BILL ANALYSIS

Senate Research Center

C.S.S.B. 8
By: Nelson
Health & Human Services
4/1/2011
Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

The goal of C.S.S.B. 8 is to improve the quality and efficiency of health care in Texas.

C.S.S.B. 8 amends current law relating to improving the quality and efficiency of health care.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance (commissioner) in SECTION 3.01 (Sections 848.054 and 848.108, Insurance Code) of this bill.

Rulemaking authority is expressly granted to the commissioner and the attorney general in SECTION 3.01 (Sections 848.151 and 848.152, Insurance Code) of this bill.

Rulemaking authority is expressly granted to the commissioner, the attorney general, and the board of directors of the Texas Institute of Health Care Quality and Efficiency in SECTION 3.07 of this bill.

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission (executive commissioner) in SECTIONS 4.01 (Section 311.004, Health and Safety Code), 5.03 (Section 98.103, Health and Safety Code), 5.04 (Section 98.1045, Health and Safety Code), 5.08 (Section 98.1065, Health and Safety Code), and 5.09 (Section 98.108, Health and Safety Code) of this bill.

Rulemaking authority previously granted to the executive commissioner is modified in SECTIONS 5.06 (Section 98.105, Health and Safety Code), and 5.09 (Section 98.108, Health and Safety Code) of this bill.

Rulemaking authority previously granted to the Texas Health Care Information Council is transferred to the executive commissioner in SECTIONS 6.04 (Section 108.013, Health and Safety Code) and 6.05 (108.0135, Health and Safety Code) of this bill.

SECTION BY SECTION ANALYSIS

ARTICLE 1. LEGISLATIVE FINDING AND INTENT; COMPLIANCE WITH ANTITRUST LAWS

SECTION 1.01. (a)-(b) Sets forth the legislative findings of this Act.

(c) Provides that the legislature intends to exempt from antitrust laws and provide immunity from federal antitrust laws through the state action doctrine a health care collaborative that holds a certificate of authority certified under Chapter 848, Insurance Code, as added by Article 3 of this Act, and that collaborative's negotiations of contracts with payors. Provides that the legislature does not intend or authorize any person or entity to engage in activities or to conspire to engage in activities that would constitute per se violations of federal antitrust laws.

(d) Provides that the legislature intends to permit the use of alternative payment mechanisms, including bundled or global payments and quality-based payments, among

physicians and other health care providers participating in a health care collaborative that holds a certificate of authority under Chapter 848, Insurance Code, as added by Article 3 of this Act. Provides that the legislature intends to authorize a health care collaborative to contract for and accept payments from governmental and private payors based on alternative payment mechanisms, and intends that the receipt and distribution of payments to participating physicians and health care providers is not a violation of any existing state law.

ARTICLE 2. TEXAS INSTITUTE OF HEALTH CARE QUALITY AND EFFICIENCY

SECTION 2.01. Amends Title 12, Health and Safety Code, by adding Chapter 1002, as follows:

CHAPTER 1002. TEXAS INSTITUTE OF HEALTH CARE QUALITY AND EFFICIENCY

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1002.001. DEFINITIONS. Defines "board," "commission," "department," "executive commissioner," "health care collaborative," "health care facility," "institute," "potentially preventable admission," "potentially preventable ancillary service," "potentially preventable complication," "potentially preventable event," "potentially preventable hospital emergency room visit," and "potentially preventable readmission" in this chapter.

Sec. 1002.002. ESTABLISHMENT; PURPOSE. Establishes and sets forth the purpose of the Texas Institute of Health Care Quality and Efficiency (TIHCQE).

[Reserves Sections 1002.003-1002.050 for expansion.]

SUBCHAPTER B. ADMINISTRATION

Sec. 1002.051. APPLICATION OF SUNSET ACT. Provides that TIHCQE is subject to Chapter 325 (Texas Sunset Act), Government Code. Provides that, unless continued in existence as provided by that chapter, TIHCQE is abolished and this chapter expires September 1, 2017.

Sec. 1002.052. COMPOSITION OF BOARD OF DIRECTORS. (a) Provides that TIHCQE is governed by a board of 15 directors appointed by the governor.

(b) Provides that certain ex officio, nonvoting members as set forth in this subsection also serve on the board.

(c) Requires the governor and lieutenant governor to appoint as board members health care providers, payors, consumers, and health care quality experts or persons who possess expertise in any other area the governor finds necessary for the successful operation of TIHCQE.

(d) Prohibits a person from serving as a voting member of the board if the person serves on or advises another board or advisory board of a state agency.

Sec. 1002.053. TERMS OF OFFICE. (a) Provides that appointed members of the board serve two-year terms ending January 31 of each odd-numbered year.

(b) Authorizes board members to serve consecutive terms.

Sec. 1002.054. ADMINISTRATIVE SUPPORT. (a) Provides that TIHCQE is administratively attached to the Health and Human Services Commission (HHSC).

(b) Requires HHSC to coordinate administrative responsibilities with TIHCQE to streamline and integrate TIHCQE's administrative operations and avoid unnecessary duplication of effort and costs.

Sec. 1002.055. EXPENSES. (a) Provides that members of the board serve without compensation but, subject to the availability of appropriated funds, may receive reimbursement for actual and necessary expenses incurred in attending meetings of the board.

(b) Provides that information relating to the billing and payment of expenses under this section is subject to Chapter 552 (Public Information), Government Code.

Sec. 1002.056. OFFICER; CONFLICT OF INTEREST. (a) Requires the governor to designate a member of the board as presiding officer to serve in that capacity at the pleasure of the governor.

(b) Requires any board member or a member of a committee formed by the board with direct interest, personally or through an employer, in a matter before the board to abstain from deliberations and actions on the matter in which the conflict of interest arises and to further abstain on any vote on the matter, and prohibits the member from otherwise participating in a decision on the matter.

(c) Requires each board member to:

(1) file a conflict of interest statement and a statement of ownership interests with the board to ensure disclosure of all existing and potential personal interests related to board business; and

(2) update the statements described by Subdivision (1) at least annually.

(d) Provides that a statement filed under Subsection (c) is subject to Chapter 552, Government Code.

Sec. 1002.057. PROHIBITION ON CERTAIN CONTRACTS AND EMPLOYMENT. (a) Prohibits the board from compensating, employing, or contracting with any individual who serves as a member of the board of, or on an advisory board or advisory committee for, any other governmental body, including any agency, council, or committee, in this state.

(b) Prohibits the board from compensating, employing, or contracting with any person that provides financial support to the board, including a person who provides a gift, grant, or donation to the board.

Sec. 1002.058. MEETINGS. (a) Authorizes the board to meet as often as necessary, but requires the board to meet at least once each calendar quarter.

(b) Requires the board to develop and implement policies that provide the public with a reasonable opportunity to appear before the board and to speak on any issue under the authority of TIHCQE.

Sec. 1002.059. BOARD MEMBER IMMUNITY. (a) Prohibits a board member from being held civilly liable for an act performed, or omission made, in good faith in the performance of the members' powers and duties under this chapter.

