaborative;
- demonstrate the collaborative contracts with a sufficient number of primary care physicians to serve the service area;
- show sufficient working capital and reserves;
- demonstrate the willingness and potential ability to ensure health care service collaboration and integration, the promotion of quality-based health outcomes and patient engagement, reduced occurrence of potentially preventable events, cost containment without jeopardizing patient care, and data reporting processes; and

- show that it would not reduce competition in any market for physician, hospital, or ancillary services and was not likely to possess market power.

The TDI commissioner would have to forward to the OAG applications deemed compliant with requirements. The OAG would have to determine within 60 days whether the application did not reduce market competition and did not possess market power and inform the TDI commissioner of its decision. A certificate would have a one-year term, and its renewal application would have to show, among other items, an evaluation of the quality and cost of provided health care services; its processes to promote evidence-based medicine, patient engagement, and the coordination of health care services; and the number, nature, and disposition of any complaints.

The collaborative would be governed by a board that had an even number of participating physicians and an equal number other health care providers. The board also would have to have one individual member with business expertise who was selected by unanimous vote of the members. The board would be required to establish a compensation advisory committee to make recommendations regarding charges, fees, payments, or other compensation assessed for rendered health care services.

A collaborative would have all the powers of a partnership, association, corporation, or limited liability company. It could contract with insurers to provide insurance, reinsurance, and indemnification and could enter into agreements under certain conditions to delegate the provision of care by other networks and providers. It could contract with a preferred provider benefit plan and could use a payment methodology other than fee-for-service or discounted fees and not be subject to HMO requirements. A hospital district also could create a nonprofit health care collaborative. A collaborative could not prohibit a participating physician or other health care provider from participating in another collaborative.

The bill also would specify rulemaking, examination, and enforcement actions and powers of the OAG and TDI. It would add references to health care collaboratives to other sections of current law.

Patient risk identification. The bill would require DSHS to coordinate with hospitals to develop a statewide standardized patient risk identification system to identify patients with medical risks to hospital

personnel. HHSC would be required to appoint an ad hoc committee of hospital representatives to assist DSHS. DSHS would have to require hospitals to use the standardized system, unless the hospital had adopted another best-practice risk system.

Health care quality recognition. DSHS, in consultation with the Institute, would have to develop a program to recognize exemplary health care facilities for superior quality of care.

Health facility reporting. HHSC could designate the federal Centers for Disease Control and Prevention's National Health Care Safety Network or its successor to receive reports of health care associated infections from health care facilities on behalf of DSHS and could likewise designate the federal Department of Health and Human Services to receive reports of preventable adverse events. Health care facilities would have to authorize DSHS access to the reported data. HHSC could adopt rules requiring reporting more frequently than quarterly if necessary to meet federal requirements. DSHS would be required to study which adverse health conditions commonly occurred in long-term care facilities, and of those, which were potentially preventable, and develop recommendations for facility reporting of adverse health conditions. The bill also would repeal current law that exempts rural providers from reporting requirements on September 1, 2014.

Health data reporting and disclosure. DSHS would have to publicly report outcomes for potentially preventable complications and readmissions, in consultation with the institute. The bill would create an institutional review board at DSHS to review and approve requests for access to data not contained in public use data. DSHS could disclose collected nonpublic use data to a department or commission only if the disclosure was reviewed and approved by the institutional review board. Confidential information would remain confidential.

Effective date. The bill would take effect September 1, 2011.

SUPPORTERS SAY:

SB 8 would improve health outcomes and reduce health care costs through the efficient delivery of integrated services supported by alternative payment systems, evidence-based practice standards, and streamlined and protected data reporting. The bill would not have a cost. It would help put in place health care delivery features that would realize substantial savings in health care expenditures over the long term for all Texans.

Currently, physicians and hospitals cannot receive payment as a group without fear of violating state and federal antitrust regulations. They also cannot receive innovative payments, such as bundled payments, because of state restrictions against fee splitting. SB 8 would allow health care providers to organize within a certified collaborative and thereby accept bundled and other types of alternative payments, because the certification process would entail a review by the OAG for potential antitrust issues. The bill also would establish a state action doctrine that would allow Texas to overcome federal antitrust barriers. The Federal Trade Commission (FTC) is being disingenuous in suggesting that clinical integration — to the extent that it would allow the streamlining and innovative payment that this bill would create — already is possible without antitrust protection.

Developing alternative health care delivery structures is not a new proposal for Texas. Previously enacted statutes have directed ERS and TRS to pilot innovative delivery and payment models that would improve care and reduce cost. But as a result of federal regulatory barriers, these pilots could not move forward and ended up being limited.

