

By: Nelson
(Kolkhorst)

S.B. No. 8

A BILL TO BE ENTITLED

AN ACT

relating to improving the quality and efficiency of health care.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

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

SECTION 1.01. (a) The legislature finds that it would
benefit the State of Texas to:

(1) explore innovative health care delivery and
payment models to improve the quality and efficiency of health care
in this state;

(2) improve health care transparency;

(3) give health care providers the flexibility to
collaborate and innovate to improve the quality and efficiency of
health care; and

(4) create incentives to improve the quality and
efficiency of health care.

(b) The legislature finds that the use of certified health
care collaboratives will increase pro-competitive effects as the
ability to compete on the basis of quality of care and the
furtherance of the quality of care through a health care
collaborative will overcome any anticompetitive effects of joining
competitors to create the health care collaboratives and the
payment mechanisms that will be used to encourage the furtherance
of quality of care. Consequently, the legislature finds it

1 appropriate and necessary to authorize health care collaboratives
2 to promote the efficiency and quality of health care.

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

12 (d) The legislature intends to permit the use of alternative
13 payment mechanisms, including bundled or global payments and
14 quality-based payments, among physicians and other health care
15 providers participating in a health care collaborative that holds a
16 certificate of authority under Chapter 848, Insurance Code, as
17 added by Article 3 of this Act. The legislature intends to
18 authorize a health care collaborative to contract for and accept
19 payments from governmental and private payors based on alternative
20 payment mechanisms, and intends that the receipt and distribution
21 of payments to participating physicians and health care providers
22 is not a violation of any existing state law.

23 ARTICLE 2. TEXAS INSTITUTE OF HEALTH CARE QUALITY AND EFFICIENCY

24 SECTION 2.01. Title 12, Health and Safety Code, is amended
25 by adding Chapter 1002 to read as follows:

1 CHAPTER 1002. TEXAS INSTITUTE OF HEALTH CARE QUALITY AND

2 EFFICIENCY

3 SUBCHAPTER A. GENERAL PROVISIONS

4 Sec. 1002.001. DEFINITIONS. In this chapter:

5 (1) "Board" means the board of directors of the Texas
6 Institute of Health Care Quality and Efficiency established under
7 this chapter.

8 (2) "Commission" means the Health and Human Services
9 Commission.

10 (3) "Department" means the Department of State Health
11 Services.

12 (4) "Executive commissioner" means the executive
13 commissioner of the Health and Human Services Commission.

14 (5) "Health care collaborative" has the meaning
15 assigned by Section 848.001, Insurance Code.

16 (6) "Health care facility" means:

17 (A) a hospital licensed under Chapter 241;

18 (B) an institution licensed under Chapter 242;

19 (C) an ambulatory surgical center licensed under
20 Chapter 243;

21 (D) a birthing center licensed under Chapter 244;

22 (E) an abortion facility licensed under Chapter
23 245;

24 (F) an end stage renal disease facility licensed
25 under Chapter 251; or

26 (G) a freestanding emergency medical care
27 facility licensed under Chapter 254.

1 (7) "Institute" means the Texas Institute of Health
2 Care Quality and Efficiency established under this chapter.

3 (8) "Potentially preventable admission" means an
4 admission of a person to a health care facility that could
5 reasonably have been prevented if care and treatment had been
6 provided by a health care provider in accordance with accepted
7 standards of care.

8 (9) "Potentially preventable ancillary service" means
9 a health care service provided or ordered by a health care provider
10 to supplement or support the evaluation or treatment of a patient,
11 including a diagnostic test, laboratory test, therapy service, or
12 radiology service, that is not reasonably necessary for the
13 provision of quality health care or treatment.

14 (10) "Potentially preventable complication" means a
15 harmful event or negative outcome with respect to a person,
16 including an infection or surgical complication, that:

17 (A) occurs after the person's admission to a
18 health care facility;

19 (B) may result from the care or treatment
20 provided or the lack of care during the health care facility stay
21 rather than from a natural progression of an underlying disease;
22 and

23 (C) could reasonably have been prevented if care
24 and treatment had been provided in accordance with accepted
25 standards of care.

26 (11) "Potentially preventable event" means a
27 potentially preventable admission, a potentially preventable

ancillary service, a potentially preventable complication, a potentially preventable emergency room visit, a potentially preventable readmission, or a combination of those events.

(12) "Potentially preventable emergency room visit" means treatment of a person in a hospital emergency room or freestanding emergency medical care facility for a condition that does not require emergency medical attention because the condition could be treated by a health care provider in a nonemergency setting.

(13) "Potentially preventable readmission" means a return hospitalization of a person within a period specified by the commission that may result from deficiencies in the care or treatment provided to the person during a previous hospital stay or from deficiencies in post-hospital discharge follow-up. The term does not include a hospital readmission necessitated by the occurrence of unrelated events after the discharge. The term includes the readmission of a person to a hospital for:

(A) the same condition or procedure for which the person was previously admitted;

(B) an infection or other complication resulting from care previously provided;

(C) a condition or procedure that indicates that a surgical intervention performed during a previous admission was unsuccessful in achieving the anticipated outcome; or

(D) another condition or procedure of a similar nature, as determined by the executive commissioner in consultation with the institute.

1 Sec. 1002.002. ESTABLISHMENT; PURPOSE. The Texas Institute
2 of Health Care Quality and Efficiency is established to improve
3 health care quality, accountability, education, and cost
4 containment in this state by encouraging health care provider
5 collaboration, effective health care delivery models, and
6 coordination of health care services.

7 [Sections 1002.003-1002.050 reserved for expansion]

8 SUBCHAPTER B. ADMINISTRATION

9 Sec. 1002.051. APPLICATION OF SUNSET ACT. The institute is
10 subject to Chapter 325, Government Code (Texas Sunset Act). Unless
11 continued in existence as provided by that chapter, the institute
12 is abolished and this chapter expires September 1, 2017.