(b) Provides that a cause of action does not arise against a member of the board for an act or omission described by Subsection (a).

Sec. 1002.060. PRIVACY OF INFORMATION. (a) Provides that protected health information and individually identifiable health information collected, assembled, or

maintained by TIHCQE is confidential and is not subject to disclosure under Chapter 552, Government Code.

(b) Requires TIHCQE to comply with all state and federal laws and rules relating to the protection, confidentiality, and transmission of health information, including the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191) and rules adopted under that Act, 42 U.S.C. Section 290dd-2, and 42 C.F.R. Part 2.

(c) Prohibits HHSC, the Department of State Health Services (DSHS), or TIHCQE or an officer or employee of HHSC, DSHS, or TIHCQE, including a board member, from disclosing any information that is confidential under this section.

(d) Provides that information, documents, and records that are confidential as provided by this section are not subject to subpoena or discovery and may not be introduced into evidence in any civil or criminal proceeding.

(e) Prohibits an officer or employee of HHSC, DSHS, or TIHCQE, including a board member, from being examined in a civil, criminal, special, administrative, or other proceeding as to information that is confidential under this section.

Sec. 1002.061. FUNDING. (a) Authorizes TIHCQE to be funded through the General Appropriations Act and to request, accept, and use gifts, grants, and donations as necessary to implement its functions.

(b) Authorizes TIHCQE to participate in other revenue-generating activity that is consistent with TIHCQE's purposes.

(c) Requires each state agency represented on the board as a nonvoting member to provide funds to support TIHCQE and implement this chapter. Requires HHSC to establish a funding formula to determine the level of support each state agency is required to provide.

[Reserves Sections 1002.062-1002.100 for expansion.]

SUBCHAPTER C. POWERS AND DUTIES

Sec. 1002.101. GENERAL POWERS AND DUTIES. Requires TIHCQE to make recommendations to the legislature on:

(1) improving quality and efficiency of health care delivery by:

(A) providing a forum for regulators, payors, and providers to discuss and make recommendations for initiatives that promote the use of best practices, increase health care provider collaboration, improve health care outcomes, and contain health care costs;

(B) researching, developing, supporting, and promoting strategies to improve the quality and efficiency of health care in this state;

(C) determining the outcome measures that are the most effective measures of quality and efficiency;

(D) reducing the incidence of potentially preventable events; and

(E) creating a state plan that takes into consideration the regional differences of the state to encourage the improvement of the quality and efficiency of health care services;

(2) improving reporting, consolidation, and transparency of health care information; and

(3) implementing and supporting innovative health care collaborative payment and delivery systems under Chapter 848, Insurance Code.

Sec. 1002.102. GOALS FOR QUALITY AND EFFICIENCY OF HEALTH CARE; STATEWIDE PLAN. (a) Requires TIHCQE to study and develop recommendations to improve the quality and efficiency of health care delivery in this state, including:

(1) quality-based payment systems that align payment incentives with high-quality, cost-effective health care;

(2) alternative health care delivery systems that promote health care coordination and provider collaboration; and

(3) quality of care and efficiency outcome measurements that are effective measures of prevention, wellness, coordination, provider collaboration, and cost-effective health care.

(b) Requires TIHCQE to study and develop recommendations for measuring quality of care and efficiency across:

(1) all state employee and state retiree benefit plans;

(2) employee and retiree benefit plans provided through the Teacher Retirement System of Texas;

(3) the state medical assistance program under Chapter 32 (Medical Assistance Program), Human Resources Code; and

(4) the child health plan under Chapter 62 (Child Health Plan for Certain Low-Income Children), Health and Safety Code.

(c) Prohibits TIHCQE, in developing recommendations under Subsections (a) and (b), from basing its recommendations solely on actuarial data.

(d) Requires TIHCQE, using the studies described by Subsections (a) and (b), to develop recommendations for a statewide plan for quality and efficiency of the delivery of health care.

[Reserves Sections 1002.103-1002.150 for expansion.]

SUBCHAPTER D. HEALTH CARE COLLABORATIVE GUIDELINES AND SUPPORT

Sec. 1002.151. INSTITUTE STUDIES AND RECOMMENDATIONS REGARDING HEALTH CARE PAYMENT AND DELIVERY SYSTEMS. (a) Requires TIHCQE to study and make recommendations for alternative health care payment and delivery systems.

(b) Requires TIHCQE to recommend methods to evaluate a health care collaborative's effectiveness, including methods to evaluate:

(1) the efficiency and effectiveness of cost-containment methods used by the collaborative;

(2) alternative health care payment and delivery systems used by the collaborative;

(3) the quality of care;

(4) health care provider collaboration and coordination;

(5) the protection of patients; and

(6) patient satisfaction.

[Reserves Sections 1002.152-1002.200 for expansion.]

SUBCHAPTER E. IMPROVED TRANSPARENCY

Sec. 1002.201. HEALTH CARE ACCOUNTABILITY; IMPROVED TRANSPARENCY. (a) Requires TIHCQE, with the assistance of DSHS, to complete an assessment of all health-related data collected by the state and how the public and health care providers benefit from this information, including health care cost and quality information.

(b) Requires TIHCQE to develop a plan:

(1) for consolidating reports of health-related data from various sources to reduce administrative costs to the state and reduce the administrative burden to health care providers;

(2) for improving health care transparency to the public and health care providers by making information available in the most effective format; and

(3) providing recommendations to the legislature on enhancing existing health-related information available to health care providers and the public, including provider reporting of additional information not currently required to be reported under existing law, to improve quality of care.

Sec. 1002.202. ALL PAYOR CLAIMS DATABASE. (a) Requires TIHCQE to study the feasibility and desirability of establishing a centralized database for health care claims information across all payors.

(b) Requires TIHCQE to consult with DSHS and the Texas Department of Insurance (TDI) to develop recommendations to submit to the legislature on the establishment of the centralized claims database described by Subsection (a).

SECTION 2.02. Repealer: Chapter 109 (Texas Health Care Policy Council), Health and Safety Code.

SECTION 2.03. Provides that, on the effective date of this Act:

(1) the Texas Health Care Policy Council established under Chapter 109, Health and Safety Code, is abolished; and

(2) any unexpended and unobligated balance of money appropriated by the legislature to the Texas Health Care Policy Council established under Chapter 109, Health and Safety Code, as it existed immediately before the effective date of this Act, is transferred to TIHCQE created by Chapter 1002, Health and Safety Code, as added by this Act.

SECTION 2.04. Requires the governor to appoint voting members of the board of directors of TIHCQE under Section 1002.052, Health and Safety Code, as added by this Act, as soon as practicable after the effective date of this Act.

