

SUBJECT: Requiring a statewide system of neonatal and maternal levels of care

COMMITTEE: Public Health — committee substitute recommended

VOTE: 10 ayes — Kolkhorst, Naishtat, Collier, Cortez, S. Davis, Guerra, S. King, Laubenberg, J.D. Sheffield, Zedler

0 nays

1 absent — Coleman

WITNESSES: For — Emily Briggs; Charles Brown, Society of Maternal-Fetal Medicine; Patricia Burch, Doctors Hospital at Renaissance; Frank Cho; Cris Daskevich, Texas Children's Hospital & Children's Hospital Association of Texas; Elizabeth Elliott; John Gianopoulos; Barbara Greer; Charleta Guillory, March of Dimes; Margaret Kelley, Texas Association of Obstetricians and Gynecologists; Brenda Morris; Michael Nix; Sheila Owens-Collins; Michael Speer, Texas Medical Association and Texas Pediatric Society; Michael Stanley, Pediatrix; John Thoppil; Eugene Toy; Steve Woerner, Neonatal Council; (*Registered, but did not testify*: Anastasia Benson; Eileen Garcia, Texans Care for Children; Lisa Hollier, Texas District of American Congress of Obstetricians and Gynecologists; Rebekah Schroeder, Texas Children's Hospital; James Willman, Texas Nurses Association)

Against — None

On — Mark Chassay and Matt Ferrara, HHSC; John Hawkins, Texas Hospital Association; Robert Hendler, Tenet Healthcare Corporation;

(*Registered, but did not testify*: Sam Cooper and Jane Guerrero, DSHS)

BACKGROUND: The 82nd Legislature (HB 2636 by Kolkhorst) created the Neonatal Intensive Care Unit Council. The council expires on June 1, 2013.

DIGEST: CSHB 15 would require the executive commissioner of the Health and Human Services Commission (HHSC) to assign level of care designations to hospitals based on the neonatal and maternal services provided at the hospital.

**Rules.** The executive commissioner, with input from the Department of State Health Services (DSHS), would adopt rules to:

- establish levels of neonatal and maternal care to be assigned to hospitals, specify the criteria and minimum requirements for each level designation, and post this information on the DSHS website;
- create an assignment process and grant the appropriate designation to any hospital that met the minimum requirements;
- establish a procedure for amending the level of care designation requirements, including a process to help hospitals implement changes;
- divide the state into neonatal and maternal care regions;
- facilitate transfer agreements between hospitals; and
- require payment for neonatal and maternal services, other than quality or outcome-based funding, to be based on services provided regardless of the level of care designation.

The executive commissioner would be required to adopt these rules by March 1, 2017. CSHB 15 also would require HHSC to study patient transfers that were not medically necessary but might be cost-effective. If the study indicated these transfers were feasible and desirable, the executive commissioner could adopt rules addressing them.

**Assignment.** Every hospital would be assigned a neonatal level of care by August 31, 2017 and a maternal level of care by August 31, 2019. After those dates, a hospital would be required to have a level of care designation to receive Medicaid reimbursement for neonatal and maternal services, except in emergency situations. A hospital's neonatal and maternal services would be separately evaluated and could be assigned different levels. A hospital that did not meet the minimum requirements could not be assigned a level of care. Each level of care designation would require hospitals to submit outcome data and other requested information to DSHS.

Every three years, the executive commissioner and DSHS would review each hospital's level of care designation and, if necessary, change or remove the designation. At any time, a hospital could seek a different designation by requesting a review by the executive commissioner and DSHS.

**Perinatal advisory council.** This bill would create the Perinatal Advisory Council and require the executive commissioner to appoint 17

members by December 1, 2013. The council would consist of physicians, registered nurses, hospital representatives, and an HHSC representative. If possible, the executive commissioner would appoint former members of the NICU council. Members would serve staggered three-year terms and could be reappointed to the council. They would not be compensated, but could be reimbursed for council-related travel expenses.

The Perinatal Advisory Council would be required to:

- develop and recommend criteria and minimum requirements for neonatal and maternal levels of care;
- develop and recommend a process for designating levels of care;
- recommend neonatal and maternal regions;
- examine neonatal and maternal utilization trends; and
- recommend ways to improve neonatal and maternal care.

The council would be required to consider the geographic and different needs of Texas citizens, as well as information from the Society of Maternal-Fetal Medicine, American Academy of Pediatrics (AAP), and the American Congress of Obstetricians and Gynecologists (ACOG), including "Guidelines for Perinatal Care." They would also be required to update their recommendations based on relevant scientific or medical developments. The council would submit a report of findings and recommendations to the executive commissioner and DSHS by September 1, 2015. Using these recommendations, DSHS would develop a process to assign and update neonatal and maternal levels of care.

The Perinatal Advisory Council would be subject to Sunset review and would be abolished on September 1, 2025, unless continued.

**Federal authorization.** A state agency would be required to seek any necessary federal authorization and could delay the implementation of any provision until permission was granted.