13 Sec. 1002.052. COMPOSITION OF BOARD OF DIRECTORS. (a) The
14 institute is governed by a board of 15 directors appointed by the
15 governor.

16 (b) The following ex officio, nonvoting members also serve
17 on the board:

- 18 (1) the commissioner of the department;
19 (2) the executive commissioner;
20 (3) the commissioner of insurance;
21 (4) the executive director of the Employees Retirement
22 System of Texas;
23 (5) the executive director of the Teacher Retirement
24 System of Texas;
25 (6) the state Medicaid director of the Health and
26 Human Services Commission;
27 (7) the executive director of the Texas Medical Board;

1 and

2 (8) a representative from each state agency or system
3 of higher education that purchases or provides health care
4 services, as determined by the governor.

5 (c) The governor shall appoint as board members health care
6 providers, payors, consumers, and health care quality experts or
7 persons who possess expertise in any other area the governor finds
8 necessary for the successful operation of the institute.

9 (d) A person may not serve as a voting member of the board if
10 the person serves on or advises another board or advisory board of a
11 state agency.

12 Sec. 1002.053. TERMS OF OFFICE. (a) Appointed members of
13 the board serve two-year terms ending January 31 of each
14 odd-numbered year.

15 (b) Board members may serve consecutive terms.

16 Sec. 1002.054. ADMINISTRATIVE SUPPORT. (a) The institute
17 is administratively attached to the commission.

18 (b) The commission shall coordinate administrative
19 responsibilities with the institute to streamline and integrate the
20 institute's administrative operations and avoid unnecessary
21 duplication of effort and costs.

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

26 (b) Information relating to the billing and payment of
27 expenses under this section is subject to Chapter 552, Government

1 Code.

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

5 (b) Any board member or a member of a committee formed by the
6 board with direct interest, personally or through an employer, in a
7 matter before the board shall abstain from deliberations and
8 actions on the matter in which the conflict of interest arises and
9 shall further abstain on any vote on the matter, and may not
10 otherwise participate in a decision on the matter.

11 (c) Each board member shall:

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

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

18 (d) A statement filed under Subsection (c) is subject to
19 Chapter 552, Government Code.

20 Sec. 1002.057. PROHIBITION ON CERTAIN CONTRACTS AND
21 EMPLOYMENT. (a) The board may not compensate, employ, or contract
22 with any individual who serves as a member of the board of, or on an
23 advisory board or advisory committee for, any other governmental
24 body, including any agency, council, or committee, in this state.

25 (b) The board may not compensate, employ, or contract with
26 any person that provides financial support to the board, including
27 a person who provides a gift, grant, or donation to the board.

1 Sec. 1002.058. MEETINGS. (a) The board may meet as often
2 as necessary, but shall meet at least once each calendar quarter.

3 (b) The board shall develop and implement policies that
4 provide the public with a reasonable opportunity to appear before
5 the board and to speak on any issue under the authority of the
6 institute.

7 Sec. 1002.059. BOARD MEMBER IMMUNITY. (a) A board member
8 may not be held civilly liable for an act performed, or omission
9 made, in good faith in the performance of the member's powers and
10 duties under this chapter.

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

13 Sec. 1002.060. PRIVACY OF INFORMATION. (a) Protected
14 health information and individually identifiable health
15 information collected, assembled, or maintained by the institute is
16 confidential and is not subject to disclosure under Chapter 552,
17 Government Code.

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

24 (c) The commission, department, or institute or an officer
25 or employee of the commission, department, or institute, including
26 a board member, may not disclose any information that is
27 confidential under this section.

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

5 (e) An officer or employee of the commission, department, or
6 institute, including a board member, may not be examined in a civil,
7 criminal, special, administrative, or other proceeding as to
8 information that is confidential under this section.

9 Sec. 1002.061. FUNDING. (a) The institute may be funded
10 through the General Appropriations Act and may request, accept, and
11 use gifts, grants, and donations as necessary to implement its
12 functions.

13 (b) The institute may participate in other
14 revenue-generating activity that is consistent with the
15 institute's purposes.

16 (c) Each state agency represented on the board as a
17 nonvoting member shall provide funds to support the institute and
18 implement this chapter. The commission shall establish a funding
19 formula to determine the level of support each state agency is
20 required to provide.

21 [Sections 1002.062-1002.100 reserved for expansion]

22 SUBCHAPTER C. POWERS AND DUTIES

23 Sec. 1002.101. GENERAL POWERS AND DUTIES. The institute
24 shall make recommendations to the legislature on:

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

27 (A) providing a forum for regulators, payors, and

1 providers to discuss and make recommendations for initiatives that
2 promote the use of best practices, increase health care provider
3 collaboration, improve health care outcomes, and contain health
4 care costs;

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

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

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

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

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

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

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

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

27 (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) The institute shall 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, Human Resources Code; and

(4) the child health plan under Chapter 62.

(c) In developing recommendations under Subsections (a) and
(b), the institute may not base its recommendations solely on
actuarial data.

(d) Using the studies described by Subsections (a) and (b),
the institute shall develop recommendations for a statewide plan
for quality and efficiency of the delivery of health care.

[Sections 1002.103-1002.150 reserved 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) The
institute shall study and make recommendations for alternative
health care payment and delivery systems.

(b) The institute shall 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.

[Sections 1002.152-1002.200 reserved for expansion]

SUBCHAPTER E. IMPROVED TRANSPARENCY

Sec. 1002.201. HEALTH CARE ACCOUNTABILITY; IMPROVED TRANSPARENCY. (a) With the assistance of the department, the institute shall 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) The institute shall 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

1 enhancing existing health-related information available to health
2 care providers and the public, including provider reporting of
3 additional information not currently required to be reported under
4 existing law, to improve quality of care.