SECTION 2.05. (a) Requires TIHCQE, not later than December 1, 2012, to submit a report regarding recommendations for improved health care reporting to the governor, the lieutenant

governor, the speaker of the house of representatives, and the chairs of the appropriate standing committees of the legislature outlining:

(1) the initial assessment conducted under Section 1002.201(a), Health and Safety Code, as added by this Act;

(2) the plans initially developed under Section 1002.201(b), Health and Safety Code, as added by this Act;

(3) the changes in existing law that would be necessary to implement the assessment and plans described by Subdivisions (1) and (2) of this subsection; and

(4) the cost implications to state agencies, small businesses, micro businesses, and health care providers to implement the assessment and plans described by Subdivisions (1) and (2) of this subsection.

(b) Requires TIHCQE, not later than December 1, 2012, to submit a report regarding recommendations for an all payor claims database to the governor, the lieutenant governor, the speaker of the house of representatives, and the chairs of the appropriate standing committees of the legislature outlining:

(1) the feasibility and desirability of establishing a centralized database for health care claims;

(2) the recommendations developed under Section 1002.202(b), Health and Safety Code, as added by this Act;

(3) the changes in existing law that would be necessary to implement the recommendations described by Subdivision (2) of this subsection; and

(4) the cost implications to state agencies, small businesses, microbusinesses, and health care providers to implement the plan described by Subdivision (2) of this subsection.

ARTICLE 3. HEALTH CARE COLLABORATIVES

SECTION 3.01. Amends Subtitle C, Title 6, Insurance Code, by adding Chapter 848, as follows:

CHAPTER 848. HEALTH CARE COLLABORATIVES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 848.001. DEFINITIONS. Defines "affiliate," "health care collaborative," "health care services," "health care provider," "health maintenance organization," "hospital," "institute," "physician," and "potentially preventable event" in this chapter.

Sec. 848.002. EXCEPTION: DELEGATED ENTITIES. (a) Provides that this section applies only to an entity, other than a health maintenance organization, that:

(1) by itself or through a subcontract with another entity, undertakes to arrange for or provide medical care or health care services to enrollees in exchange for predetermined payments on a prospective basis; and

(2) accepts responsibility for performing functions that are required by:

(A) Chapter 222 (Life, Health, and Accident Insurance Premium Tax), 251 (General Provisions), 258 (Health Maintenance Organizations), or 1272 (Delegation of Certain Functions by Health Maintenance Organization), as applicable, to a health maintenance organization; or

(B) Chapter 843 (Health Maintenance Organizations), Chapter 1271 (Benefits Provided by Health Maintenance Organizations; Evidence of Coverage; Charges), Section 1367.053 (Coverage Required), Subchapter A (Credentialing of Physicians and Providers by Health Maintenance Organizations), Chapter 1452 (Physician and Provider Credentials), or Subchapter B (Consumer Choice of Benefits Health Maintenance Organization Plans), Chapter 1507 (Consumer Choice of Benefits Plans), as applicable, solely on behalf of health maintenance organizations.

(b) Provides that an entity described by Subsection (a) is subject to Chapter 1272 and is not required to obtain a certificate of authority or determination of approval under this chapter.

Sec. 848.003. USE OF INSURANCE-RELATED TERMS BY HEALTH CARE COLLABORATIVE. Prohibits a health care collaborative that is not an insurer or health maintenance organization from using in its name, contracts, or literature certain words or initials, or any other words or initials that meet certain criteria.

Sec. 848.004. APPLICABILITY OF INSURANCE LAWS. Prohibits an organization from arranging for or providing health care services to enrollees on a prepaid or indemnity basis through health insurance or a health benefit plan, including a health care plan, as defined by Section 843.002 (Definitions), unless the organization as an insurer or health maintenance organization holds the appropriate certificate of authority issued under another chapter of this code.

Sec. 848.005. CERTAIN INFORMATION CONFIDENTIAL. Provides that a health care collaborative's written description of a compensation agreement made or to be made with a health benefit plan, insurer, or health care provider in exchange for the provision or arrangement to provide services to enrollees is confidential and is not subject to disclosure under Chapter 552, Government Code.

[Reserves Sections 848.006-848.050 for expansion.]

SUBCHAPTER B. AUTHORITY TO ENGAGE IN BUSINESS

Sec. 848.051. OPERATION OF HEALTH CARE COLLABORATIVE. Authorizes a health care collaborative that is certified by TDI under this chapter to provide or arrange to provide health care services under a contract with a governmental or private entity.

Sec. 848.052. FORMATION AND GOVERNANCE OF HEALTH CARE COLLABORATIVE. (a) Provides that a health care collaborative is governed by a board of directors.

(b) Requires the person who establishes a health care collaborative to appoint an initial board of directors. Provides that each member of the initial board serves a term of not more than 18 months. Requires subsequent members of the board to be elected to serve two-year terms by physicians and health care providers who participate in the health care collaborative as provided by this section. Requires the board to elect a chair from among its members.

(c) Requires each member of the board of directors, if the participants in a health care collaborative are all physicians, to be an individual physician who is a participant in the health care collaborative.

(d) Requires the board of directors, if the participants in a health care collaborative are both physicians and other health care providers, to consist of:

(1) an even number of members who are individual physicians, selected by physicians who participate in the health care collaborative;

(2) a number of members equal to the number of members under Subdivision (1) who represent health care providers, one of whom is an individual physician, selected by health care providers who participate in the health care collaborative; and

(3) one individual member with business expertise, selected by unanimous vote of the members described by Subdivisions (1) and (2).

(e) Authorizes the board of directors to include nonvoting ex officio members.

(f) Prohibits an individual from serving on the board of directors of a health care collaborative if the individual has an ownership interest in, serves on the board of directors of, or maintains an officer position with:

(1) another health care collaborative that provides health care services in the same service area as the health care collaborative; or

(2) a physician or health care provider that:

(A) does not participate in the health care collaborative; and

(B) provides health care services in the same service area as the health care collaborative.

(g) Requires the board of directors of a health care collaborative, in addition to the requirements of Subsection (f), to adopt a conflict of interest policy to be followed by members.

(h) Authorizes the board of directors to remove a member for cause. Prohibits a member from being removed from the board without cause.

(i) Prohibits the organizational documents of a health care collaborative from conflicting with any provision of this chapter, including this section.

Sec. 848.053. COMPENSATION ADVISORY COMMITTEE. Requires the board of directors of a health care collaborative to establish a compensation advisory committee (advisory committee) to develop and make recommendations to the board regarding charges, fees, payments, distributions, or other compensation assessed for health care services provided by physicians or health care providers who participate in the health care collaborative. Requires the committee to include:

(1) a member of the board of directors; and

(2) if the health care collaborative consists of physicians and other health care providers:

(A) a physician who is not a participant in the health care collaborative, selected by the physicians who are participants in the collaborative; and

(B) a member selected by the other health care providers who participate in the collaborative.

Sec. 848.054. CERTIFICATE OF AUTHORITY AND DETERMINATION OF APPROVAL REQUIRED. (a) Prohibits an organization from organizing or operating a health care collaborative in this state unless the organization holds a certificate of authority issued under this chapter.

(b) Requires the commissioner of insurance (commissioner) to adopt rules governing the application for a certificate of authority under this subchapter.

