

SUBJECT: Creating the Texas Health Care Information Council

COMMITTEE: Public Health — committee substitute recommended

VOTE: 9 ayes — Berlanga, Hirschi, Coleman, Delisi, Glaze, Janek, Maxey, McDonald, Rodriguez

0 nays

WITNESSES: For — Joe Da Silva, Texas Hospital Association; Lisa McGiffert, Consumers Union; John Rodrigue, Henry Noey, James G. Cummings, Nancy Sims, Janet Kutchka, Will Kleck, Texas Business Group on Health; Ann Heiligenstein, Conference of Catholic Health Facilities; Jacqueline Shannon, Texas Alliance for the Mentally Ill; Richard Levy, Texas AFL/CIO; Dinah Welsh, Texas Association of Business and Chambers of Commerce; Roy Ray, AARP; Anne Dunkelberg, Center for Public Policy Priorities; Bob Stout, Mitchell Energy and Development Corp; King Hillier, Texas Association of Public and Nonprofit Hospitals; Jose Camacho, Texas Association of Community Health Centers; Jeff Kloster, Don Gessler, PCA Health Plans; Bruce P. Bower, Houston Welfare Rights Organization; Gerald Bluhm; Jon Comola, Blue Cross/Blue Shield; Richard LaValle, Advocacy, Inc.; Kathy Page, Occidental Chemical Corp.; Leslie Lanham, National Association of Social Workers of Texas

Against — Karen Kenney, Texas Pharmacy Association; Carolyn Galloway, Texas Eagle Forum

On — Ann Henry, Texas Department of Health; Robin Herskowitz, Texas Comptroller's Office

DIGEST: CSHB 1048 would create an 18-member Health Care Information Council to promote the accessibility of cost-effective, good quality care by developing a statewide system to collect data on health care charges, utilization, provider quality and outcome of care. The Texas Department of Health (TDH) would contract with the council to collect data and would provide administrative and legal assistance.

Except for rural providers, individual physicians and certain physician groups, all health care facilities, health maintenance organizations and physicians would be required to submit data required by the council. "Health care facilities" would refer to hospitals, ambulatory surgical centers, chemical dependency centers, renal dialysis facilities, birthing centers, rural health clinics and federally qualified health centers. "Physicians" would refer to doctors licensed under the Medical Practice Act.

CSHB 1048 would take effect September 1, 1995, and the council would be required to make recommendations on the consolidation of existing health data collection programs by December 1, 1996.

Health Care Information Council. The council would be composed of three nonvoting ex officio state agency members (the commissioners of public health, health and human services and insurance) and 15 members appointed by the governor: three business community representatives, two labor representatives, two consumer representatives, two hospital representatives, one HMO representative, three physician representatives and two experts in health planning, health economics, quality assurance or health data. The governor would appoint the chair, and the appointed members would serve six-year staggered terms.

The council could appoint subcommittees and would be required to appoint technical advisory committees, including one on interpreting provider quality data and disseminating consumer education information and another on the use of peer review and the development of data elements and report formats on the quality of inpatient and provider care.

Members of the council would not receive a salary or per diem but would be reimbursed for actual expenses. Advisory committee members would not be entitled to compensation or travel expense reimbursement. The council and its subcommittees and technical advisory committees would be subject to the open meetings law.

Council duties would include building on, and not duplicating or conflicting with, other required data collection activities, working with appropriate agencies and consolidating data collection programs where appropriate, assuring data is made available and accessible to interested persons,

implementing data collection and dissemination methodologies through rulemaking and working with the Department of Information Resources in developing and implementing the system.

The council would also be required to develop and implement a health care information plan to be used by TDH to support public health initiatives, to assist in the delivery of primary and preventive care, to facilitate the establishment of appropriate benchmark data to measure performance improvements, to maintain a systematic approach for the collection, storage and analysis of health care data and to develop and use protocols to identify individuals and populations at risk.

The council would also be required to report to the Legislature, the governor and the public on health care charges, the effectiveness of the council and recommendations, if applicable, for further legislation. The council could not establish or recommend rates of payment for health care services. The council also could not accept a donation from a person or business required to provide data or that supplies goods or services to the council.

Data collection. TDH would be the single collection point for data submission. The council, through TDH and subject to reasonable rules and guidelines, could inspect documents and records used by data sources that are required to compile data and reports and could compel providers to produce accurate documents and records.

Data would be required to be collected according to uniform submission formats, and the council would be required to adopt rules to implement data submission in appropriate stages to allow for the development of efficient data submission. The council could not require providers to submit data more frequently than quarterly, but providers could submit data more frequently. Reasonable alternate data submission procedures would be established by rule for entities lacking electronic data processing capacity.

The council could not collect data from rural providers, individual physicians or entities composed entirely of physicians that are organized under the Texas Professional Association Act (VACS art. 1528f), a limited liability partnership organized under the Texas Revised Partnership Act

(VACS art. 6132b-3.08 or under the Texas Limited Liability Company Act (VACS art. 1528n) except to the extent such entities own and operate a health care facility.

