Texas Healthcare Transformation and Quality Improvement — The Physician Perspective
October 5, 2016

As physician leaders in North Texas, we have concerning news to share with you. Health care for the most vulnerable patients in Texas will be threatened even more as less federal funding is heading our way. Last year, the State of Texas asked the federal government (through the office of the Centers for Medicare/Medicaid, or CMS) for a renewal of a funding model (we know it as the 1115 Waiver) that would have totaled more than $30 billion (with a "B") statewide! The request was only partially granted. CMS gave Texas 15 months of funding instead of the five years requested; this would reduce our state's healthcare system funding by more than $20 billion. Time is running out for the state to address some of CMS' concerns and receive approval for all the funds previously requested, and it does not take a physician to diagnose this as a serious problem. Not making a counteroffer would create a disaster to the already tenuous safety net. To provide a counteroffer, the physicians of the Dallas County Medical Society, along with community partners, spent the last two years building a model healthcare delivery plan that we believe can solve this very large problem. We call it the Dallas Choice Plan.

Initiated in 2012, the 1115 Waiver funding program called the Texas Healthcare Transformation and Quality Improvement Program was intended to "redesign healthcare delivery" with an overarching goal to "transform the current delivery of care and payment systems in Texas to a system that is more transparent and accountable…." While the 1115 Waiver program has served to incentivize transformation of healthcare delivery in hospitals and healthcare systems that receive CMS funds toward uncompensated care, the waiver has not had a tangible positive impact on the health of the community at large, nor on physicians who provide care for the vulnerable population in our county and state. We believe the Dallas Choice Plan is a solution that Texas and CMS are looking for, enabling the restoration of the federal government's funding for the most vulnerable in our county and state.

We are in the process of asking Governor Abbott, Lt. Governor Patrick, Speaker Straus, and Health Commissioner Smith to look at our plan. We believe it could serve as the next step and the next model of care for communities across Texas after the 1115 Waiver ends next year.

Instead of debating how to reform our local healthcare system, the Dallas Choice Plan proposes a pragmatic and creative solution to address the "access gap" that still impacts about 30 percent of our citizens. Thousands of patients in the gap today are in working families with children. Lack of affordable health care for parents and children affects each family's security and well-being, and affects us all through the impact on our businesses, schools, hospitals, and neighborhoods.

Before we share the basics of the Dallas Choice Plan, let's look at why we need a new model. Dallas is a great city, with great communities and great people. However, Dallas has its blemishes. Although our healthcare industry exists under a free-market economy, today's crushing, competitive environment among Dallas' large hospital systems diverts attention from effective

planning and execution of community-based health delivery solutions for vulnerable populations. As hospital systems continue to use profits and federal funds for competitive advantage, they minimize investments in prevention and before-hospital health care, placing at risk those vulnerable patients who could benefit from such services. Hospitals clearly hold the largest share of resources and carry the greatest influence toward supporting community-wide solutions. Yet currently, none of these funds go toward covering costs for health care provided by independent private physicians; this seriously limits nonhospital access to physician services for vulnerable patients.

Here are two simple examples of the unfortunate outcomes of the competitive landscape among our Dallas hospitals. While no patient prefers waiting in a crowded emergency room to treat an issue that could be managed in a doctor's office, the waiver funds rarely are used to address this concern. Further, no one wants a second or third MRI test simply because our hospitals do not want to share information among themselves.

As Matt Goodman wrote in D Healthcare on Sept. 8, 2016, the federal government has provided more than $3 billion directly to hospitals in North Texas over the last five years through 1115 Waiver funding. Instead of using these funds to transform the system, we have seen what could be described as a "medical arms race" in hospital facility construction. This surge of hospital construction has targeted the more affluent (and insured) areas of North Dallas, not the needier areas in southern and western Dallas County. This is contrary to the purpose for which we believe these funds were earmarked — to address the unmet needs of thousands of people without health insurance or unable to pay for health care themselves. The 1115 Waiver Community Needs Assessment Task Force in 2012 listed "Primary and Specialty Care Capacity" as the region's top community healthcare priorities, stating that "demand exceeds available medical physicians in these areas, thus limiting healthcare access." Because 1115 Waiver funds flowed entirely into Dallas hospitals, we believe these funds have not been utilized to their full potential to help solve the decades-long problem of unequal access to primary and specialty physician health care for vulnerable people in Dallas.

As an alternative, the heart of the Dallas Choice Plan is a true Community-based Accountable Care Organization (ACO). A Community ACO is a new term for a healthcare organization that includes physicians, hospitals and other health providers to care for a population of people. The organization is transparent with regard to performance of its provider network in relation to costs and quality. All health providers in a Community ACO must meet quality and efficiency standards within budget. This is just what the doctors are ordering for Dallas' solution to this vexing access problem.

The Dallas Choice Plan would rely on Parkland Health and Hospital System's support and leadership to anchor the Community ACO. Just as the community strongly supported building Parkland's state-of-the-art hospital facility, we see a great opportunity for Parkland to be supported in this new role. Physicians in North Texas have a strong connection to Parkland, as most of us either trained or worked at this great institution during our careers. This trusted community health system could be the foundation that recruits private hospitals and independent physicians, along with community clinics and a host of other community-based health providers, thereby further strengthening Dallas' healthcare safety net.

The Dallas Choice Plan is transparent, accountable and transformative in its emphasis on real and meaningful access to care. It was designed by many of our long-time partners in the Dallas community who care deeply about vulnerable patients. We long ago reached out to Dr. Fred Cerise, CEO of Parkland Health and Hospital System, and his team; they agree with many of our ideas and have expressed an interest in working with us on this. Certainly, much work needs to be done, but let's be sure to create a model that supports everyone who is serving this patient population. Let's not waste one more dollar on competing hospital systems.

We propose to test this model in Dallas County, and if successful, believe it could be effective in other areas of Texas. But to even test the model, we need state leaders and CMS to agree to try.

As leaders of the Dallas County Medical Society for the past three decades, we believe our state, our county and our patients need a viable alternative now.

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The mission of the Dallas County Medical Society is to promote public health, advocate for physicians and their relationship with patients, while upholding professionalism in the practice of medicine.