5 Sec. 1002.202. ALL PAYOR CLAIMS DATABASE. (a) The
6 institute shall study the feasibility and desirability of
7 establishing a centralized database for health care claims
8 information across all payors.

9 (b) The institute shall consult with the department and the
10 Texas Department of Insurance to develop recommendations to submit
11 to the legislature on the establishment of the centralized claims
12 database described by Subsection (a).

13 SECTION 2.02. Chapter 109, Health and Safety Code, is
14 repealed.

15 SECTION 2.03. On the effective date of this Act:

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

18 (2) any unexpended and unobligated balance of money
19 appropriated by the legislature to the Texas Health Care Policy
20 Council established under Chapter 109, Health and Safety Code, as
21 it existed immediately before the effective date of this Act, is
22 transferred to the Texas Institute of Health Care Quality and
23 Efficiency created by Chapter 1002, Health and Safety Code, as
24 added by this Act.

25 SECTION 2.04. The governor shall appoint voting members of
26 the board of directors of the Texas Institute of Health Care Quality
27 and Efficiency under Section 1002.052, Health and Safety Code, as

1 added by this Act, as soon as practicable after the effective date
2 of this Act.

3 SECTION 2.05. (a) Not later than December 1, 2012, the
4 Texas Institute of Health Care Quality and Efficiency shall submit
5 a report regarding recommendations for improved health care
6 reporting to the governor, the lieutenant governor, the speaker of
7 the house of representatives, and the chairs of the appropriate
8 standing committees of the legislature outlining:

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

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

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

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

20 (b) Not later than December 1, 2012, the Texas Institute of
21 Health Care Quality and Efficiency shall submit a report regarding
22 recommendations for an all payor claims database to the governor,
23 the lieutenant governor, the speaker of the house of
24 representatives, and the chairs of the appropriate standing
25 committees of the legislature outlining:

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

(2) the recommendations developed under Subsection (b), Section 1002.202, 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, micro businesses, and health care providers to implement the plan described by Subdivision (2) of this subsection.

ARTICLE 3. HEALTH CARE COLLABORATIVES

SECTION 3.01. Subtitle C, Title 6, Insurance Code, is amended by adding Chapter 848 to read as follows:

CHAPTER 848. HEALTH CARE COLLABORATIVES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 848.001. DEFINITIONS. In this chapter:

(1) "Affiliate" means a person who controls, is controlled by, or is under common control with one or more other persons.

(2) "Health care collaborative" means an organization:

(A) that consists of:

(i) participating physicians;

(ii) participating physicians and health care providers; or

(iii) entities contracting on behalf of participating physicians or health care providers;

(B) that is organized within a formal legal structure to provide or arrange to provide health care services;

1 and

2 (C) that is capable of receiving and distributing
3 payments to participating physicians or health care providers.

4 (3) "Health care services" means services provided by
5 a physician or health care provider to prevent, alleviate, cure, or
6 heal human illness or injury. The term includes:

7 (A) pharmaceutical services;

8 (B) medical, chiropractic, or dental care; and

9 (C) hospitalization.

10 (4) "Health care provider" means any person,
11 partnership, professional association, corporation, facility, or
12 institution licensed, certified, registered, or chartered by this
13 state to provide health care services. The term includes a hospital
14 but does not include a physician.

15 (5) "Health maintenance organization" means an
16 organization operating under Chapter 843.

17 (6) "Hospital" means a general or special hospital,
18 including a public or private institution licensed under Chapter
19 241 or 577, Health and Safety Code.

20 (7) "Institute" means the Texas Institute of Health
21 Care Quality and Efficiency established under Chapter 1002, Health
22 and Safety Code.

23 (8) "Physician" means:

24 (A) an individual licensed to practice medicine
25 in this state;

26 (B) a professional association organized under
27 the Texas Professional Association Act (Article 1528f, Vernon's

1 Texas Civil Statutes) or the Texas Professional Association Law by
2 an individual or group of individuals licensed to practice medicine
3 in this state;

4 (C) a partnership or limited liability
5 partnership formed by a group of individuals licensed to practice
6 medicine in this state;

7 (D) a nonprofit health corporation certified
8 under Section 162.001, Occupations Code;

9 (E) a company formed by a group of individuals
10 licensed to practice medicine in this state under the Texas Limited
11 Liability Company Act (Article 1528n, Vernon's Texas Civil
12 Statutes) or the Texas Professional Limited Liability Company Law;
13 or

14 (F) an organization wholly owned and controlled
15 by individuals licensed to practice medicine in this state.

16 (9) "Potentially preventable event" has the meaning
17 assigned by Section 1002.001, Health and Safety Code.

18 Sec. 848.002. EXCEPTION: DELEGATED ENTITIES. (a) This
19 section applies only to an entity, other than a health maintenance
20 organization, that:

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

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

27 (A) Chapter 222, 251, 258, or 1272, as

applicable, to a health maintenance organization; or

(B) Chapter 843, Chapter 1271, Section 1367.053, Subchapter A, Chapter 1452, or Subchapter B, Chapter 1507, as applicable, solely on behalf of health maintenance organizations.

(b) 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. A health care collaborative that is not an insurer or health maintenance organization may not use in its name, contracts, or literature:

(1) the following words or initials:

(A) "insurance";

(B) "casualty";

(C) "surety";

(D) "mutual";

(E) "health maintenance organization"; or

(F) "HMO"; or

(2) any other words or initials that are:

(A) descriptive of the insurance, casualty, surety, or health maintenance organization business; or

(B) deceptively similar to the name or description of an insurer, surety corporation, or health maintenance organization engaging in business in this state.

Sec. 848.004. APPLICABILITY OF INSURANCE LAWS. An organization may not arrange for or provide health care services to enrollees on a prepaid or indemnity basis through health insurance

1 or a health benefit plan, including a health care plan, as defined
2 by Section 843.002, unless the organization as an insurer or health
3 maintenance organization holds the appropriate certificate of
4 authority issued under another chapter of this code.

