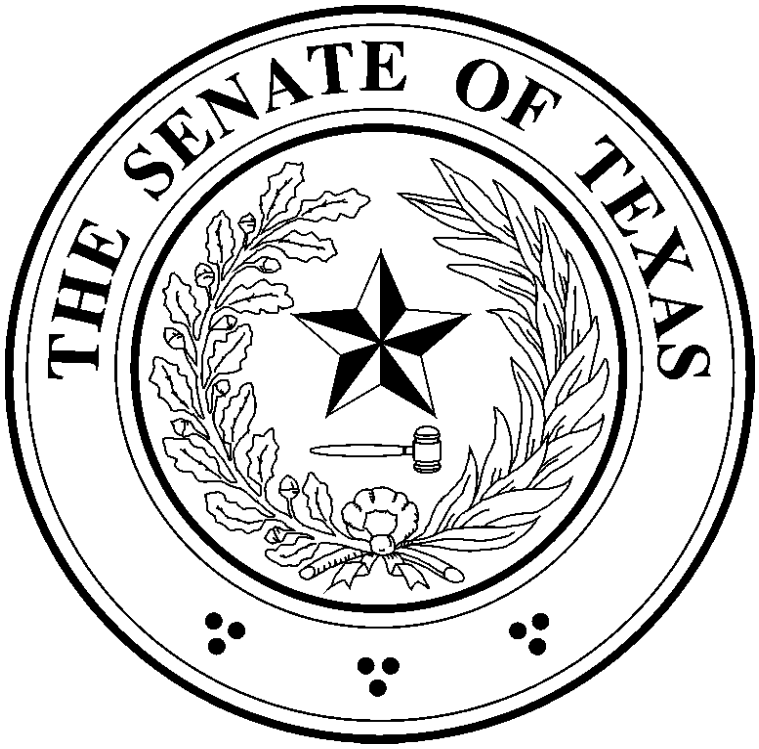

Senate Finance Subcommittee on Trauma Care

Interim Report to the 78th Legislature

November, 2002

Please direct questions and comments to:

Senator Chris Harris, Chair
Senate Finance Subcommittee on Trauma Care
P.O. Box 12068
Austin, Texas 78711
512/463-0111

Interim Report prepared by:

Michael Grimes, Chief of Staff, Senator Chris Harris
Angelica Marin, Budget/Policy Analyst, Senate Finance Committee

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Texas Senate Committee on Finance
Interim Committee on Trauma Care
Interim Report

November, 2002

INTRODUCTION

Trauma can occur at any time and is the leading cause of death in Texans between the ages of one and forty-four. Trauma care is an essential service because critical injury victims must reach definitive care within a short period of time to prevent death or disability. The Texas Legislature recognized the need for availability of trauma care resources to every citizen of the state, and in 1989, took action with passage of the Omnibus Rural Health Care Rescue Act. This legislation directed the Texas Department of Health's Bureau of Emergency Management to develop and implement a statewide emergency medical services (EMS) and trauma system, designate trauma facilities, and develop a trauma registry to monitor the system and provide statewide cost and epidemiological statistics. However, no funding was provided for the effort at that time.

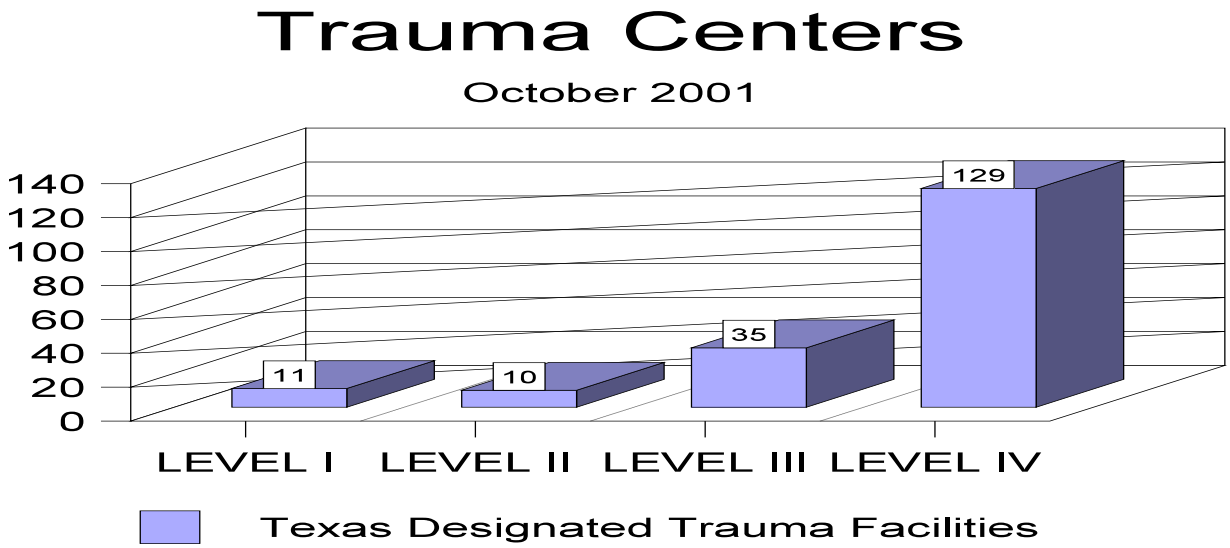
In 1992, the Texas Board of Health adopted rules for implementation of a statewide trauma system which divided the state into 22 regions called Trauma Service Areas (TSAs), and formed Regional Advisory Councils (RACs) in each area to develop and implement the region's trauma plan. These rules also delineated the trauma facility designation process and developed a state trauma registry. Trauma facility designation rules require the use of the American College of Surgeon's criteria for classifying facilities as Level I and Level II trauma centers, and the rules also developed criteria for designation of Level III and Level IV facilities.

LEVEL I - Level I trauma facilities manage major and severe patients and conduct trauma research.