Sec. 848.055. EXCEPTIONS. (a) Provides that an organization is not required to obtain a certificate of authority under this chapter if the organization holds an appropriate certificate of authority issued under another chapter of this code.

(b) Provides that a person is not required to obtain a certificate of authority under this chapter to the extent that the person is:

(1) a physician engaged in the delivery of medical care; or

(2) a health care provider engaged in the delivery of health care services other than medical care as part of a health maintenance organization delivery network.

Sec. 848.056. APPLICATION FOR CERTIFICATE OF AUTHORITY. (a) Authorizes an organization to apply to the commissioner for and obtain a certificate of authority to organize and operate a health care collaborative.

(b) Requires that an application for a certificate of authority:

(1) comply with all rules adopted by the commissioner;

(2) be verified under oath by the applicant or an officer or other authorized representative of the applicant;

(3) be reviewed by the division within the office of attorney general that is primarily responsible for enforcing the antitrust laws of this state and of the United States under Section 848.059;

(4) demonstrate that the health care collaborative contracts with a sufficient number of primary care physicians in the health care collaborative's service area;

(5) state that enrollees may obtain care from any physician or health care provider in the health care collaborative; and

(6) identify a service area within which medical services are available and accessible to enrollees.

(c) Requires the commissioner, not later than the 190th day after the date an applicant submits an application to the commissioner under this section, to approve or deny the application.

Sec. 848.057. REQUIREMENTS FOR APPROVAL OF APPLICATION. Requires the commissioner to issue a certificate of authority on payment of the application fee prescribed by Section 848.152 if the commissioner is satisfied that:

(1) the applicant meets the requirements of Section 848.056;

(2) with respect to health care services to be provided, the applicant:

(A) has demonstrated the willingness and potential ability to ensure that the health care services will be provided in a manner that:

(i) increases collaboration among health care providers and integrates health care services;

(ii) promotes quality-based health care outcomes, patient engagement, and coordination of services; and

(iii) reduces the occurrence of potentially preventable events;

(B) has processes that contain health care costs without jeopardizing the quality of patient care;

(C) has processes to develop, compile, evaluate, and report statistics relating to the quality and cost of health care services, the pattern of utilization of services, and the availability and accessibility of services; and

(D) has processes to address complaints made by patients receiving services provided through the organization;

(3) the applicant is in compliance with all rules adopted by the commissioner under Section 848.151;

(4) the applicant has working capital and reserves sufficient to operate and maintain the health care collaborative and to arrange for services and expenses incurred by the health care collaborative;

(5) the applicant's proposed health care collaborative is not likely to reduce competition in any market for physician, hospital, or ancillary health care services due to:

(A) the size of the health care collaborative; or

(B) the composition of the collaborative, including the distribution of physicians by specialty within the collaborative in relation to the number of competing health care providers in the health care collaborative's geographic market; and

(6) the applicant's proposed health care collaborative is not likely to possess market power.

Sec. 848.058. DENIAL OF CERTIFICATE OF AUTHORITY. (a) Prohibits the commissioner from issuing a certificate of authority if the commissioner determines that the applicant's proposed plan of operation does not meet the requirements of Section 848.057.

(b) Requires the commissioner, if the commissioner denies an application for a certificate of authority under Subsection (a), to notify the applicant that the plan is deficient and to specify the deficiencies.

Sec. 848.059. REVIEW BY ATTORNEY GENERAL. (a) Requires the commissioner, if the commissioner determines that an application for a certificate of authority filed under Section 848.056 complies with the requirements of Section 848.057, to forward the application to the attorney general. Requires the attorney general to review the application and, if the attorney general determines that the commissioner's review of the application under Sections 848.057(5) and (6) is adequate, to notify the commissioner of this determination.

(b) Requires the attorney general, if the attorney general determines that the commissioner's review of the application under Sections 848.057(5) and (6) is not adequate, to notify the commissioner of this determination.

(c) Requires that a determination under this section be made not later than the 60th day after the date the attorney general receives the application from the commissioner.

(d) Requires the attorney general, if the attorney general lacks sufficient information to make a determination as to the adequacy of the commissioner's review of the application under Sections 848.057(5) and (6) within 60 days of the attorney general's receipt of the application, to inform the commissioner that the attorney general lacks sufficient information as well as what information the attorney general requires. Requires that the commissioner then either provide the additional information to the attorney general or request the additional information from the applicant. Requires that the commissioner promptly deliver any such additional information to the attorney general. Requires that the attorney general then have 30 days from receipt of the additional information to make a determination under Subsection (a) or (b).

(e) Requires the commissioner, if the attorney general notifies the commissioner that the commissioner's review under Sections 848.057(5) and (6) is not adequate, notwithstanding any other provision of this subchapter, to, then, deny the application.

Sec. 848.060. RENEWAL OF CERTIFICATE OF AUTHORITY AND DETERMINATION OF APPROVAL. (a) Requires a health collaborative, not later than the 180th day before the one-year anniversary of the date on which the health care collaborative's certificate of authority was issued, to file with the commissioner an application to renew the certificate.

(b) Requires that an application for renewal:

(1) be verified by at least two principal officers of the health care collaborative; and

(2) include:

(A) a financial statement of the health care collaborative, including a balance sheet and receipts and disbursements for the preceding calendar year, certified by an independent certified public accountant;

(B) a description of the service area of the health care collaborative;

(C) a description of the number and types of physicians and health care providers participating in the health care collaborative;

(D) an evaluation of the quality and cost of health care services provided by the health care collaborative;

(E) an evaluation of the health care collaborative's processes to promote evidence-based medicine, patient engagement, and coordination of health care services provided by the health care collaborative; and

(F) the number, nature, and disposition of any complaints filed with the health care collaborative under Section 848.107.

(c) Provides that, if a completed application for renewal is filed under this section:

(1) the commissioner is required to deliver the application for renewal to the attorney general, who shall conduct a review under Section 848.059 as if the application for renewal was a new application; and

(2) the commissioner is required to renew or deny the renewal of a certificate of authority at least 20 days before the one-year anniversary of the date on which a health care collaborative's certificate of authority was issued.

(d) Provides that, if the commissioner does not act on a renewal application before the one-year anniversary of the date on which a health care collaborative's certificate of authority was issued, the health care collaborative's certificate of authority expires on the 90th day after the date of the one-year anniversary unless the renewal of the certificate of authority or determination of approval, as applicable, is approved before that date.

[Reserves Sections 848.061-848.100 for expansion.]

SUBCHAPTER C. GENERAL POWERS AND DUTIES OF HEALTH CARE COLLABORATIVE

Sec. 848.101. PROVIDING OR ARRANGING FOR SERVICES. (a) Authorizes a health care collaborative to provide or arrange for health care services through contracts with physicians and health care providers or with entities contracting on behalf of participating physicians and health care providers.

(b) Prohibits a health care collaborative from prohibiting a physician or other health care provider, as a condition of participating in the health care collaborative, from participating in another health care collaborative.

(c) Prohibits a health care collaborative from using a covenant not to compete to prohibit a physician from providing medical services or participating in another health care collaborative in the same service area after the termination of the physician's contract with the health care collaborative.