**Effective date.** This bill would take effect September 1, 2013.

SUPPORTERS  
SAY:

CSHB 15 would improve health outcomes and reduce costs for the state by mandating a statewide system based on national best practices, coordination of care, and improved efficiency.

**Uniformity.** Texas needs a better way to evaluate a hospital's level of neonatal and maternal care. Although hospitals are aware of the perinatal

standards of the American Academy of Pediatrics (AAP), they currently use the DSHS annual survey to self-designate their level of care. An informal review of the responses to the survey suggested that nearly one-third of hospitals did not meet the AAP best practices for their levels. These inconsistencies are disturbing and reflect the need for additional regulations. Further, mandatory standards are not unprecedented — Texas already defines trauma and stroke levels of care. This bill would promote uniformity and protect consumers by requiring a statewide system for maternal and neonatal levels of care.

**Better outcomes.** A uniform system based on national best practices is critical to improving health outcomes. In 2010, 51 percent of very low birth weight infants were not born in a hospital with an adequate level of care, putting Texas in the bottom 5 percent of the country on this quality measure. As a result, these infants had a 60 percent worse chance of survival. Moreover, Texas' maternal mortality rate is higher than the national average. By mandating standards based on national best practices, this bill would improve the quality of care, decrease the number of premature births, and reduce infant and maternal mortality. Additionally, CSHB 15 would improve data collection, allowing DSHS to better evaluate changes in health outcomes.

**Cost savings.** CSHB 15 also would be financially prudent. The average stay in a neonatal intensive care unit costs about \$60,000 and the services are often paid by Texas Medicaid. From 2000 to 2010, the rate of very low birth weight infants in Texas remained relatively stable, but the number of neonatal intensive care unit beds has increased by 74 percent. Although some argue the proliferation of these specialized units matches increased demand, others contend that hospitals are motivated by the high reimbursement rates for the services. By mandating standards shown to reduce premature births, CSHB 15 would reduce the need for expensive stays in neonatal intensive care units. These standards would also ensure infants received an appropriate level of care and hospitals were reimbursed accordingly.

**Coordinated care.** Hospitals are not communicating well with each other, creating a fragmented and inefficient system of neonatal and maternal care. CSHB 15 would encourage cooperation and collaboration between and among hospitals by dividing the state into neonatal and maternal care regions and facilitating transfer agreements.

Although opponents argue that CSHB 15 would create substantial uncertainty about reimbursement and rules, the bill would require a lengthy and transparent rulemaking process, allowing all stakeholders to voice their opinions. Further, the bill would clarify the payment process by requiring that reimbursement be based on services provided by the facility, regardless of its level of care designation.

OPPONENTS  
SAY:

CSHB 15 would needlessly burden Texas' hospitals and doctors with additional regulations. Hospitals already follow the neonatal and maternal best practices established by the American Academy of Pediatrics (AAP), so mandatory, statewide standards based on the same guidelines is both unnecessary and onerous.

Additional regulations are unnecessary because over-utilization of neonatal intensive care units was largely eliminated when, in 2011, the Legislature directed HHSC to find ways to reduce elective births before the 39th week of gestation. There has since been a reduction in the number of premature infants needing neonatal intensive care services.

The bill would create uncertainty about reimbursements for neonatal and maternal services. The Legislative Budget Board suggests that CSHB 15 could decrease reimbursement and increase uncompensated care. Any lost revenue would be difficult for hospitals to absorb, particularly for those already operating in the red. Hospitals are still grappling with the substantial changes made to Texas Medicaid in 2011, and CSHB 15 could result in additional changes to the payment process.

By requiring the executive commissioner and DSHS to develop new rules related to neonatal and maternal care, this bill also would generate uncertainty about the ultimate substance of those rules. It would open the door for arbitrary standards that could make it difficult for some hospitals to achieve even the most basic level of care.

NOTES:

The committee substitute differs from the bill as filed in that it would:

- require reimbursement for neonatal and maternal services in an emergency situation and specified that reimbursement be based on services provided;
- delay the rulemaking and assignment time line and set different assignment dates for neonatal and maternal care, respectively;
- require the executive commissioner to consult with DSHS during the rulemaking process and substantially modify the content of the

rules;

- direct the executive commissioner to study certain types of patient transfers;
- change the designation review to every three years and allow a hospital to request a review at any time; and
- change the name, composition, and duties of the Perinatal Advisory Council and add the Society of Maternal-Fetal Medicine as a source of information.

According to the Legislative Budget Board, there would be no significant costs to the state to implement CSHB 15 in fiscal 2014-15. The state would spend \$378,372 in general revenue in fiscal 2016 for staff and travel reimbursement, \$405,174 in fiscal 2017, and \$480,523 in fiscal 2018. Modifications to claims processing would cost the state \$199,532 from general revenue as part of a one-time, all-funds expenditure of \$798,219 in fiscal 2017.