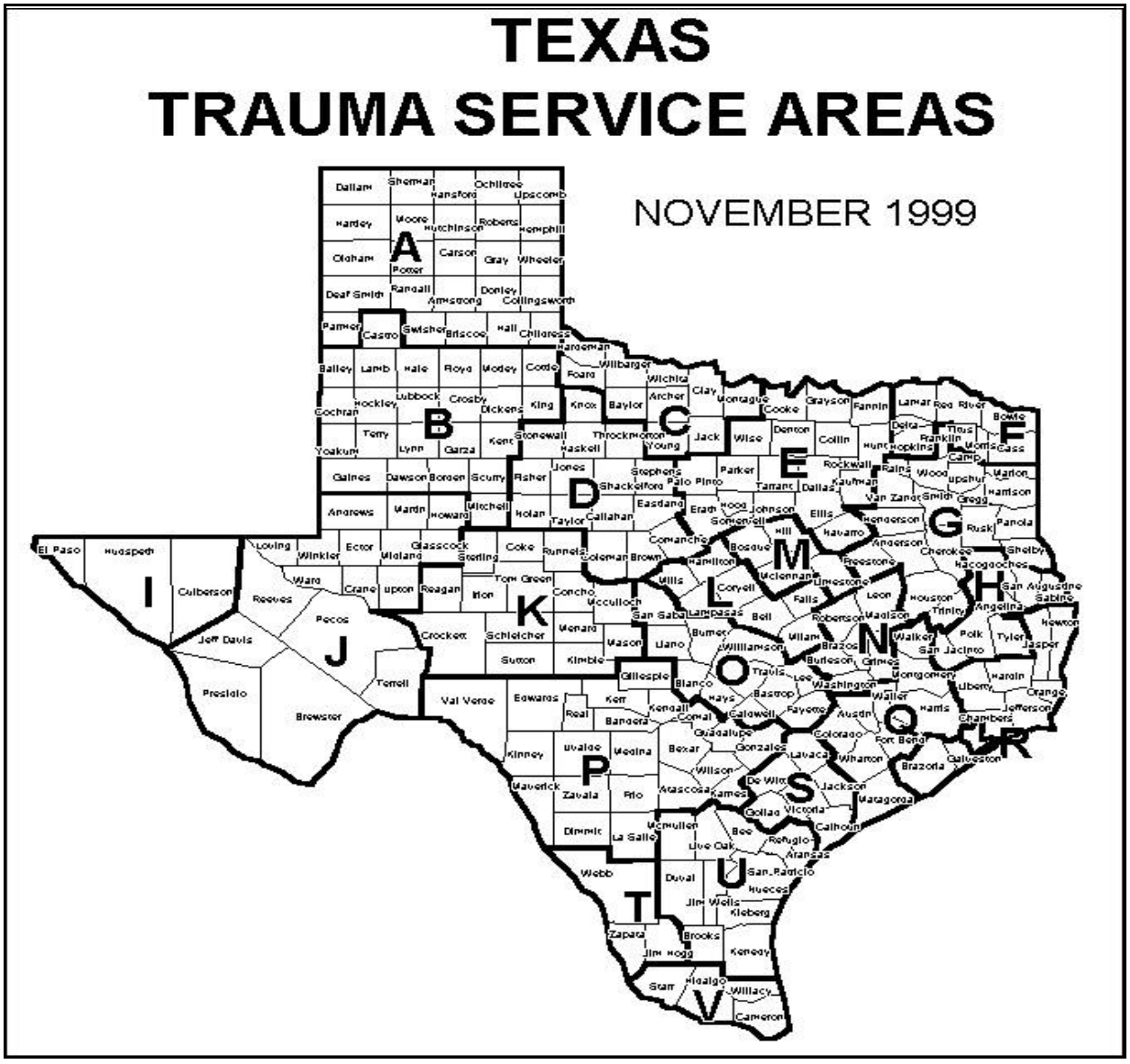
LEVEL II - Level II facilities provide similar services to the Level I , with the exception of research and some medical specialty areas.

LEVEL III - Level III general trauma facilities provide resuscitation, stabilization, and assessment of injury victims and either provide treatment or arrange for transfer to a higher level trauma facility.

LEVEL IV - Level IV basic trauma facilities provide resuscitation, stabilization, and also arrange for transfer of major and severe trauma patients to a higher level of trauma center.



Today there are 11 Level I (comprehensive), 10 Level II (major), 35 Level III (general), and 129 Level IV (basic) designated trauma facilities in Texas which served 56,072 severely injured trauma patients in 2001. All designated facilities provide ongoing education in trauma-related topics for



Source: Texas Department of Health, Bureau of Emergency Management

health professionals and the public, and implement targeted injury prevention programs.

FACTS

What is the difference between emergency care and trauma care?

Medically, "trauma" refers to a serious or critical bodily injury, wound, or shock.

"Emergency care" is the provision of medical and surgical care to patients arriving at the hospital in need of immediate care as a result of injury or illness.

Therefore, "trauma care" is the immediate treatment of a serious or critical bodily injury, wound, or shock.