(d) Requires a health care collaborative, except as provided by Subsection (f), on written consent of a patient who was treated by a physician participating in the health care collaborative, to provide the physician with the medical records of the patient, regardless of whether the physician is participating in the health care collaborative at the time the request for the records is made.

(e) Requires that records provided under Subsection (d) be made available to the physician in the format in which the records are maintained by the health care collaborative. Authorizes the health care collaborative to charge the physician a fee for copies of the records, as established by the Texas Medical Board.

(f) Provides that if a physician requests a patient's records from a health care collaborative under Subsection (d) for the purpose of providing emergency treatment to the patient:

(1) the health care collaborative is prohibited from charging a fee to the physician under Subsection (e); and

(2) the health care collaborative is required to provide the records to the physician regardless of whether the patient has provided written consent.

Sec. 848.102. INSURANCE, REINSURANCE, INDEMNITY, AND REIMBURSEMENT. Authorizes a health care collaborative to contract with an insurer authorized to engage in business in this state to provide insurance, reinsurance, indemnification, or reimbursement against the cost of health care and medical care

services provided by the health care collaborative. Provides that this section does not affect the requirement that the health care collaborative maintain sufficient working capital and reserves.

Sec. 848.103. PAYMENT BY GOVERNMENTAL OR PRIVATE ENTITY. (a) Authorizes a health care collaborative to:

(1) contract for and accept payments from a governmental or private entity for all or part of the cost of services provided or arranged for by the health care collaborative; and

(2) distribute payments to participating physicians and health care providers.

(b) Authorizes a health care collaborative, notwithstanding any other law, to contract for and accept payments from governmental or private payors based on alternative payment mechanisms, including:

(1) bundled or global payments; and

(2) quality-based payments.

Sec. 848.104. CONTRACTS FOR ADMINISTRATIVE OR MANAGEMENT SERVICES. Authorizes a health care collaborative to contract with any person, including an affiliated entity, to perform administrative, management, or any other required business functions on behalf of the health care collaborative.

Sec. 848.105. CORPORATION, PARTNERSHIP, OR ASSOCIATION POWERS. Provides that a health care collaborative has all powers of a partnership, association, corporation, or limited liability company, including a professional association or corporation, as appropriate under the organizational documents of the health care collaborative, that are not in conflict with this chapter or other applicable law.

Sec. 848.106. QUALITY AND COST OF HEALTH CARE SERVICES. (a) Requires a health care collaborative to establish policies to improve the quality and control the cost of health care services provided by participating physicians and health care providers that are consistent with prevailing professionally recognized standards of medical practice. Requires that the policies include standards and procedures relating to:

(1) the selection and credentialing of participating physicians and health care providers;

(2) the development, implementation, and monitoring of evidence-based best practices and other processes to improve the quality and control the cost of health care services provided by participating physicians and health care providers, including practices or processes to reduce the occurrence of potentially preventable events;

(3) the development, implementation, and monitoring of processes to improve patient engagement and coordination of health care services provided by participating physicians and health care providers; and

(4) complaints initiated by participating physicians and health care providers under Section 848.107.

(b) Requires the governing body of a health care collaborative to establish a procedure for the periodic review of quality improvement and cost control measures.

Sec. 848.107. COMPLAINT SYSTEMS. Requires a health care collaborative to implement and maintain complaint systems that provide reasonable procedures to resolve an oral or written complaint initiated by:

(1) a patient who received health care services provided by a participating physician or health care provider; or

(2) a participating physician or health care provider.

(b) Requires that the complaint system for complaints initiated by patients include a process for the notice and appeal of a complaint.

(c) Prohibits a health care collaborative from taking a retaliatory or adverse action against a physician or health care provider who files a complaint with a regulatory authority regarding an action of the health care collaborative.

Sec. 848.108. DELEGATION AGREEMENTS. (a) Provides that, except as provided by Subsection (b), a health care collaborative that enters into a delegation agreement described by Section 1272.001 (Definitions) is subject to the requirements of Chapter 1272 in the same manner as a health maintenance organization.

(b) Provides that Section 1272.301 (Access to Out-of-Network Services) does not apply to a delegation agreement entered into by a health care collaborative.

(c) Authorizes a health care collaborative to enter into a delegation agreement with an entity licensed under Chapter 841 (Life, Health, or Accident Insurance Companies), 842 (Group Hospital Service Corporations), or 883 (Mutual Insurance Companies Other than Mutual Life Insurance Companies) if the delegation agreement assigns to the entity responsibility for:

(1) a function regulated by:

(A) Chapter 222;

(B) Chapter 841;

(C) Chapter 842;

(D) Chapter 883;

(E) Chapter 1272;

(F) Chapter 1301 (Preferred Provider Benefit Plans);

(G) Chapter 4201 (Utilization Review Agents);

(H) Section 1367.053; or

(I) Subchapter A (Consumer Choice of Benefits Health Insurance Plans), Chapter 1507; or

(2) another function specified by commissioner rule.

(d) Requires that a health care collaborative that enters into a delegation agreement under this section to maintain reserves and capital in addition to the amounts required under Chapter 1272, in an amount and form determined by rule of the commissioner to be necessary for the liabilities and risks assumed by the health care collaborative.

(e) Provides a health care collaborative that enters into a delegation agreement under this section is subject to Chapters 404 (Financial Condition), 441 (Supervision and Conservatorship), and 443 (Insurer Receivership Act) and is considered to be an insurer for purposes of those chapters.

Sec. 848.109. VALIDITY OF OPERATIONS AND TRADE PRACTICES OF HEALTH CARE COLLABORATIVES. Provides that the operations and trade practices of a health care collaborative that are consistent with the provisions of this chapter, the rules adopted under this chapter, and applicable federal antitrust laws are presumed to be consistent with Chapter 15 (Monopolies, Trust and Conspiracies in Restraint of Trade), Business & Commerce Code, or any other applicable provision of law.

Sec. 848.110. RIGHTS OF PHYSICIANS; LIMITATIONS ON PARTICIPATION. (a) Entitles a physician, before a complaint against the physician under Section 848.107 is resolved, or before a physician's association with a health care collaborative is terminated, to an opportunity to dispute the complaint or termination through a process that includes:

(1) written notice of the complaint or basis of the termination;

(2) an opportunity for a hearing not earlier than the 30th day after receiving notice under Subdivision (1);

(3) the right to provide information at the hearing, including testimony and a written statement; and

(4) a written decision that includes the specific facts and reasons for the decision.

(b) Authorizes a health care collaborative to limit a physician or group of physicians from participating in the health care collaborative if the limitation is based on an established development plan approved by the board of directors. Requires that each applicant physician or group be provided with a copy of the development plan.

[Reserves Sections 848.111-848.150 for expansion.]

SUBCHAPTER D. REGULATION OF HEALTH CARE COLLABORATIVES

Sec. 848.151. RULES. Authorizes the commissioner and attorney general to adopt reasonable rules as necessary and proper to implement the requirements of this chapter.

