HOUSE
RESEARCH
ORGANIZATION bill analysis 3/29/2017

HB 1148
S. Davis
(CSHB 1148 by Sheffield)

SUBJECT: Establishing administrative cooperatives for regional advisory councils

COMMITTEE: Public Health — committee substitute recommended

VOTE: 10 ayes — Price, Sheffield, Arévalo, Burkett, Coleman, Cortez, Guerra, Klick, Oliverson, Zedler

0 nays

1 absent — Collier

WITNESSES: For — Jennifer Henager, Central Texas Regional Advisory Council; Hilary Watt, Coastal Bend Regional Advisory Council; Christine Reeves, Heart of Texas Regional Advisory Council; Kenneth Mattox and Darrell Pile, Southeast Texas Regional Advisory Council; Eric Epley, Southwest Texas Regional Advisory Council; Dudley Wait, TSA-P; (*Registered, but did not testify*: Shelby Massey, American Heart Association; Kathy Hutto, AstraZeneca Pharmaceuticals; Jessica Follett, CHI St. Luke's Health; Chrystal Brown, Cathryn El Burley, Cassandra Campbell, Connie Castleberry, Gabrielle Frey, Kimberley Grant, Cynthia Hill, Karen Jeffries, Janice Miller, Dorothy Sanders-Thompson, Jill Steinbach, Texas Nurses Association; Emily Alexanderson and Melinda Hester, Texas State University School of Nursing; Craig Holzheauser, Texas Emergency Medical Services Alliance; Sofia Hernandez; Maria Martinez; Crissie Richardson)

Against — Paul Vazaldua, Trauma RAC-RGV

On — William Rice, Regional Advisory Council N; (*Registered, but did not testify*: Jon Huss, Department of State Health Services; Dinah Welsh, Texas Emergency Medical Services, Trauma and Acute Care Foundation)

BACKGROUND: 25 TAC, part 1, ch. 157, subch. G, sec. 157.122 divides the state into 22 trauma service areas, each of which must have at least one lead general trauma facility.

Sec. 157.123 establishes a regional advisory council (RAC) for each trauma service area. RACs develop trauma system plans that address the coordination of injury prevention, system access, communications, pre-hospital triage, medical oversight, bypass and diversion protocols, regional medical control, and regional trauma treatment guidelines.

DIGEST:

CSHB 1148 would require the Department of State Health Services (DSHS) to designate at least eight trauma service area regional advisory councils (RACs) as administrative cooperatives, making them responsible for the administrative functions of RACs in the public health region served by the cooperative.

The cooperatives would perform the following administrative functions on behalf of their RACs:

- contract management;
- grant application management;
- employee benefit management;
- human resource management;
- payroll;
- centralized purchasing agreements; and
- disbursal of funds according to population, annual number of trauma care runs, geographic size, and annual number of deaths.

An administrative cooperative's duties would not include program activities or activity coordination performed by RACs.

RACs could apply to be administrative cooperatives by September 1, 2018. To be designated as a cooperative, an RAC would have to demonstrate that it had the personnel, knowledge, skills, and resources necessary to provide administrative functions for the RACs in its public health region. If no eligible RAC in a public health region applied, DSHS would select the one with the most appropriate qualifications. The bill would require the department to designate cooperatives by September 1, 2019, and the cooperatives would have to begin carrying out their duties by September 1, 2020.

CSHB 1148 also would require the cooperatives to consult with their RACs and the DSHS Advisory Council to produce a written 25-year plan for coordinating statewide emergency health care services, including trauma, stroke, cardiac, neonatal, maternal, mental health crisis, and emergency medical services. The plan would have to be submitted by September 1, 2021.

RACs could request to retain an administrative function delegated to a cooperative. DSHS would have to grant any request for which it determined that the RAC had the personnel, knowledge, skills, and resources to perform the function in a more cost-effective way than the cooperative.

The bill also would allow RACs to apply for a transfer to the jurisdiction of another administrative cooperative. The Health and Human Services executive commissioner would have to develop criteria to determine which cooperative could provide the necessary services to an RAC in a more cost-effective way.

Cooperatives would have to report annually on the amount of money spent by the cooperative compared to the amount that would have been spent if each RAC provided its own administrative services.

The bill would take effect September 1, 2017, and would apply only to a contract executed on or after that date.

SUPPORTERS SAY:

CSHB 1148 would promote efficient coordination of statewide emergency services through administrative cooperatives for trauma service area regional advisory councils (RACs). The 25-year plan required by the bill would integrate each region's requirements and demographic expectations to proactively address the state's emergency health care needs. It would result in a more efficient use of resources, reducing fatalities and allowing the state to respond to public health challenges such as lack of access to pre- and neonatal services.

Administrative cost savings produced by the bill would allow regional advisory councils (RACs) to focus on programmatic funding. Consolidating a region's administrative duties would alleviate the burden on smaller RACs that currently use their limited budgets to hire part-time administrative staff. RACs instead could concentrate their resources on delivering emergency services that save lives.

CSHB 1148 also would increase efficiency and reduce costs through centralized purchasing agreements. This would allow cooperatives to remove duplication in administrative service contracts, freeing money for other purposes.

The bill's annual reporting requirements would protect individual RACs from budgetary losses because cooperatives would have to continually demonstrate they could perform administrative functions for their RACs at a lower cost.

CSHB 1148 would not infringe on RAC autonomy. Under the bill, an RAC could retain an administrative function if it showed it could handle it more efficiently than the cooperative, and RACs could request a transfer of jurisdiction to another administrative cooperative. Even an RAC that left state grant management in the hands of the cooperative still could independently apply for other grants.

The bill also would protect against RACs "flip-flopping" unnecessarily between jurisdictions by requiring the Health and Human Services executive commissioner to determine that the new jurisdiction could more cost-effectively serve the RAC before a change was approved. Changing jurisdictions requires substantial investment and reorganization on behalf of the RACs, which would limit excessive changeover.

Consolidation of administrative responsibility would be preferable to the current system of 22 separate entities. The bill would allow the establishment of eight "or more" cooperatives to give any RAC the chance to opt out of consolidation by becoming its own cooperative.

OPPONENTS SAY:

CSHB 1148 could infringe on the autonomy of individual RACs by removing their control over procedures such as grant management and purchasing. This could result in administrative cooperatives neglecting the needs of certain RACs, which especially could affect smaller councils with already limited resources. The broad administrative structure created by the bill could end up being more expensive and inefficient than the current system, potentially leaving RACs with less programmatic funding, rather than more.

CSHB 1148 would create the potential for confusion and sunk costs by allowing RACs to switch between administrative jurisdictions. This could result in RACs "flip-flopping" between cooperatives, creating inefficiencies in budgeting, staffing, and planning.

The bill could invite expansion of bureaucracy by providing for eight "or more" administrative cooperatives. Without an upper limit, the cooperative system could continue to expand, creating an expensive and confusing regulatory challenge.

NOTES:

CSHB 1148 differs from the bill as filed by:

- using the term administrative "cooperatives," rather than "hubs";
- allowing only RACs to apply to be administrative cooperatives, rather than allowing health care entities, including RACs, to apply;
- specifying that an administrative cooperative's duties did not include program activities or activity coordination performed by RACs; and
- specifying that the cooperative to which an RAC requested to transfer would have to be able to provide administrative services in a more cost-effective way than the cooperative currently serving the RAC.