A strategic plan for the statewide trauma system was developed through these efforts, but no state funding was applied until 1997. During the 75th legislative session, approximately $4 million from surplus 911 funds was appropriated to establish the EMS/Trauma Care System Fund. The money was distributed through the RACs for system development and through counties to EMS providers, with 2 percent set aside and distributed to Level I-III facilities for uncompensated care. In 1999, the 76th Legislature shifted responsibility of EMS allotment from the counties to the RACs and established the EMS and Trauma Care Tobacco Endowment, with interest proceeds being used for three grant programs: EMS Local Project, RAC System Development, and Hospital System Development. The 76th Legislature also established the Tertiary Care Fund to help pay for uncompensated tertiary care provided to out-of-county and out-of-service-area patients by designated trauma facilities. Funding for the Tertiary Care Fund comes from unclaimed lottery funds. For fiscal year 2001, this program distributed $16.4 million to 132 hospitals. The Texas Department of Health (TDH) has estimated that $46 million will be available in FY 2002.[1]

Funding Sources for EMS/Trauma Systems Grants

Source	FY98	FY99	FY00	FY01	FY02	FY03
State Fund 6 Highway Monies	$2,000,000	$2,000,000				
Federal Blood Alcohol Content Incentive Funds			$2,500,000	$2,500,000		
911 Equalization Surcharge funds	$1,500,000	$2,500,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000
EMS and Trauma Care Tobacco Endowment			$4,526,569	$4,451,234	$3,578,856	$3,800,000* *Budgeted 9/02
Total	$3,500,000	$4,500,000	$9,026,569	$8,951,234	$5,578,856	$5,800,000

Source: Texas Department of Health, Bureau of Emergency Management

EMERGING CHALLENGES

During the course of pursuing information on this interim charge, the Senate Finance Subcommittee on Trauma Care received testimony outlining the obstacles faced by those responsible for the delivery of trauma care in Texas. The information collected by the Subcommittee has been categorized in an effort to identify the difficulties facing the medical community in providing care for patients with traumatic injuries. The categories are as follows:

- Growing demand for services, coupled with diminishing capacity;
- Adequate funding and compensation for trauma-related services;
- Shortages in available workforce;
- Increases in the cost of liability insurance for hospitals and physicians; and
- Lack of a comprehensive Emergency Medical Services (EMS) system across the entire state.

It is worth noting that there exists no single source of reliable data on trauma care in Texas. In fact, the Subcommittee received data from several unique sources, all with somewhat different results. Sources include: the Texas Department of Health; the Texas Institute for Health Policy Research; a Bishop+ Associates study conducted specifically for the Houston-based group Save Our ERs; a study conducted by the Texas Hospital Association of its members; and sizeable testimony and submissions from hospitals, EMS providers, physicians, nurses, organizations, and other individual stakeholders in the quality of trauma care delivered in Texas.

CATEGORIES OF PROBLEMS

DEMAND AND CAPACITY

Most hospital emergency departments are working at or beyond capacity because demand has increased significantly while the number of beds has declined. The Texas population has grown 7.8 percent and emergency room visits, of which one-fourth are trauma patients, have increased 12.2 percent from 1996 to 2000. During this same period, the number of licensed and staffed hospital beds has declined 1.8 percent from 52,152 beds in 1996 to 51,193 beds in 2000. Compounding the situation is the fact that the population of Texas is aging, and older Texans have more health problems and need more services. According to a Texas Hospital Association member survey, all Level I and Level II trauma facilities contacted report working at or above capacity, and 84 percent of Level III facilities have similar problems.[2] This has resulted in overcrowding and the diversion of patients to other facilities, creating life-threatening situations. A hospital requests diversion of ambulances when it is unable to provide the level of care demanded by the patient's injuries or has temporarily exhausted its resources. In a recent assessment of Houston area emergency departments, hospitals reported a 77 percent increase in the number of ambulance diversion hours between 2000 and 2001.[3]

Of the hospitals experiencing diversion problems, 75 percent report a deficiency in available patient beds.[4] The volume of emergency and trauma care visits is reported to cause a strain on the urgent care system. Non-emergency care patients who call on emergency rooms for primary care are intensifying the problem, with more than half of all total emergency room visits made by

non-emergency patients. A lack of primary care options often causes those who seek minor medical attention to access more costly medical services in the emergency room. Many cannot obtain care from a private physician, and some have actually reported being referred to emergency facilities by primary care physicians.[5] This problem is exacerbated by the lack of primary care alternatives during peak periods, specifically at night and on weekends.

Given the limited capability and capacity of today's emergency care system, concerns exist related to disaster readiness and the ability to handle the demands a bioterrorist attack might generate. As cities and regions enhance their disaster readiness, plans are based on attempting to contain the disaster and transport survivors to hospitals. With hospitals routinely operating near capacity, the ability to handle a disaster with mass casualties warrants consideration.

UNCOMPENSATED/UNDERCOMPENSATED CARE

The Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986 is a federal law which mandates that a hospital must perform an evaluation of any patient who comes to the ER regardless of the patient's ability to pay. If an emergency condition exists, the hospital must also provide care for the patient if the hospital has the capability and capacity to do so. If the hospital does not have the capability to care for the patient, it must transfer the patient to a hospital that provides a higher level of care. The intended receiving hospital must then accept the patient, regardless of ability to pay, if it has capacity. This is also the case for the treatment of trauma patients.

Uncompensated emergency room care has caused a significant drain on available resources, and continues to increase. Uninsured trauma patients account for 32 percent of all trauma patients statewide, and cost trauma facilities a minimum of $181 million in 2001 to treat. This constitutes an average of 20 percent of all charges to patients who use emergency services.[6] For example, University Health System in San Antonio collects only 63 percent of its costs for trauma patients who are hospitalized.

Another major cost driver for the trauma system in Texas is the utilization of the emergency department for primary care. Hospital emergency departments are intended to provide life-saving care and stabilization to patients who have experienced a severe injury or serious medical condition requiring immediate intervention. **Of the 106 million annual visits to emergency departments nationwide, nearly 62 million, or 58 percent, are for treatment of patients who could have sought care in less acute-care settings.**[7] This phenomenon continues even with the expansion of Medicaid and creation of the Children's Health Insurance Program (CHIP).

The Subcommittee also received extensive testimony highlighting the fiscal consequences of delayed reimbursement from insurance companies and insufficient reimbursement of services for Medicaid patients. Statewide, 17 percent of hospitals' emergency department losses are attributable to patients covered by Medicaid who receive care which costs more than the rate of reimbursement.[8]

WHO PAYS FOR TRAUMA CARE?