Provider quality data. The methodology for collecting provider quality data (also referred to as quality outcome data) would be established through the council's rulemaking process. An initial methodology would be required to be adopted by January 1, 1997, but not before the first anniversary of the date on which a majority of the council is appointed. The council could extend the deadline by a two-thirds vote if additional time for the development of the initial methodology was needed. The council would also be required to adopt rules allowing a provider to submit written comments regarding any data to be released concerning the provider.

The council would be required to test the methodology for one year, to report findings to applicable providers and to allow providers to review and comment on the data. After a review and revision process, the council would be required to publish the data unless the data does not provide the intended result, or is inaccurate or inappropriate for dissemination. A provider's comments could be attached to any public release of data.

The methodology adopted by the council for measuring quality would be required to include case-mix qualifiers, severity adjustment factors and any other factors necessary. A quality outcome data report could not identify an individual physician by name, but could identify the physician by the uniform physician identifier.

Data dissemination. TDH would be required to promptly provide data to those requesting it and to prepare reports relating to providers, subject to confidentiality and provider data restrictions. Provider-related reports would be required to identify the individual provider and to compare data elements for all providers. Individual physicians would be identified by uniform physician identifiers only. The council would be required to adopt procedures to verify the accuracy of the data before a report is released.

If data is requested about a specific provider, the council would be required to notify the provider about the release of the data. A report would have to

be submitted for a reasonable review and comment period before final publication.

Computer-to-computer access to data would be provided by the council. The council could charge a fee for the data, which would be deposited to the general revenue fund in a designated account in which funds would carry over from biennium to biennium.

Confidentiality. The council would be required to designate by rule the characters to be used by providers as uniform patient identifiers. The council could not release information that could reasonably be expected to reveal the identity of a patient or physician, that would disclose provider discounts or differentials between payments and billed charges or that would disclose payments made by a payer.

Data would be subject to the confidentiality provisions and penalties in Health and Safety Code secs. 311.037 and 81.103 and in the Medical Practice Act (VACS art. 4495b, sec. 5.08). A person who knowingly or negligently released data in violation of the act would also be liable for a civil penalty not to exceed \$10,000. A person who failed to supply available data to the council would be liable for a \$1,000 - \$10,000 civil penalty for each act of violation.

(Health and Safety Code sec. 311.037 states that data regarding a specific patient or financial data submitted by a provider before September 1, 1987, is confidential and disclosure would constitute a Class B misdemeanor or a maximum penalty of 180 days in jail and a \$2,000 fine. Sec. 81.103 states that an HIV test result is confidential and disclosure with criminal negligence to unauthorized persons constitutes a Class A misdemeanor offense, or a maximum penalty of one year in jail and a \$4,000 fine. The Medical Practice Act sec. 5.08 protects physician-patient communications and allows persons aggrieved by unlawful disclosure of protected communications to petition the district court of Travis County or the county in which the person resides and to prove a cause of action for civil damages.)

**SUPPORTERS
SAY:**

CSHB 1048 would help create a more financially efficient and accountable health care system by giving consumers, workers, employers and state policymakers access to data that could identify service utilization, costs and expenditures, quality of care, gaps in services, population needs and fraud and abuse. It would centralize, coordinate and facilitate existing disjointed or sporadic data collection efforts and follow a trend adopted by many states and recommended by several Texas governmental bodies.

CSHB 1048 would help build a truly competitive health care marketplace by giving health care purchasers needed information to make appropriate and cost-effective decisions. Health care constitutes one of the most expensive expenditures for employers, patients and state and local governments, yet choices are being made virtually in the dark without basic, reliable, statewide, comparative data about utilization, costs and quality. The panel of experts on the council and its advisory committees would ensure the data was disseminated in formats that are relevant, useful, accurate and understandable. CSHB 1048 would allow the free-market, not the government, to drive efforts to reduce costs.

Coordinated, centralized data collection would help the state evaluate the adequacy and appropriateness of current services and better plan for future needs. It would also help assure taxpayers that their tax dollars are being spent wisely and efficiently. Current data collection efforts are spread throughout state, federal and local agencies and programs and private organizations — there is no coordinated, centralized system to tell the whole story about health care spending and utilization.

TDH has a good track record with data collection and keeping data confidential. It also offers a location reasonably shielded from health provider, academic and research turf battles. Most states that have attempted to contract with private organizations for statewide health data collection now recommend a state-centered data organization.

CSHB 1048 is not a cost-savings panacea, but the collection and dissemination of health care data would help contain the rapid growth of health care expenditures by helping consumers and payers negotiate fairer rates and select effective, high-quality care. Health care costs are consuming an increasingly greater portion of the U.S. gross national

product, which at about 14 percent of the GNP far exceeds the expenditure levels of other westernized countries.

Data collection duplication and confusion would be minimized if not eliminated since the council would build on, and not add to, commonly used forms and required reports. CSHB 1048 also could offer some providers a streamlined way to respond to most state, federal, local and private data demands.