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

11 [Sections 848.006-848.050 reserved for expansion]

12 SUBCHAPTER B. AUTHORITY TO ENGAGE IN BUSINESS

13 Sec. 848.051. OPERATION OF HEALTH CARE COLLABORATIVE. A
14 health care collaborative that is certified by the department under
15 this chapter may provide or arrange to provide health care services
16 under contract with a governmental or private entity.

17 Sec. 848.052. FORMATION AND GOVERNANCE OF HEALTH CARE
18 COLLABORATIVE. (a) A health care collaborative is governed by a
19 board of directors.

20 (b) The person who establishes a health care collaborative
21 shall appoint an initial board of directors. Each member of the
22 initial board serves a term of not more than 18 months. Subsequent
23 members of the board shall be elected to serve two-year terms by
24 physicians and health care providers who participate in the health
25 care collaborative as provided by this section. The board shall
26 elect a chair from among its members.

27 (c) If the participants in a health care collaborative are

1 all physicians, each member of the board of directors must be an
2 individual physician who is a participant in the health care
3 collaborative.

4 (d) If the participants in a health care collaborative are
5 both physicians and other health care providers, the board of
6 directors must consist of:

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

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

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

17 (e) The board of directors may include nonvoting ex officio
18 members.

19 (f) An individual may not serve on the board of directors of
20 a health care collaborative if the individual has an ownership
21 interest in, serves on the board of directors of, or maintains an
22 officer position with:

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

26 (2) a physician or health care provider that:

27 (A) does not participate in the health care

1 collaborative; and

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

4 (g) In addition to the requirements of Subsection (f), the
5 board of directors of a health care collaborative shall adopt a
6 conflict of interest policy to be followed by members.

7 (h) The board of directors may remove a member for cause. A
8 member may not be removed from the board without cause.

9 (i) The organizational documents of a health care
10 collaborative may not conflict with any provision of this chapter,
11 including this section.

12 Sec. 848.053. COMPENSATION ADVISORY COMMITTEE. The board
13 of directors of a health care collaborative shall establish a
14 compensation advisory committee to develop and make
15 recommendations to the board regarding charges, fees, payments,
16 distributions, or other compensation assessed for health care
17 services provided by physicians or health care providers who
18 participate in the health care collaborative. The committee must
19 include:

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

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

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

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

1 Sec. 848.054. CERTIFICATE OF AUTHORITY AND DETERMINATION OF
2 APPROVAL REQUIRED. (a) An organization may not organize or
3 operate a health care collaborative in this state unless the
4 organization holds a certificate of authority issued under this
5 chapter.

6 (b) The commissioner shall adopt rules governing the
7 application for a certificate of authority under this subchapter.

8 Sec. 848.055. EXCEPTIONS. (a) An organization is not
9 required to obtain a certificate of authority under this chapter if
10 the organization holds an appropriate certificate of authority
11 issued under another chapter of this code.

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

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

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

19 Sec. 848.056. APPLICATION FOR CERTIFICATE OF AUTHORITY.

20 (a) An organization may apply to the commissioner for and obtain a
21 certificate of authority to organize and operate a health care
22 collaborative.

23 (b) An application for a certificate of authority must:

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

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

27 (3) be reviewed by the division within the office of

1 attorney general that is primarily responsible for enforcing the
2 antitrust laws of this state and of the United States under Section
3 848.059;

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

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

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

12 (c) Not later than the 190th day after the date an applicant
13 submits an application to the commissioner under this section, the
14 commissioner shall approve or deny the application.

15 Sec. 848.057. REQUIREMENTS FOR APPROVAL OF APPLICATION.
16 The commissioner shall issue a certificate of authority on payment
17 of the application fee prescribed by Section 848.152 if the
18 commissioner is satisfied that:

19 (1) the applicant meets the requirements of Section
20 848.056;

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

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

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

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

3 (iii) reduces the occurrence of potentially
4 preventable events;

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

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

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

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

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

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

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

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

27 (6) the applicant's proposed health care collaborative

1 is not likely to possess market power.

2 Sec. 848.058. DENIAL OF CERTIFICATE OF AUTHORITY. (a) The
3 commissioner may not issue a certificate of authority if the
4 commissioner determines that the applicant's proposed plan of
5 operation does not meet the requirements of Section 848.057.

6 (b) If the commissioner denies an application for a
7 certificate of authority under Subsection (a), the commissioner
8 shall notify the applicant that the plan is deficient and specify
9 the deficiencies.

10 Sec. 848.059. REVIEW BY ATTORNEY GENERAL. (a) If the
11 commissioner determines that an application for a certificate of
12 authority filed under Section 848.056 complies with the
13 requirements of Section 848.057, the commissioner shall forward the
14 application to the attorney general. The attorney general shall
15 review the application and, if the attorney general determines that
16 the commissioner's review of the application under Sections
17 848.057(5) and (6) is adequate, the attorney general shall notify
18 the commissioner of this determination.

19 (b) If the attorney general determines that the
20 commissioner's review of the application under Sections 848.057(5)
21 and (6) is not adequate, the attorney general shall notify the
22 commissioner of this determination.

23 (c) A determination under this section shall be made not
24 later than the 60th day after the date the attorney general receives
25 the application from the commissioner.

26 (d) If the attorney general lacks sufficient information to
27 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, the attorney general shall inform the commissioner that the attorney general lacks sufficient information as well as what information the attorney general requires. The commissioner shall then either provide the additional information to the attorney general or request the additional information from the applicant. The commissioner shall promptly deliver any such additional information to the attorney general. The attorney general shall then have 30 days from receipt of the additional information to make a determination under Subsection (a) or (b).

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

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

(b) An application for renewal must:

(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

1 disbursements for the preceding calendar year, certified by an
2 independent certified public accountant;

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

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

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

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

14 (F) the number, nature, and disposition of any
15 complaints filed with the health care collaborative under Section
16 848.107.