Share of cost for treatment of trauma patients, for a total of $564.4 million in FY 2001, is presented by payor class in the chart below:

TEXAS TRAUMA CENTER PAYOR MIX FY 2001
LEVELS I - IV

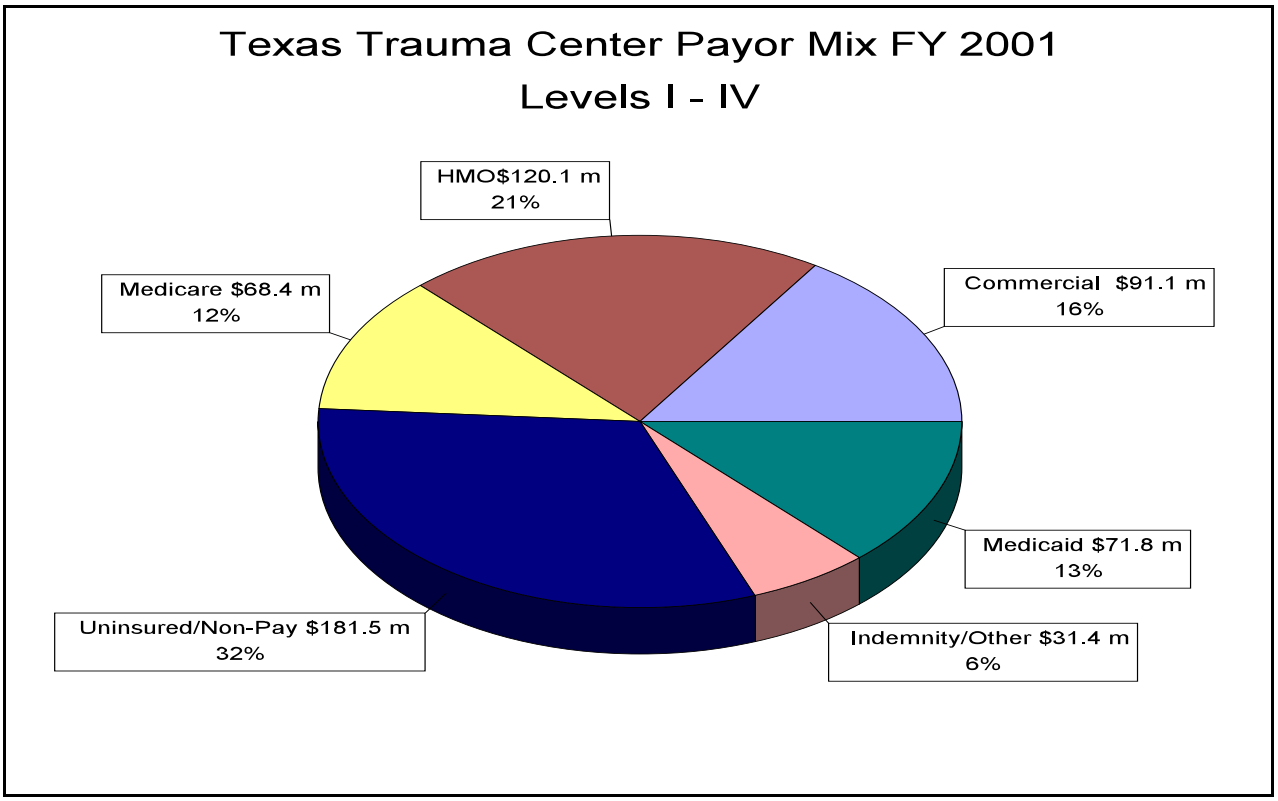
Payor	Total Costs	Percent of Total Costs
Commercial Insurance	$ 91,135,842	16 %
Managed Care (HMO)	$ 120,127,197	21 %
Medicare	$ 68,438,289	12 %
Medicaid	$ 71,767,712	13 %
Uninsured/Non-Pay	$ 181,500,170	32 %
Indemnity/Other	$ 31,427,581	6 %
TOTAL	**$ 564,396,791**	**100%**

Level I and II trauma centers comprised 72 percent of total trauma patient costs in 2001. These patients had a self-pay rate of 35% and incurred $141,403,403 in self-pay costs, or 78 percent of the state's total trauma self-pay costs.

TEXAS TRAUMA CENTER COSTS
LEVEL I - II FY 2001

Payor	Total Costs	Percent of Total Costs
Commercial	$68,681,654	16 %
Managed Care	$84,842,043	22 %
Medicare	$36,360,875	9 %
Medicaid	$52,521,264	13 %
Uninsured/Non-Pay	$141,403,403	35 %
Indemnity/Other	$20,200,486	5 %
Total	**$404,009,725**	**100 %**

Level III - IV trauma centers had a significantly lower self-pay rate than did Level I - II trauma centers, 25 percent versus 35 percent, respectively.