CSHB 1048 would take an important first step in obtaining and disseminating quality of care data. This data is probably the most important consideration in obtaining health care services, for both employers and consumers. CSHB 1048 would require a carefully phased-in approach that would protect providers from mistakenly damaging or misleading information, and give providers ample opportunities for review and comment on any released data.

CSHB 1048 would be building an infrastructure that would benefit Texans for years to come, and the cost of building and maintaining a coordinated, effective system may save the state from future unnecessary or excessive health care expenditures. Additional appropriations to the department would be necessary to ensure that tightly budgeted health services are not reduced by data collection activities. A designated account would help provide the long-term funding and state commitment needed to implement such a large data collection, coordination, storage, analysis and dissemination effort.

Because the program is new and implementation would be phased-in, revenue estimates were difficult to project. Last session the Texas Business Group on Health made a one-time \$2 million offer to help fund state data collection. Researchers, hospitals, marketing firms, other health care providers, insurance purchasers and consumers would be willing to pay for good comparative data.

At least 30 states collect health care data on a statewide basis, and a Texas data collection system has been recommended since 1992 by various governmental bodies including the Texas Performance Review (in both

Gaining Ground and Against the Grain), the House Public Health Committee and Governor Ann Richards's Health Policy Task Force.

OPPONENTS
SAY:

CSHB 1048 would create an expensive data collection system that may not reduce costs and could inhibit the provision of quality care through the release of misleading or inaccurate information.

CSHB 1048 is expected to cost the state \$2.7 million in fiscal 1996-97, and \$1.7 million each year after. CSHB 1048 would also incur costs on providers who are required to submit data. Overall statewide health care costs may not be significantly reduced because many expenditures and costs are driven by factors outside of negotiated charges or utilization controls, such as medical technology research and development costs, malpractice insurance premium rates and the chronic medical problems of an aging Texas population. If the statewide effort is not coordinated and implemented well, it would serve to add costs, bureaucracy and confusion to current data collection efforts.

Data collected under CSHB 1048 may be useful to only a few segments of the population, and unless carefully presented or used could serve to unduly alarm patients, erode public trust and reduce or dictate provider practices. Most people lack the health care background or statistical expertise to understand the relevancy or meaning of utilization, outcome and financial data. "Big Brother" oversight from collected data could serve to restrain private marketplace and physician health care practices.

The state should not be in the business of evaluating quality of care. Quality of care is an especially difficult measurement because it is usually based on the consideration of multiple factors, quantitative and subjective, and scientific methodologies for its calculation are still evolving. Inaccurate or misleading information identifying providers of poor quality care could financially or professionally ruin those providers.

A designated general revenue account would tie up state funds that could be used for other purposes, and the expected revenue predictions support questions about the usefulness of data collection. Although the state would be spending \$1.7 million a year to collect and disseminate the data, it

expects to receive only \$75,000 a year from people willing to pay for the data.

OTHER
OPPONENTS
SAY:

CSHB 1048 would not go far enough to capture the health care "story" in Texas. CSHB 1048 should include provisions that would phase-in data submission requirements from insurers, individual physicians and physician groups, dentists, chiropractors and other health care providers. Individual physicians also should be identified.

CSHB 1048 also would allow the creation of a huge gap of knowledge of the health care system by exempting rural providers from data submission requirements — about 225 out of a total of 475 hospitals would not be required to submit data. The definition of "rural" in the committee substitute would also be hard to monitor because it would entail identifying certain segments of urban counties.

Establishing a private, nonprofit data collection organization, as recommended by the Texas Performance Review in the 1993 report *Against the Grain*, may be a lower-cost alternative to an entirely state-funded program. Schools of public health may be another good location for data collection efforts because of existing health planning and statistical expertise, research interests and computer resources.

NOTES:

Major provisions in the committee substitute that are different from the original version include: the definition of "rural" was expanded to include parts of urban counties; some health care facilities were removed from the act's requirements; physician exemptions from data submission and physician identifier protections were added; requirements to coordinate with the Department of Information Resources were added and release of payer information under certain circumstances was removed.

Also, part of the composition of the council was changed from three consumers, one non-hospital health care facility and one physician to two consumers, three physicians and no non-hospital health care facility representatives. Two required technical advisory committees were also added.

Rep. Maxey plans to introduce an amendment to the bill that would make some clarifying changes, require the appointment of two more technical advisory committees and prohibit the appropriation of general revenue funds for fiscal 1996-97 for the purpose of this act.

SB 1143 by Patterson, referred to the Senate Health and Human Services Committee, is similar to the committee substitute version except in the composition and appointment of the council, in physician exemption provisions and payer information release provisions. It also has no provisions relating to DIR or requirements for technical advisory committees. Under SB 1143 the governor would appoint eight members of the council and the lieutenant governor would appoint seven members. Unlike CSHB 1048, the council membership would include three consumer representatives, one health care facility, one physician representative and one expert in health planning. Individual physicians would be exempt from data collection requirements but not limited partnerships. The council could release actual payment data to payers requesting their own data or to entities entitled to that payer's data.