Sec. 848.152. FEES AND ASSESSMENTS. (a) Requires the commissioner, within the limits prescribed by this section, to prescribe the fees to be charged and the assessments to be imposed under this section.

(b) Requires that amounts collected under this section be deposited to the credit of the TDI operating account.

(c) Requires a health care collaborative to pay to TDI:

(1) an application fee in an amount determined by commissioner rule; and

(2) an annual assessment in an amount determined by commissioner rule.

(d) Requires the commissioner to set fees and assessments under this section in an amount sufficient to pay the reasonable expenses of TDI and attorney general in administering this chapter, including the direct and indirect expenses incurred by TDI and attorney general in examining and reviewing health care collaboratives. Requires that fees and assessments imposed under this section be

allocated among health care collaboratives on a pro rata basis to the extent that the allocation is feasible.

Sec. 848.153. EXAMINATIONS. (a) Authorizes the attorney general to examine the financial affairs and operations of any health care collaborative or applicant for a certificate of authority under this chapter.

(b) Requires a health care collaborative to make its books and records relating to its financial affairs and operations available for an examination by the commissioner or attorney general.

(c) Requires a health care collaborative, on request of the commissioner or attorney general, to provide to the commissioner or attorney general, as applicable:

(1) a copy of any contract, agreement, or other arrangement between the health care collaborative and a physician or health care provider; and

(2) a general description of the fee arrangements between the health care collaborative and the physician or health care provider.

(d) Provides that documentation provided to the commissioner or attorney under this section is confidential and is not subject to disclosure under Chapter 552, Government Code.

[Reserves Sections 848.154-848.200 for expansion.]

SUBCHAPTER E. ENFORCEMENT

Sec. 848.201. ENFORCEMENT ACTIONS. (a) Authorizes the commissioner, after notice and opportunity for a hearing, to:

(1) suspend or revoke a certificate of authority issued to a health care collaborative under this chapter;

(2) impose sanctions under Chapter 82 (Sanctions);

(3) issue a cease and desist order under Chapter 83 (Emergency Cease and Desist Orders); or

(4) impose administrative penalties under Chapter 84 (Administrative Penalties).

(b) Authorizes the commissioner to take an enforcement action listed in Subsection (a) against a health care collaborative if the commissioner finds that the health care collaborative:

(1) is operating in a manner that is:

(A) significantly contrary to its basic organizational documents; or

(B) contrary to the manner described in and reasonably inferred from other information submitted under Section 848.057;

(2) does not meet the requirements of Section 848.057;

(3) cannot fulfill its obligation to provide health care services as required under its contracts with governmental or private entities;

(4) does not meet the requirements of Chapter 1272, if applicable;

(5) has not implemented the complaint system required by Section 848.107 in a manner to resolve reasonably valid complaints;

(6) has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner or a person on behalf of the health care collaborative has advertised or merchandised the health care collaborative's services in an untrue, misrepresentative, misleading, deceptive, or untrue manner;

(7) has not complied substantially with this chapter or a rule adopted under this chapter; or

(8) has not taken corrective action the commissioner considers necessary to correct a failure to comply with this chapter, any applicable provision of this code, or any applicable rule or order of the commissioner not later than the 30th day after the date of notice of the failure or within any longer period specified in the notice and determined by the commissioner to be reasonable.

Sec. 848.202. OPERATIONS DURING SUSPENSION OR AFTER REVOCATION OF CERTIFICATE OF AUTHORITY. (a) Prohibits the health care collaborative, during the period a certificate of authority of a health care collaborative is suspended, from:

(1) entering into a new contract with a governmental or private entity; or

(2) advertising or soliciting in any way.

(b) Provides that after a certificate of authority of a health care collaborative is revoked:

(1) the health care collaborative, immediately following the effective date of the order of revocation, is required to conclude its affairs;

(2) the health care collaborative is prohibited from conducting further business except as essential to the orderly conclusion of its affairs; and

(3) the health care collaborative is prohibited from advertising or soliciting in any way.

(c) Authorizes the commissioner, notwithstanding Subsection (b), by written order, to permit the further operation of the health care collaborative to the extent that the commissioner finds necessary to serve the best interest of governmental or private entities that have entered into contracts with the health care collaborative.

Sec. 848.203. INJUNCTIONS. Authorizes the attorney general, if the commissioner believes that a health care collaborative or another person is violating or has violated this chapter or a rule adopted under this chapter, at the request of the commissioner to bring an action in a Travis County district court to enjoin the violation and obtain other relief the court considers appropriate.

SECTION 3.02. Amends Section 74.001(a)(12)(A), Civil Practice and Remedies Code, to redefine "health care provider."

SECTION 3.03. Amends Subchapter B, Chapter 1301, Insurance Code, by adding sections 1301.0625 and 1301.0626, as follows:

Sec. 1301.0625. HEALTH CARE COLLABORATIVES. (a) Authorizes an insurer to enter into an agreement with a health care collaborative for the purpose of offering a network of preferred providers.

(b) Authorizes an insurer's preferred provider benefit plan to:

(1) offer access to other preferred providers; or

(2) limit access only to preferred providers who participate in the health care collaborative.

(c) Authorizes an insurer to offer a preferred provider benefit plan with enhanced benefits for services from preferred providers who participate in the health care collaborative.

(d) Authorizes an insurer offering a preferred provider benefit plan with access to a health care collaborative is not subject to Sections 1301.0046 (Coinsurance Requirements for Services of Nonpreferred Providers) and 1301.005(a) (relating to requiring an insurer offering a preferred provider benefit plan to ensure that both preferred provider benefits and basic level benefits are reasonably available to all insureds within a designated service area).

Sec. 1301.0626. ALTERNATIVE PAYMENT METHODOLOGIES IN HEALTH CARE COLLABORATIVES. Authorizes a preferred provider contract between an insurer and a health care collaborative to use a payment methodology other than a fee-for-service or discounted fee basis. Provides that an insurer is not subject to Chapter 843 solely because an agreement between the insurer and a health care collaborative uses an alternative payment methodology under this section.

SECTION 3.04. Amends Subchapter O, Chapter 285, Health and Safety Code, by adding Section 285.303, as follows:

Sec. 285.303. ESTABLISHMENT OF HEALTH CARE COLLABORATIVE. (a) Authorizes a hospital district created under general or special law to form and sponsor a nonprofit health care collaborative that is certified under Chapter 848, Insurance Code.

(b) Authorizes the hospital district to contribute money to or solicit money for the health care collaborative. Requires the district, if the district contributes money to or solicits money for the health care collaborative, to establish procedures and controls sufficient to ensure that the money is used by the health care collaborative for public purposes.

SECTION 3.05. Amends Section 102.005, Occupations Code, to provide that Section 102.001 does not apply, in addition to certain other individuals and entities, to a health care collaborative certified under Chapter 848, Insurance Code.

SECTION 3.06. Amends Section 151.002(a)(5), Occupations Code, to redefine "health care entity."