TEXAS TRAUMA CENTER COSTS
LEVEL III - IV FY 2001

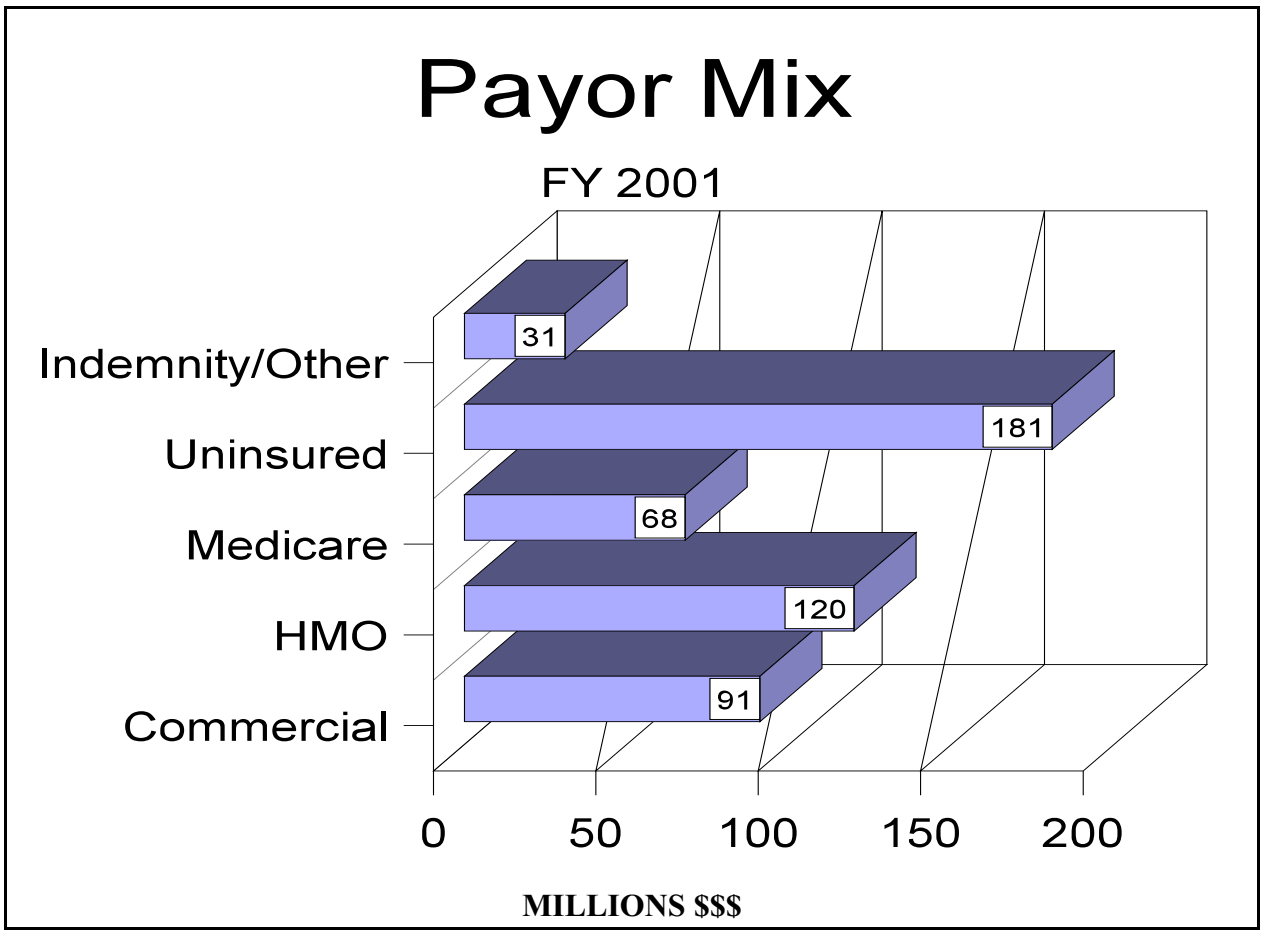
Payor	Total Costs	Percent of Total Costs
Commercial	$22,454,189	14 %
Managed Care	$35,285,155	22 %
Medicare	$32,077,413	20 %
Medicaid	$19,246,448	12 %
Uninsured/Non-Pay	$40,096,767	25 %
Indemnity/Other	$11,227, 094	7 %
Total	**$160,387,066**	**100 %**

Key factors underlying the poor financial condition of Texas' trauma centers include:

- $181 million in uncompensated care for treatment provided to uninsured patients in 2001;
- Relatively low payments in relation to the high costs of trauma care resulted in a $27.2 million loss on patients covered by Medicaid in 2001;
- Medicaid and self-pay patients incur longer stays due to lack of rehabilitation funding; and
- Texas trauma centers have a low level of public financial support from state and local sources.
-

Texas trauma facilities statewide incurred $564 million in costs to provide treatment to trauma patients. As noted in the figure below, $181 million in costs were incurred treating uninsured patients. This proportion (32 percent) is well above the national average.

It is important to note that these costs do not include the costs to keep trauma centers fully staffed and in a constant state of readiness.[9]



Source: Texas Trauma Economic Assessment and System Survey, prepared for Save Our ERs

STAFF SHORTAGES

Extensive testimony was presented to the Subcommittee regarding the impact personnel shortages are having on trauma care delivery in Texas. These shortages exist among every category of health care practitioners, including nurses, physician's assistants, pharmacists, Emergency Medical Technicians (EMTs), and physicians. This shortage compromises the number of beds available to treat trauma and other patients, therefore limiting access to timely and adequate care. The supply of registered nurses (RNs) is limited, and of growing concern is the shortage of qualified critical care nurses in trauma care facilities. Texas currently needs 28,000 RNs to meet the national ratio of nurse to population criteria.[10] Immediate improvement to this situation is not expected. With the median age for nurses at 45, many registered nurses are reaching retirement age. At the same time, the number of graduates from nursing schools has been in decline in recent years.[11]

Additionally, facilities are closing as a direct result of inadequate physician staffing; and a major factor in the decline of physicians practicing is the high cost of medical malpractice coverage. In July 2002, the University of Nevada Medical Center closed its trauma center in Las Vegas for ten days because its surgeons walked out, citing inability to pay sharply increased premiums.[12] An average of 55 percent of hospitals in Texas, and 71 percent of Level I and II hospitals experience difficulty in having specialty physicians on-call to treat emergency department patients. Medical liability

exposure was cited as the primary reason for the difficulty in obtaining and maintaining physician coverage for the emergency department.[13] And a recent U.S. Department of Health and Human Services report found that health care costs overall have increased due to the indirect costs to the health care system resulting from higher malpractice premiums.

MEDICAL LIABILITY PROTECTION COST INCREASES

The Subcommittee also received testimony indicating a disturbing trend of physicians who are limiting their scope of practice or merely retiring early in order to limit their vulnerability to medical malpractice lawsuits. The lack of available physicians who treat trauma patients is currently a severe problem in the Rio Grande Valley and Corpus Christi regions of Texas, but is affecting the entire state at an alarmingly increasing rate.