17 (c) If a completed application for renewal is filed under
18 this section:

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

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

27 (d) 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.

[Sections 848.061-848.100 reserved for expansion]

SUBCHAPTER C. GENERAL POWERS AND DUTIES OF HEALTH CARE

COLLABORATIVE

Sec. 848.101. PROVIDING OR ARRANGING FOR SERVICES. (a) A health care collaborative may 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) A health care collaborative may not prohibit 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) A health care collaborative may not use 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) Except as provided by Subsection (f), on written consent of a patient who was treated by a physician participating in a health care collaborative, the health care collaborative shall provide the physician with the medical records of the patient,

1 regardless of whether the physician is participating in the health
2 care collaborative at the time the request for the records is made.

3 (e) Records provided under Subsection (d) shall be made
4 available to the physician in the format in which the records are
5 maintained by the health care collaborative. The health care
6 collaborative may charge the physician a fee for copies of the
7 records, as established by the Texas Medical Board.

8 (f) If a physician requests a patient's records from a
9 health care collaborative under Subsection (d) for the purpose of
10 providing emergency treatment to the patient:

11 (1) the health care collaborative may not charge a fee
12 to the physician under Subsection (e); and

13 (2) the health care collaborative shall provide the
14 records to the physician regardless of whether the patient has
15 provided written consent.

16 Sec. 848.102. INSURANCE, REINSURANCE, INDEMNITY, AND
17 REIMBURSEMENT. A health care collaborative may contract with an
18 insurer authorized to engage in business in this state to provide
19 insurance, reinsurance, indemnification, or reimbursement against
20 the cost of health care and medical care services provided by the
21 health care collaborative. This section does not affect the
22 requirement that the health care collaborative maintain sufficient
23 working capital and reserves.

24 Sec. 848.103. PAYMENT BY GOVERNMENTAL OR PRIVATE ENTITY.

25 (a) A health care collaborative may:

26 (1) contract for and accept payments from a
27 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) Notwithstanding any other law, a health care
collaborative may 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. A health care collaborative may 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. 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) A health care collaborative shall 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. The policies must 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) The governing body of a health care collaborative shall establish a procedure for the periodic review of quality improvement and cost control measures.

Sec. 848.107. COMPLAINT SYSTEMS. (a) A health care collaborative shall 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) The complaint system for complaints initiated by

1 patients must include a process for the notice and appeal of a
2 complaint.

3 (c) A health care collaborative may not take a retaliatory
4 or adverse action against a physician or health care provider who
5 files a complaint with a regulatory authority regarding an action
6 of the health care collaborative.

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

12 (b) Section 1272.301 does not apply to a delegation
13 agreement entered into by a health care collaborative.

14 (c) A health care collaborative may enter into a delegation
15 agreement with an entity licensed under Chapter 841, 842, or 883 if
16 the delegation agreement assigns to the entity responsibility for:

17 (1) a function regulated by:

18 (A) Chapter 222;

19 (B) Chapter 841;

20 (C) Chapter 842;

21 (D) Chapter 883;

22 (E) Chapter 1272;

23 (F) Chapter 1301;

24 (G) Chapter 4201;

25 (H) Section 1367.053; or

26 (I) Subchapter A, Chapter 1507; or

27 (2) another function specified by commissioner rule.

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

7 (e) A health care collaborative that enters into a
8 delegation agreement under this section is subject to Chapters 404,
9 441, and 443 and is considered to be an insurer for purposes of
10 those chapters.

11 Sec. 848.109. VALIDITY OF OPERATIONS AND TRADE PRACTICES OF
12 HEALTH CARE COLLABORATIVES. The operations and trade practices of
13 a health care collaborative that are consistent with the provisions
14 of this chapter, the rules adopted under this chapter, and
15 applicable federal antitrust laws are presumed to be consistent
16 with Chapter 15, Business & Commerce Code, or any other applicable
17 provision of law.

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

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

26 (2) an opportunity for a hearing not earlier than the
27 30th day after receiving notice under Subdivision (1);

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

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

5 (b) A health care collaborative may limit a physician or
6 group of physicians from participating in the health care
7 collaborative if the limitation is based on an established
8 development plan approved by the board of directors. Each
9 applicant physician or group shall be provided with a copy of the
10 development plan.

11 [Sections 848.111-848.150 reserved for expansion]

12 SUBCHAPTER D. REGULATION OF HEALTH CARE COLLABORATIVES

13 Sec. 848.151. RULES. The commissioner and the attorney
14 general may adopt reasonable rules as necessary and proper to
15 implement the requirements of this chapter.

16 Sec. 848.152. FEES AND ASSESSMENTS. (a) The commissioner
17 shall, within the limits prescribed by this section, prescribe the
18 fees to be charged and the assessments to be imposed under this
19 section.

20 (b) Amounts collected under this section shall be deposited
21 to the credit of the Texas Department of Insurance operating
22 account.

23 (c) A health care collaborative shall pay to the department:
24 (1) an application fee in an amount determined by
25 commissioner rule; and
26 (2) an annual assessment in an amount determined by
27 commissioner rule.

1 (d) The commissioner shall set fees and assessments under
2 this section in an amount sufficient to pay the reasonable expenses
3 of the department and attorney general in administering this
4 chapter, including the direct and indirect expenses incurred by the
5 department and attorney general in examining and reviewing health
6 care collaboratives. Fees and assessments imposed under this
7 section shall be allocated among health care collaboratives on a
8 pro rata basis to the extent that the allocation is feasible.

9 Sec. 848.153. EXAMINATIONS. (a) The attorney general may
10 examine the financial affairs and operations of any health care
11 collaborative or applicant for a certificate of authority under
12 this chapter.