SECTION 3.07. Requires the commissioner, the attorney general, and the board of directors of TIHCQE, not later than April 1, 2012, to adopt rules as necessary to implement this article.

ARTICLE 4. PATIENT IDENTIFICATION

SECTION 4.01. Amends Subchapter A, Chapter 311, Health and Safety Code, by adding Section 311.004, as follows:

Sec. 311.004. STANDARDIZED PATIENT RISK IDENTIFICATION SYSTEM. (a) Defines "department" and "hospital" in this section.

(b) Requires DSHS to coordinate with hospitals to develop a statewide standardized patient risk identification system under which a patient with a specific medical risk may be readily identified through the use of a system that communicates to hospital personnel the existence of that risk. Requires the executive commissioner of HHSC (executive commissioner) to appoint an ad hoc committee of hospital representatives to assist DSHS in developing the statewide system.

(c) Requires DSHS to require each hospital to implement and enforce the statewide standardized patient risk identification system developed under Subsection (b) unless DSHS authorizes an exemption for the reason stated in Subsection (d).

(d) Authorizes DSHS to exempt from the statewide standardized patient risk identification system a hospital that seeks to adopt another patient risk identification methodology supported by evidence-based protocols for the practice of medicine.

(e) Requires DSHS to modify the statewide standardized patient risk identification system in accordance with evidence-based medicine as necessary.

(f) Authorizes the executive commissioner to adopt rules to implement this section.

ARTICLE 5. REPORTING OF HEALTH CARE-ASSOCIATED INFECTIONS

SECTION 5.01. Amends Section 98.001, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, by adding Subdivision (10-a) to define "potentially preventable complication" and "potentially preventable readmission."

SECTION 5.02. Amends Section 98.102(c), Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, to require that the data reported by health care facilities to DSHS contain sufficient patient identifying information to, in addition to certain provisions, allow DSHS, for data reported under Section 98.103 (Reportable Infections), rather than under Section 98.103 or 98.104 (Alternative for Reportable Surgical Site Infections), risk adjust the facilities' infection rates.

SECTION 5.03. Amends Section 98.103, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, by amending Subsection (b) and adding Subsection (d-1), as follows:

(b) Requires a pediatric and adolescent hospital to report the incidence of surgical site infections, including the causative pathogen if the infection is laboratory-confirmed, occurring in, in addition to certain other procedures, ventricular shunt procedures, rather than ventriculoperitoneal shunt procedures, to DSHS.

(d-1) Authorizes the executive commissioner by rule to designate the federal Centers for Disease Control and Prevention's National Healthcare Safety Network, or its successor, to receive reports of health care-associated infections from health care facilities on behalf of DSHS. Requires a health care facility to file a report required in accordance with a designation made under this subsection in accordance with the National Healthcare Safety Network's definitions, methods, requirements, and procedures. Requires a health care facility to authorize DSHS to have access to facility-specific data contained in a report filed with the National Healthcare Safety Network in accordance with a designation made under this subsection.

SECTION 5.04. Amends Section 98.1045, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, by adding Subsection (c), as follows:

(c) Authorizes the executive commissioner by rule to designate an agency of the United States Department of Health and Human Services to receive reports of preventable adverse events by health care facilities on behalf of DSHS. Requires a health care facility to authorize DSHS to have access to facility-specific data contained in a report made in accordance with a designation made under this subsection.

SECTION 5.05. Amends Subchapter C, Chapter 98, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, by adding Sections 98.1046 and 98.1047, as follows:

Sec. 98.1046. PUBLIC REPORTING OF CERTAIN POTENTIALLY PREVENTABLE EVENTS FOR HOSPITALS. (a) Requires DSHS, in consultation with TIHCQE under Chapter 1002, to publicly report outcomes for potentially preventable complications and potentially preventable readmissions for hospitals.

(b) Requires DSHS to make the reports compiled under Subsection (a) available to the public on DSHS's Internet website.

(c) Prohibits DSHS from disclosing the identity of a patient or health care provider in the reports authorized in this section.

Sec. 98.1047. STUDIES ON LONG-TERM CARE FACILITY REPORTING OF ADVERSE HEALTH CONDITIONS. (a) Requires DSHS to study which adverse health conditions commonly occur in long-term care facilities and, of those health conditions, which are potentially preventable.

(b) Requires DSHS to develop recommendations for reporting adverse health conditions identified under Subsection (a).

SECTION 5.06. Amends Section 98.105, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, as follows:

Sec. 98.105. REPORTING SYSTEM MODIFICATIONS. Authorizes the executive commissioner by rule, based on the recommendations of the advisory panel, to modify in accordance with this chapter the list of procedures that are reportable under Section 98.103, rather than under Section 98.103 or 98.104. Requires that the modifications be based on changes in reporting guidelines and in definitions established by the federal Centers for Disease Control and Prevention.

SECTION 5.07. Amends Sections 98.106(a), (b), and (d), Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, as follows:

(a) Requires DSHS to compile and make available to the public a summary, by health care facility, of, in addition to certain events, the infections reported by facilities under Section 98.103, rather than under Sections 98.103 and 98.104.

(b) Requires that information included in the departmental summary with respect to infections reported by facilities under Section 98.103, rather than under Sections 98.103 and 98.104, be risk adjusted and include a comparison of the risk-adjusted infection rates for each health care facility in this state that is required to submit a report under Section 98.103, rather than under Sections 98.103 and 98.104.

(d) Requires DSHS to publish the departmental summary at least annually and may publish the summary more frequently as DSHS considers appropriate. Requires that data made available to the public include aggregate data covering a period of at least a full calendar quarter.

SECTION 5.08. Amends Subchapter C, Chapter 98, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, by adding Section 98.1065, as follows:

Sec. 98.1065. INCENTIVES; RECOGNITION FOR HEALTH CARE QUALITY. (a) Requires DSHS, in consultation with TIHCQE, to develop a recognition program to recognize exemplary health care facilities for superior quality of health care.

(b) Authorizes DSHS to:

(1) make available to the public the list of exemplary facilities recognized under this section; and

(2) authorize the facilities to use the receipt of the recognition in their advertising materials.

(c) Authorizes the executive commissioner to adopt rules to implement this section.

SECTION 5.09. Amends Section 98.108, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, as follows:

Sec. 98.108. FREQUENCY OF REPORTING. (a) Creates this subsection from existing text. Requires the executive commissioner by rule, in consultation with the advisory panel, to establish the frequency of reporting by health care facilities required under Sections 98.103 and 98.1045 (Reporting of Preventable Adverse Events), rather than under Sections 98.103, 98.104, and 98.1045.

(b) Prohibits facilities, except as provided by Subsection (c), from being required to report more frequently than quarterly. Makes a nonsubstantive change.

(c) Authorizes the executive commissioner to adopt rules requiring reporting more frequently than quarterly if more frequent reporting is necessary to meet the requirements for participation in the federal Centers for Disease Control and Prevention's National Healthcare Safety Network.