Medical liability insurance offers coverage to health care providers and hospitals for errors which may occur during the process of providing care. These types of policies cover claims for medical error or neglect, but do not include coverage for intentional or criminal malfeasance. The market for medical liability insurance has become extremely volatile, with carriers experiencing accelerating loss trends and many carriers exiting the market due to significant increases in claims and severity of claims. Between 1996 and 2000, an average of 25 percent of doctors statewide had a medical malpractice claim against them, with some regions of the state like the Rio Grande Valley experiencing the number of claims filed growing at a rate of 60 percent per year. The average claim cost per insured physician has increased approximately 15 percent during this same time period.[14]

Hospitals, especially those that serve high risk patients in trauma centers, also are experiencing rapid increases in the cost of medical liability coverage due to the growing number of lawsuits and the size of awards. In some instances, hospitals are no longer offering certain risky treatments that increase their vulnerability to malpractice lawsuits, and are reluctant to report problems and participate in joint efforts to improve care because they fear being implicated in additional lawsuits.[15]

EMERGENCY MEDICAL SERVICES

One of the resources necessary to deliver effective trauma care is pre-hospital care, more commonly known as Emergency Medical Services (EMS). EMS is often the first critical link in the process of providing medical treatment to victims of trauma. However, EMS providers face some of the same challenges impacting trauma care as a whole.

Although EMS is not a state mandated service, an estimated 724 entities provide EMS services across the state of Texas. Providers include municipalities, counties, private ambulance companies, hospitals, Emergency Service Districts (ESDs), and Rural Fire Prevention Districts (RFPDs). ESDs and RFPDs are taxing entities that use revenues to pay for EMS. Many of these entities are faced with an increasing need for services; like hospitals, EMS providers may not turn away patients based on ability to pay or medical condition. The same factors that contribute to increased volume in emergency rooms impact EMS providers, especially an aging population and lack of available primary care.

Another commonality EMS providers share with hospitals is a lack of qualified personnel. It is increasingly difficult for EMS providers to recruit and retain qualified personnel due to the inability to provide competitive compensation. Additionally, once they begin working for a provider, it is difficult for personnel to obtain further education due to the long hours EMS personnel must work.

For rural and frontier counties, the challenges of providing EMS are multiplied. Due to a low population base in large geographic areas, funding is often inadequate or unavailable to these communities. Furthermore, citizens in rural areas encounter longer wait times due to the distances the vehicle must travel to pick up a patient.

POTENTIAL SOLUTIONS

The Subcommittee has determined that it has become necessary to address the following policy areas in order for the citizens of the State of Texas to have access to quality emergency and trauma care. These policy areas are provided in two groups - those which require an infusion of additional revenue, and those which are revenue neutral. Considering the challenging budget situation the 78th Legislature will face, the Subcommittee has attempted to provide a variety of options for consideration when significant revenue is necessary to fund a proposal. This report reflects the Subcommittee's understanding that a source of revenue must be identified to fund any recommendations with an associated cost.

CONSIDER INCREASING FUNDING TO FULLY IMPLEMENT THE STATEWIDE TRAUMA SYSTEM AND OFFSET UNCOMPENSATED CARE

Many rural and low income areas of the state are suffering from a lack of comprehensive trauma services. As a result, the death rate in rural areas has been estimated at as much as 85 percent higher than in urban areas. Not all areas of the state have designated trauma facilities available. For instance, Trauma Service Area S, which includes Victoria and the surrounding area, does not currently have a designated trauma facility. Any trauma patients in this area would have to be transported to San Antonio or Houston to receive trauma care, increasing already significant pressure on those regions.

The Bureau of Emergency Management Division of TDH has indicated that it would take approximately $10 million dollars annually to ensure the full implementation of the Texas Trauma Care System infrastructure, as first envisioned by the Legislature in 1989. This level of state financial support has never been applied to the trauma system in Texas.

The bulk of testimony identified the major cost driver associated with providing trauma services as uncompensated care. The legislature could consider increasing the level of funding for the Tertiary Medical Care Program, and revise the program so that funds are allocated proportionately among all levels of designated facilities (Level I-IV) to offset losses resulting from uncompensated trauma care. The Tertiary Medical Care Program was created by the legislature in 1999, to assist designated trauma facilities in paying the cost of providing certain medical services to patients who live outside the county or outside the service area. Transfers to the Tertiary Care Fund were $17.2 million in FY 2001, and $46.9 million in FY 2002.

The Legislature also could consider modifying Medicaid payment schedules to compensate commensurately for higher cost critical care unit services. With almost half of the state's emergency care being delivered by non-designated hospitals, the state should create incentives for hospitals to participate in the trauma system by seeking designation. Currently, hospitals must seek trauma designation to qualify to receive Medicaid disproportionate share funds. Another approach would be to separate disproportionate share funds from designation and provide a more meaningful incentive

to obtain trauma designation.

FUNDING SOURCES

OPTION: Existing General Revenue and/or Federal Funds

Consider funding the Texas Trauma Care System through existing General Revenue and/or Federal Funds. TDH estimates the cost to fully fund the infrastructure of the system, including the EMS/Trauma Care System Fund and Systems Development Grants, as intended by the Legislature, at approximately $10 million per annum. To fully fund the Tertiary Medical Care Program will require substantially more resources. For example, in 2002, hospitals statewide applied for an amount adjusted by TDH to $260 million , with only $16 million being funded by the Legislature.[16]

One possible course of legislative action would be to leverage resources in an effort to draw federal bioterrorism grants for the purpose of funding part or all of the trauma care system, as trauma centers would be a first line of response in the event an act of terrorism occurs in this state.