13 (b) A health care collaborative shall make its books and
14 records relating to its financial affairs and operations available
15 for an examination by the commissioner or attorney general.

16 (c) On request of the commissioner or attorney general, a
17 health care collaborative shall provide to the commissioner or
18 attorney general, as applicable:

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

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

25 (d) Documentation provided to the commissioner or attorney
26 general under this section is confidential and is not subject to
27 disclosure under Chapter 552, Government Code.

[Sections 848.154-848.200 reserved for expansion]

SUBCHAPTER E. ENFORCEMENT

Sec. 848.201. ENFORCEMENT ACTIONS. (a) After notice and opportunity for a hearing, the commissioner may:

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

(2) impose sanctions under Chapter 82;

(3) issue a cease and desist order under Chapter 83; or

(4) impose administrative penalties under Chapter 84.

(b) The commissioner may 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;

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

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

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

16 Sec. 848.202. OPERATIONS DURING SUSPENSION OR AFTER
17 REVOCATION OF CERTIFICATE OF AUTHORITY. (a) During the period a
18 certificate of authority of a health care collaborative is
19 suspended, the health care collaborative may not:

20 (1) enter into a new contract with a governmental or
21 private entity; or

22 (2) advertise or solicit in any way.

23 (b) After a certificate of authority of a health care
24 collaborative is revoked, the health care collaborative:

25 (1) shall proceed, immediately following the
26 effective date of the order of revocation, to conclude its affairs;

27 (2) may not conduct further business except as

1 essential to the orderly conclusion of its affairs; and

2 (3) may not advertise or solicit in any way.

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

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

14 SECTION 3.02. Paragraph (A), Subdivision (12), Subsection
15 (a), Section 74.001, Civil Practice and Remedies Code, is amended
16 to read as follows:

17 (A) "Health care provider" means any person,
18 partnership, professional association, corporation, facility, or
19 institution duly licensed, certified, registered, or chartered by
20 the State of Texas to provide health care, including:

21 (i) a registered nurse;

22 (ii) a dentist;

23 (iii) a podiatrist;

24 (iv) a pharmacist;

25 (v) a chiropractor;

26 (vi) an optometrist; ~~or~~

27 (vii) a health care institution; or

1 (viii) a health care collaborative
2 certified under Chapter 848, Insurance Code.

3 SECTION 3.03. Subchapter B, Chapter 1301, Insurance Code,
4 is amended by adding Sections 1301.0625 and 1301.0626 to read as
5 follows:

6 Sec. 1301.0625. HEALTH CARE COLLABORATIVES. (a) An
7 insurer may enter into an agreement with a health care
8 collaborative for the purpose of offering a network of preferred
9 providers.

10 (b) An insurer's preferred provider benefit plan may:
11 (1) offer access to other preferred providers; or
12 (2) limit access only to preferred providers who
13 participate in the health care collaborative.

14 (c) An insurer may offer a preferred provider benefit plan
15 with enhanced benefits for services from preferred providers who
16 participate in the health care collaborative.

17 (d) An insurer offering a preferred provider benefit plan
18 with access to a health care collaborative is not subject to
19 Sections 1301.0046 and 1301.005(a).

20 Sec. 1301.0626. ALTERNATIVE PAYMENT METHODOLOGIES IN
21 HEALTH CARE COLLABORATIVES. A preferred provider contract between
22 an insurer and a health care collaborative may use a payment
23 methodology other than a fee-for-service or discounted fee basis.
24 An insurer is not subject to Chapter 843 solely because an agreement
25 between the insurer and a health care collaborative uses an
26 alternative payment methodology under this section.

27 SECTION 3.04. Subchapter O, Chapter 285, Health and Safety

Code, is amended by adding Section 285.303 to read as follows:

Sec. 285.303. ESTABLISHMENT OF HEALTH CARE COLLABORATIVE.

(a) A hospital district created under general or special law may form and sponsor a nonprofit health care collaborative that is certified under Chapter 848, Insurance Code.

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

SECTION 3.05. Section 102.005, Occupations Code, is amended to read as follows:

Sec. 102.005. APPLICABILITY TO CERTAIN ENTITIES. Section 102.001 does not apply to:

(1) a licensed insurer;

(2) a governmental entity, including:

(A) an intergovernmental risk pool established under Chapter 172, Local Government Code; and

(B) a system as defined by Section 1601.003, Insurance Code;

(3) a group hospital service corporation; ~~or~~

(4) a health maintenance organization that reimburses, provides, offers to provide, or administers hospital, medical, dental, or other health-related benefits under a health benefits plan for which it is the payor; or

(5) a health care collaborative certified under

Chapter 848, Insurance Code.

SECTION 3.06. Subdivision (5), Subsection (a), Section 151.002, Occupations Code, is amended to read as follows:

(5) "Health care entity" means:

(A) a hospital licensed under Chapter 241 or 577, Health and Safety Code;

(B) an entity, including a health maintenance organization, group medical practice, nursing home, health science center, university medical school, hospital district, hospital authority, or other health care facility, that:

(i) provides or pays for medical care or health care services; and

(ii) follows a formal peer review process to further quality medical care or health care;

(C) a professional society or association of physicians, or a committee of such a society or association, that follows a formal peer review process to further quality medical care or health care; ~~[or]~~

(D) an organization established by a professional society or association of physicians, hospitals, or both, that:

(i) collects and verifies the authenticity of documents and other information concerning the qualifications, competence, or performance of licensed health care professionals; and

(ii) acts as a health care facility's agent under the Health Care Quality Improvement Act of 1986 (42 U.S.C.

1 Section 11101 et seq.); or

2 (E) a health care collaborative certified under
3 Chapter 848, Insurance Code.

4 SECTION 3.07. Not later than April 1, 2012, the
5 commissioner of insurance, the attorney general, and the board of
6 directors of the Texas Institute of Health Care Quality and
7 Efficiency shall adopt rules as necessary to implement this
8 article.