SECTION 5.10. Amends Section 98.110, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, as follows:

Sec. 98.110. DISCLOSURE AMONG CERTAIN AGENCIES. (a) Creates this subsection from existing text. Authorizes DSHS, notwithstanding any other law, to disclose information reported by health care facilities under Section 98.103 or 98.1045, rather than under Sections 98.103, 98.104 or 93.1045, to other programs within DSHS, to HHSC, to other health and human services agencies, as defined by Section 531.001 (Definitions), Government Code, and to the federal Centers for Disease Control and Prevention for public health research or analysis purposes only, provided that the research or analysis relates to health care-associated infections or preventable adverse events. Provides that the privilege and confidentiality provisions contained in this chapter apply to such disclosures. Makes a nonsubstantive change.

(b) Authorizes an agency, if the executive commissioner designates an agency of the United States Department of Health and Human Services to receive reports of health care-associated infections or preventable adverse events, to use the information submitted for purposes allowed by federal law.

SECTION 5.11. Repealer: Section 98.104 (Alternative for Reportable Surgical Site Infections), Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007.

ARTICLE 6. INFORMATION MAINTAINED BY DEPARTMENT OF STATE HEALTH SERVICES

SECTION 6.01. Amends Section 108.002, Health and Safety Code, by adding Subdivisions (4-a) and (8-a) and amending Subdivision (7) to define "commission" and "executive commissioner and redefine "department."

SECTION 6.02. Amends Chapter 108, Health and Safety Code, by adding Section 108.0026, as follows:

Sec. 108.0026. TRANSFER OF DUTIES; REFERENCE TO COUNCIL. (a) Provides that the powers and duties of the Texas Health Care Information Council (HCIC) under this chapter were transferred to DSHS in accordance with Section 1.19 (Transfers to the Department of State Health Services), Chapter 198 (H.B. 2292), Acts of the 78th Legislature, Regular Session, 2003.

(b) Provides that, in this chapter or other law, a reference to HCIC means DSHS.

SECTION 6.03. Amends Section 108.009(h), Health and Safety Code, as follows:

(h) Replaces references to HCIC with DSHS and makes conforming changes. Requires DSHS to accept data in the format developed by the American National Standards Institute or its successor or other nationally accepted standardized forms that hospitals and other providers use for other complementary purposes, rather than by the National Uniform Billing Committee (Uniform Hospital Billing Form UB 92) and HCFA-1500 or their successors or other universally accepted standardized forms.

SECTION 6.04. Amends Section 108.013, Health and Safety Code, by amending Subsections (a), (b), (c), (d), (g), (i), and (j) and adding Subsections (k), (l), (m), and (n), as follows:

(a) Requires that the data received by DSHS under this chapter be used by DSHS and HHSC for the benefit of the public. Requires DSHS, subject to specific limitations established by this chapter and executive commissioner rule, rather than HCIC rule, to make determinations on requests for information in favor of access. Makes conforming changes.

(b) Requires the executive commissioner, rather than HCIC, by rule to designate the characters to be used as uniform patient identifiers. Provides that the basis for assignment of the characters and the manner in which the characters are assigned are confidential.

(c) Prohibits DSHS, unless specifically authorized by this chapter, from releasing and a person or entity from gaining access to any data obtained under this chapter, in addition to certain provisions, submitted to the DSHS in a uniform submission format that is not included in the public use data set established under Sections 108.006(f) (relating to a public use data file minimum data set) and (g) (relating to an annual review of the public use data file minimum data set), except in accordance with Section 108.0135 (Scientific Review Panel). Makes conforming changes.

(d) Provides that all data collected and used by DSHS, rather than by DSHS and HCIC, under this chapter, except as provided by this section, is subject to the confidentiality provisions and criminal penalties of Section 311.037 (Confidential Data; Criminal Penalty), Section 81.103 (Confidentiality; Criminal Penalty), and Section 159.002 (Confidential Communications), Occupations Code. Makes a nonsubstantive change.

(g) Prohibits DSHS, unless specifically authorized by this chapter, from releasing data elements in a manner that will reveal the identity of a patient. Prohibits DSHS from releasing data elements in a manner that will reveal the identity of a physician. Makes conforming changes.

(i) Creates an exception under this section. Makes a conforming change.

(j) Requires the executive commissioner by rule to develop and implement a mechanism to comply with Subsections (c)(1) (relating to data that could reasonably be expected to reveal the identity of a patient) and (2) (relating to data that could reasonably be expected to reveal the identity of a physician), rather than requiring HCIC by rule with the assistance of the advisory committee under Section 108.003(g)(5) (relating to a technical advisory committee composed of providers, consumers, and individuals who have expertise in certain fields) to develop and implement a mechanism to comply with Subsections (c)(1) and (2).

(k) Authorizes DSHS to disclose data collected under this chapter that is not included in public use data to any DSHS or HHSC program if the disclosure is reviewed and approved by the institutional review board (IRB) under Section 108.0135.

(l) Provides that confidential data collected under this chapter that is disclosed to a DSHS or HHSC program remains subject to the confidentiality provisions of this chapter and other applicable law. Requires DSHS to identify the confidential data that is disclosed to a program under Subsection (k). Requires that the program maintain the confidentiality of the disclosed confidential data.

(m) Provides that the following provisions do not apply to the disclosure of data to a DSHS or HHSC program:

(1) Section 81.103 (Confidentiality; Criminal Penalty);

(2) Sections 108.010(g) (relating to the release of provider quality data) and (h) (relating to identification of physicians by a uniform physician identifier);

(3) Sections 108.011(e) (relating to notifying a data provider of the release of public use data) and (f) (relating to a report including reasonable review and comment period before public release);

(4) Section 311.037 (Confidential Data; Criminal Penalty); and

(5) Section 159.002 (Board Membership), Occupations Code.

(n) Provides that nothing in this section authorizes the disclosure of physician identifying data.

SECTION 6.05. Amends Section 108.0135, Health and Safety Code, as follows:

Sec. 108.0135. New heading: INSTITUTIONAL REVIEW BOARD. (a) Requires DSHS, rather than HCIC, to establish an institutional review board rather than a scientific review board, to review and approve requests for access to data not contained in public use data, rather than for information other than public use data. Makes a conforming change.

(b) Requires the executive commissioner to assist IRB in determining whether to approve a request for information, to adopt rules similar to federal Centers for Medicare and Medicaid Services' guidelines, rather than federal Health Care Financing Administration's guidelines, on releasing data. Makes a conforming change.

(c) Requires that a request for information other than public use data be made on the form prescribed, rather than created, by DSHS. Makes a conforming change.

(d) Requires that any approval to release information under this section require that the confidentiality provisions of this chapter be maintained and that any subsequent use of the information conform to the confidentiality provisions of this chapter.

SECTION 6.06. Repealers, effective September 1, 2014: Sections 108.002(5) (defining "council") and (18) (defining "rural provider"), 108.0025 (Rural Provider), and 108.009(c) (relating to authorizing a rural provider of hospital to provide data), Health and Safety Code.

ARTICLE 7. EFFECTIVE DATE

SECTION 7.01. Effective date, except as specifically provided by this Act: September 1, 2011.