Another approach which would result in possible sources of funding would entail increasing or adding surcharges or fees to products or activities that frequently contribute to the need for trauma care services. The Texas Department of Health breaks down the major causes of trauma into the following categories:

MAJOR TRAUMA CATEGORIES 1998

CAUSE	PERCENTAGE
Motor Vehicle Accidents	43%
Falls	30%
Assault	12%
Self-Inflicted Injuries	2%
Fire/Burns	1%

SOURCE: Texas Department of Health, Bureau of Emergency Management

OPTION: Surcharge on Certain Traffic Violations

Consider adding a surcharge on fines for traffic violations that contribute to the need for trauma care, such as DWI, reckless driving, and speeding. With almost half of all trauma occurrences being vehicle related, those who most contribute to the cost should pay a higher portion of the services. The California Legislature recently passed legislation that would add a $200 per occurrence surcharge on the aforementioned

moving violations, raising an estimated $25 million per year for the state's trauma care system.

According to the Office of the Comptroller, assuming an additional $5 fee were assessed on DWI and DUI offenders, an estimated $.5 million could be generated during the 2004-05 biennium.

OPTION: Surcharge on Motor Vehicle License Registration

Consider attaching an additional surcharge to the fee for each motor vehicle license registration issued in the state, including motorcycles. Automobile accidents in Texas are growing as the number of miles traveled annually increases. In 2000, Texas led the country in the number of motor vehicle deaths with 3,901. Motorcycle fatalities have seen double digit increases in recent years, contributing significantly to the total number of traffic fatalities. This proposal would be similar to HB 893 from the 77th Legislature, which would have mandated a $5 surcharge on motor vehicle registrations, generating an estimated $85 million per year to fund trauma services.

OPTION: Increase to Fee for Vehicle Inspections

Consider an additional $5 increase in the vehicle inspection fee. According to the Office of the Comptroller, such an increase could generate $130 million during the 2004-05 biennium, assuming full implementation by September 1, 2003 and assuming that the increase is applied uniformly across the state.

OPTION: Increase to Fee for Driver License/ID Issuance and Renewal

A similar option would be to increase the fee to obtain or renew an identification and/or a license to operate a motor vehicle, including motorcycles. According to the Department of Public Safety, the following number of licenses and identification cards are projected to be issue or renewed in FY 2003 -06:

Fiscal Year	Licenses/IDs Issued or Renewed
FY 2003	2,955,142
FY 2004	2,816,610
FY 2005	3,594,205
FY 2006	3,478,828

According to the Office of the Comptroller, a $1 fee added to the cost of driver's license renewals only could generate $7 million during the 2004-05 biennium,

assuming full implementation by September 1, 2003.

Fees for the reinstatement of suspended drivers licenses can also be considered for increase. Drivers licenses are typically suspended for infractions such as driving while intoxicated or without liability insurance. Currently, reinstatement fees range from $50 to $125.

OPTION: Surcharge to Automobile Insurance Policies

Consider adding a surcharge on each automobile insurance policy issued in Texas. Pennsylvania has implemented this type of approach in order to supplement funding for the trauma care system in the state. According to the Texas Department of Insurance, 11.7 million vehicles were insured in the state of Texas at the end of the fourth quarter of 2001.

OPTION: Require Trauma Injury Protection Provision in Auto Insurance Policies

Consider requiring automobile insurance policies to provide $50,000 in personal injury protection for trauma care, with the auto policy coverage paying the trauma center costs first, and health insurance being a secondary payor.

OPTION: Additional Tax on the Sale of Alcoholic Beverages

Consider attaching an additional tax to the sale of alcoholic beverages. Since 1993, according to the Department of Public Safety, 28.4% to 40.1% of all traffic fatalities were reported to have been alcohol-related. Since a disproportionate share of trauma occurrences are alcohol-related, levying a tax on alcoholic beverages would increase responsibility for funding on those who most often access services. Currently, a gross receipts tax is imposed on the amount received from the sale or service of mixed beverages at a rate of 14 percent of gross receipts. One approach would be to increase this rate and earmark the additional revenue for funding of trauma care services.

OPTION: Assessment on the Illegal Discharge and/or Sale of Firearms

Consider placing an assessment on the illegal discharge and/or sale of firearms and ammunition. The State of Illinois has in past introduced legislation to levy a fine on the illegal discharge of firearms and add a tax to the sale of firearms, which in 1997, would have resulted in $5 million in annual revenue. Such fines and taxes were proposed in an effort to offset trauma costs associated with violent crimes.

OPTION: Inter-County Contracts for Emergency Medical Services

According to Trauma System statute, counties without EMS districts currently have the authority to form an entity providing EMS services and/or levy a tax for this purpose. Many counties have formed EMS districts, while smaller counties generally have not. Counties without EMS services could consider collecting this tax while

contracting with a county with an organized EMS to access these services.

OPTION: Multi-County Special Districts to Fund Trauma and Emergency Medical Services

Consider authorizing the creation of new multi-county special districts that would levy a tax to fund trauma and emergency care service. If the entity were to levy an ad valorem tax, a constitutional amendment would be required authorizing that authority. According to revenue estimates from the Office of the Comptroller, if such an ad valorem tax were assessed by, for example, a special taxing district consisting of Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Harris, Liberty, Matagorda, Montgomery, Walker, Waller, and Wharton counties, $27.6 million annually could be generated. This estimate assumes a rate of one cent per hundred dollars of value with no exemptions, and collection averaging 95 percent of levies. Additionally, the Legislature could consider giving the entity the authority to levy a variety of taxes, including taxes on tobacco, alcohol, or firearm products.

REVENUE NEUTRAL OPTIONS

The following options present the Legislature with opportunities to approach the trauma care crisis in ways which would require no additional financial contribution from the state but would have a positive impact on the Texas Trauma Care System.