9 ARTICLE 4. PATIENT IDENTIFICATION

10 SECTION 4.01. Subchapter A, Chapter 311, Health and Safety
11 Code, is amended by adding Section 311.004 to read as follows:

12 Sec. 311.004. STANDARDIZED PATIENT RISK IDENTIFICATION
13 SYSTEM. (a) In this section:

14 (1) "Department" means the Department of State Health
15 Services.

16 (2) "Hospital" means a general or special hospital as
17 defined by Section 241.003. The term includes a hospital
18 maintained or operated by this state.

19 (b) The department shall coordinate with hospitals to
20 develop a statewide standardized patient risk identification
21 system under which a patient with a specific medical risk may be
22 readily identified through the use of a system that communicates to
23 hospital personnel the existence of that risk. The executive
24 commissioner of the Health and Human Services Commission shall
25 appoint an ad hoc committee of hospital representatives to assist
26 the department in developing the statewide system.

27 (c) The department shall require each hospital to implement

1 and enforce the statewide standardized patient risk identification
2 system developed under Subsection (b) unless the department
3 authorizes an exemption for the reason stated in Subsection (d).

4 (d) The department may exempt from the statewide
5 standardized patient risk identification system a hospital that
6 seeks to adopt another patient risk identification methodology
7 supported by evidence-based protocols for the practice of medicine.

8 (e) The department shall modify the statewide standardized
9 patient risk identification system in accordance with
10 evidence-based medicine as necessary.

11 (f) The executive commissioner of the Health and Human
12 Services Commission may adopt rules to implement this section.

13 ARTICLE 5. REPORTING OF HEALTH CARE-ASSOCIATED INFECTIONS

14 SECTION 5.01. Section 98.001, Health and Safety Code, as
15 added by Chapter 359 (S.B. 288), Acts of the 80th Legislature,
16 Regular Session, 2007, is amended by adding Subdivision (10-a) to
17 read as follows:

18 (10-a) "Potentially preventable complication" and
19 "potentially preventable readmission" have the meanings assigned
20 by Section 1002.001, Health and Safety Code.

21 SECTION 5.02. Subsection (c), Section 98.102, Health and
22 Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th
23 Legislature, Regular Session, 2007, is amended to read as follows:

24 (c) The data reported by health care facilities to the
25 department must contain sufficient patient identifying information
26 to:

27 (1) avoid duplicate submission of records;

1 (2) allow the department to verify the accuracy and
2 completeness of the data reported; and

3 (3) for data reported under Section 98.103 [~~or~~
4 ~~98.104~~], allow the department to risk adjust the facilities'
5 infection rates.

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

10 (b) A pediatric and adolescent hospital shall report the
11 incidence of surgical site infections, including the causative
12 pathogen if the infection is laboratory-confirmed, occurring in the
13 following procedures to the department:

14 (1) cardiac procedures, excluding thoracic cardiac
15 procedures;

16 (2) ventricular [~~ventriculoperitoneal~~] shunt
17 procedures; and

18 (3) spinal surgery with instrumentation.

19 (d-1) The executive commissioner by rule may designate the
20 federal Centers for Disease Control and Prevention's National
21 Healthcare Safety Network, or its successor, to receive reports of
22 health care-associated infections from health care facilities on
23 behalf of the department. A health care facility must file a report
24 required in accordance with a designation made under this
25 subsection in accordance with the National Healthcare Safety
26 Network's definitions, methods, requirements, and procedures. A
27 health care facility shall authorize the department to have access

1 to facility-specific data contained in a report filed with the
2 National Healthcare Safety Network in accordance with a designation
3 made under this subsection.

4 SECTION 5.04. Section 98.1045, Health and Safety Code, as
5 added by Chapter 359 (S.B. 288), Acts of the 80th Legislature,
6 Regular Session, 2007, is amended by adding Subsection (c) to read
7 as follows:

8 (c) The executive commissioner by rule may designate an
9 agency of the United States Department of Health and Human Services
10 to receive reports of preventable adverse events by health care
11 facilities on behalf of the department. A health care facility
12 shall authorize the department to have access to facility-specific
13 data contained in a report made in accordance with a designation
14 made under this subsection.

15 SECTION 5.05. Subchapter C, Chapter 98, Health and Safety
16 Code, as added by Chapter 359 (S.B. 288), Acts of the 80th
17 Legislature, Regular Session, 2007, is amended by adding Sections
18 98.1046 and 98.1047 to read as follows:

19 Sec. 98.1046. PUBLIC REPORTING OF CERTAIN POTENTIALLY
20 PREVENTABLE EVENTS FOR HOSPITALS. (a) In consultation with the
21 Texas Institute of Health Care Quality and Efficiency under Chapter
22 1002, the department shall publicly report outcomes for potentially
23 preventable complications and potentially preventable readmissions
24 for hospitals.

25 (b) The department shall make the reports compiled under
26 Subsection (a) available to the public on the department's Internet
27 website.

1 (c) The department may not disclose the identity of a
2 patient or health care provider in the reports authorized in this
3 section.

4 Sec. 98.1047. STUDIES ON LONG-TERM CARE FACILITY REPORTING
5 OF ADVERSE HEALTH CONDITIONS. (a) The department shall study
6 which adverse health conditions commonly occur in long-term care
7 facilities and, of those health conditions, which are potentially
8 preventable.

9 (b) The department shall develop recommendations for
10 reporting adverse health conditions identified under Subsection
11 (a).

12 SECTION 5.06. Section 98.105, Health and Safety Code, as
13 added by Chapter 359 (S.B. 288), Acts of the 80th Legislature,
14 Regular Session, 2007, is amended to read as follows:

15 Sec. 98.105. REPORTING SYSTEM MODIFICATIONS. Based on the
16 recommendations of the advisory panel, the executive commissioner
17 by rule may modify in accordance with this chapter the list of
18 procedures that are reportable under Section 98.103 [~~or 98.104~~].
19 The modifications must be based on changes in reporting guidelines
20 and in definitions established by the federal Centers for Disease
21 Control and Prevention.