SB 8 would create a designation that would give providers in Texas flexibility to work together to improve health care outcomes and reduce costs. It would not mandate any particular model of health care. There are several significant health care systems and physicians in Texas that are now willing to try the health care collaborative model, and this bill would facilitate that.

The collaborative governance board's composition would be appropriate because physicians ultimately are responsible for a patient's medical care. Having other providers dominate the board — and thereby decisionmaking about the collaborative's patient care and finance operations — could dangerously impede the application of sound medical judgment and undermine patient health and service delivery. Since participation in a health care collaborative would be voluntary, it would be in the best interests of all physician board members to be sensitive to the needs of other health care providers, so that the collaborative could operate successfully.

The institute as conceived by this bill would include consumer and public input, which is important to ensure the development of a health care system that is best for Texas. For example, a consumer who was an expert

in health care could serve as a board member appointed by the governor. Consumers also could participate in public hearings and other institute forums that provided a public opportunity to discuss issues.

OPPONENTS SAY:

SB 8 would be an unnecessary expansion of government that would not necessarily achieve the cost savings it predicts. In fact, it could raise costs if, despite government oversight, health care collaboratives fostered higher payments for health care providers. Also, abolishing a health policy council and establishing a similar forum called an institute would only support the perpetual study of ongoing health care issues and would not ensure that solutions will be found or implemented.

It is likely that SB 8 would increase costs to the state and could harm consumers. In a letter dated May 18, the Federal Trade Commission (FTC) stated that SB 8 could dramatically increase costs and decrease access to care because it would deprive consumers of the benefits of competition by immunizing the collaborative from anti-trust laws. The FTC also said that the review provisions appear unlikely to prevent harmful effects and questioned whether TDI or the OAG had sufficient expertise or guidance on which to base decisions regarding the effect of a health care collaborative on the marketplace.

The bill's antitrust exemptions should be removed. There have been many court challenges establishing precedent that antitrust exemptions extend benefits to a minority of interest groups, but are harmful to the overall marketplace and consumers.

The antitrust provisions of this bill are unnecessary because federal law currently allows health care collaboratives to engage in certain activities that are reasonably necessary to enhance efficiency and improve health outcomes while promoting competition within the health care market. The FTC and the U.S. Department of Justice have drafted guidance to health care providers on how to integrate clinical operations to improve access and quality of care efficiently without harming consumers by restricting competition. This bill would go beyond such guidance and therefore could pose a substantial risk of consumer harm.

This bill would not appropriately address collaborative governance, which is critical to the collaborative's health care outcomes and financial success. The board ultimately would be responsible for determining how bundled payments will be divided among participating providers, yet physicians

would dominate the collaborative board and so could influence reimbursement to benefit their practice over other participating health care providers.

OTHER OPPONENTS SAY:

While this bill would move in a good direction, using concepts similar to accountable care organizations (ACOs) in federal health care reform, it was drafted without sufficient input from groups representing consumers or patients. For example, the bill could be improved upon with the following:

- provisions authorizing TDI to develop consumer information regarding the collaborative's performance and general financial incentive systems consistent with standards promulgated for future Medicare and Medicaid ACOs;
- clarifying that a health care collaborative's complaint processes must cover consumers' complaints, in addition to provider complaints, including an opportunity to appeal to TDI or other appropriate agencies;
- exempting all preferred provider networks that have health care collaboratives as subcontractors from current standards of network adequacy and limitations on out-of-network charges;
- for the standardized patient risk identification, which is currently conceived as a special wristband, adding provisions that would ensure patients know the content and risk specified on their wristbands, and would allow them to correct any misinformation (e.g., mistaken allergy); and
- protecting patient confidentiality by ensuring that disclosed health care data did not identify patients in addition to the provision that it did not disclose physician identifying data.

Health care collaborative certification should last longer than one year because of the effort it would take to organize a collaborative and submit a complete and compliant application. Also, it would be difficult to meaningfully show health outcomes and other improvements required by the renewal within only one year of operation. It would take time to set up and stabilize a new form of operations and see health care results.

This bill needs to include more prescriptive provisions on the antitrust oversight on the part of TDI and the OAG. The bill's current provisions are limited in scope and an untested protection for consumers. The bill would not mandate ongoing state supervision of collaboratives beyond the

initial approval and the one-time renewal. The bill would not limit the term of a renewed certificate, and therefore it would be perpetually valid. The bill contains no standards governing how the OAG would judge whether the applicant possessed market power or would not reduce competition. Also, SB 8 contains no provisions that would prohibit anticompetitive mergers or acquisitions, which could limit transparency, raise prices, and reduce services and innovation.