OPTION: Prompt Reimbursement to Hospitals and Doctors

Ensure prompt and adequate reimbursement by both Medicaid and private insurers to hospitals and doctors. The Subcommittee received testimony from numerous sources regarding the monetary impact delayed payments to providers has on the financial security of the trauma care system. The Senate Special Committee on Prompt Pay of Healthcare Providers is charged with evaluating the effectiveness of current prompt pay requirements. While that committee will likely recommend adherence to current compliance rules, they acknowledge that further legislative action may be needed. For further detail, please refer to the interim report issued by the Special Committee on Prompt Pay in November 2002.

OPTION: Review Medical Malpractice Liability Insurance

Review the medical malpractice liability insurance system in Texas. The Subcommittee received substantial testimony regarding this issue from physicians, hospital administrators, and advocates. While recommendations submitted to the Subcommittee contained a variety of components, all parties agreed that the cost increases of medical malpractice insurance policies are having a significant and profound impact on the delivery of trauma care services. One significant proposal would extend the caps on hospital malpractice liability currently in place for public hospitals to coverage for all designated trauma facilities. Current law sets liability caps at $100,000 per individual and a cumulative of $300,000 per occurrence. Similar protections would be given to physicians by placing a cap on jury awards for non-

economic damages.

OPTION: Public Education Initiatives on the Use of the ER

Consider directing the Texas Department of Health to undertake education initiatives in an effort to provide information to the public regarding the appropriate use of EMS and hospital emergency rooms. The Subcommittee determined that overutilization of emergency facilities for less urgent purposes was one of the primary cost drivers for hospitals in providing emergency care. TDH should expand existing partnerships or enter into new partnerships with hospitals, EMS providers, community health centers, and others with the common goal of improving the public's understanding of the proper utilization of medical resources.

OPTION: Alleviate the Impact of Primary Care Patient Visits to the ER

Consider directing the Texas Department of Health to develop initiatives to improve access to non-emergency health care services by the public. This effort should focus on identifying the role of primary health care providers such as hospital "fast-track" programs, community health centers, or Federally Qualified Health Centers in alleviating the impact of primary care patient visits to emergency departments.

OPTION: Increase Healthcare Provider Workforce

Consider directing the Higher Education Coordinating Board to conduct a study to review the distribution of higher education resources in the fields of emergency care and health care training. This study should focus on identifying opportunities for supplying qualified graduates to meet the demands of providing a complete and competent workforce. One example would be to require a community college, in a region of the state with severe shortages of Emergency Medical Technicians, to focus the fields of study specifically to EMT training in an effort to address the regional needs of the state.

DATA SOURCES

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8. Texas Hospital Association Member Survey, July 2002

9. Texas Trauma Economic Assessment and System Survey, Bishop+Associates, prepared for Save Our ERs, 2002

10. Testimony of Patricia Starck, DSN, RN, Dean, UT Health Science Center at Houston School of Nursing, August 5, 2002

11. Emergency and Trauma Care Brief, Texas Institute for Health Policy Research, October 2002

12. Confronting the New Health Care Crisis, prepared by U.S. Department of Health and Human Services, July 24, 2002

13. Texas Hospital Association Member Survey, July 2002

14. Testimony of José Montemayor, Commissioner of the Texas Department of Insurance, August 30, 2002

15. Confronting the New Health Care Crisis, prepared by U.S. Department of Health and Human Services, July 24, 2002

16. Texas Department of Health Presentation to the Senate Finance Subcommittee on Trauma Care - February 7, 2002

EXECUTIVE SUMMARY

Access and delivery to trauma care, an essential service for the citizens of Texas, will likely be debated by the 78th Legislature. Every year, approximately 10,000 Texans die due to traumatic injuries, and six times that many are seriously injured. Studies show that severely injured patients who are treated in trauma centers in the first hour after injury, commonly referred to as "the golden hour", exhibit significantly improved survival rates over patients treated in non-specialized emergency departments.

In 1989, the Legislature determined the need and intent to make trauma care readily available to every citizen. Since then, the state has developed a trauma response system comprised of Regional Advisory Councils (RACs) charged with developing and implementing regional trauma system plans, the state trauma registry, and the designation of trauma care facilities.

FACTS

- *There are currently 185 designated trauma centers in the state of Texas.*
- *These facilities treated 56,072 trauma patients in 2001.*
- *Since the inception of the Texas Trauma System, there has been a 21% decline in the trauma death rate.*

Even in today's more organized trauma system environment, facilities and staff face continued pressure from increased demand for services; funding constraints; lack of resources from uncompensated care; staffing shortages; and increasing medical liability insurance costs.

On September 2, 2001, Lieutenant Governor William Ratliff issued six charges to the Senate Finance Committee. One of these charges directed the Senate Finance Committee to evaluate the infrastructure, capacity and funding of trauma care, and develop options to address the state's trauma care needs. On October 24, 2001, Senator Rodney Ellis, Chair, Senate Finance Committee, announced the creation of the Interim Subcommittee on Trauma Care to complete this task. Members of this subcommittee are Senator Chris Harris, Chair, Senator Mike Jackson, Senator Jon Lindsey, Senator Eddie Lucio, and Senator Judith Zaffirini.

Public hearings were held by the Subcommittee in Austin on February 7, 2002; in Houston on July 18, 2002; and in Brownsville on August 30, 2002.

This report is a compilation of information gathered during the course of this study and includes: a brief background and assessment of trauma care delivery in Texas, an analysis of the related issues, summaries of testimony given during Subcommittee hearings, and the Subcommittee's options for action based on these factors. The 78th Legislature should consider:

- Increasing funding to fully implement the statewide trauma system and offset uncompensated care.
- Helping ensure prompt and appropriate payment for trauma care services.

- Review physician and hospital liability insurance system.
- Educate the public regarding utilization of ambulance, EMS, and emergency room facilities.
- Develop and expand alternative primary medical care resources.
- Increase health care workforce through higher education incentives.

With these and other options, the state of Texas will continue development of a coordinated statewide trauma response system. Such a system will provide access to a designated trauma facility for every person within one hour of a trauma incident.

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