22 SECTION 5.07. Subsections (a), (b), and (d), Section
23 98.106, Health and Safety Code, as added by Chapter 359 (S.B. 288),
24 Acts of the 80th Legislature, Regular Session, 2007, are amended to
25 read as follows:

26 (a) The department shall compile and make available to the
27 public a summary, by health care facility, of:

(1) the infections reported by facilities under Section [~~Sections~~] 98.103 [~~and 98.104~~]; and

(2) the preventable adverse events reported by facilities under Section 98.1045.

(b) Information included in the departmental summary with respect to infections reported by facilities under Section [~~Sections~~] 98.103 [~~and 98.104~~] must 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 [~~Sections~~] 98.103 [~~and 98.104~~].

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

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

Sec. 98.1065. INCENTIVES; RECOGNITION FOR HEALTH CARE QUALITY. (a) The department, in consultation with the Texas Institute of Health Care Quality and Efficiency, shall develop a recognition program to recognize exemplary health care facilities for superior quality of health care.

(b) The department may:

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

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

3 (c) The executive commissioner of the Health and Human
4 Services Commission may adopt rules to implement this section.

5 SECTION 5.09. Section 98.108, Health and Safety Code, as
6 added by Chapter 359 (S.B. 288), Acts of the 80th Legislature,
7 Regular Session, 2007, is amended to read as follows:

8 Sec. 98.108. FREQUENCY OF REPORTING. (a) In consultation
9 with the advisory panel, the executive commissioner by rule shall
10 establish the frequency of reporting by health care facilities
11 required under Sections 98.103[~~, 98.104,~~] and 98.1045.

12 (b) Except as provided by Subsection (c), facilities
13 [Facilities] may not be required to report more frequently than
14 quarterly.

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

20 SECTION 5.10. Section 98.110, Health and Safety Code, as
21 added by Chapter 359 (S.B. 288), Acts of the 80th Legislature,
22 Regular Session, 2007, is amended to read as follows:

23 Sec. 98.110. DISCLOSURE AMONG CERTAIN AGENCIES.

24 (a) Notwithstanding any other law, the department may disclose
25 information reported by health care facilities under Section
26 98.103[~~, 98.104,~~] or 98.1045 to other programs within the
27 department, to the Health and Human Services Commission, [~~and~~] to

1 other health and human services agencies, as defined by Section
2 531.001, Government Code, and to the federal Centers for Disease
3 Control and Prevention for public health research or analysis
4 purposes only, provided that the research or analysis relates to
5 health care-associated infections or preventable adverse events.
6 The privilege and confidentiality provisions contained in this
7 chapter apply to such disclosures.

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

13 SECTION 5.11. Section 98.104, Health and Safety Code, as
14 added by Chapter 359 (S.B. 288), Acts of the 80th Legislature,
15 Regular Session, 2007, is repealed.

16 ARTICLE 6. INFORMATION MAINTAINED BY DEPARTMENT OF STATE HEALTH
17 SERVICES

18 SECTION 6.01. Section 108.002, Health and Safety Code, is
19 amended by adding Subdivisions (4-a) and (8-a) and amending
20 Subdivision (7) to read as follows:

21 (4-a) "Commission" means the Health and Human Services
22 Commission.

23 (7) "Department" means the [~~Texas~~] Department of State
24 Health Services.

25 (8-a) "Executive commissioner" means the executive
26 commissioner of the Health and Human Services Commission.

27 SECTION 6.02. Chapter 108, Health and Safety Code, is

amended by adding Section 108.0026 to read as follows:

Sec. 108.0026. TRANSFER OF DUTIES; REFERENCE TO COUNCIL.

(a) The powers and duties of the Texas Health Care Information Council under this chapter were transferred to the Department of State Health Services in accordance with Section 1.19, Chapter 198 (H.B. 2292), Acts of the 78th Legislature, Regular Session, 2003.

(b) In this chapter or other law, a reference to the Texas Health Care Information Council means the Department of State Health Services.

SECTION 6.03. Subsection (h), Section 108.009, Health and Safety Code, is amended to read as follows:

(h) The department [~~council~~] shall coordinate data collection with the data submission formats used by hospitals and other providers. The department [~~council~~] shall accept data in the format developed by the American National Standards Institute [~~National Uniform Billing Committee (Uniform Hospital Billing Form UB-92) and HCFA-1500~~] or its successor [~~their successors~~] or other nationally [~~universally~~] accepted standardized forms that hospitals and other providers use for other complementary purposes.

SECTION 6.04. Section 108.013, Health and Safety Code, is amended by amending Subsections (a) through (d), (g), (i), and (j) and adding Subsections (k) through (n) to read as follows:

(a) The data received by the department under this chapter [~~council~~] shall be used by the department and commission [~~council~~] for the benefit of the public. Subject to specific limitations established by this chapter and executive commissioner [~~council~~] rule, the department [~~council~~] shall make determinations on

requests for information in favor of access.

(b) The executive commissioner [~~council~~] by rule shall designate the characters to be used as uniform patient identifiers. The basis for assignment of the characters and the manner in which the characters are assigned are confidential.

(c) Unless specifically authorized by this chapter, the department [~~council~~] may not release and a person or entity may not gain access to any data obtained under this chapter:

(1) that could reasonably be expected to reveal the identity of a patient;

(2) that could reasonably be expected to reveal the identity of a physician;

(3) disclosing provider discounts or differentials between payments and billed charges;

(4) relating to actual payments to an identified provider made by a payer; or

(5) submitted to the department [~~council~~] in a uniform submission format that is not included in the public use data set established under Sections 108.006(f) and (g), except in accordance with Section 108.0135.

(d) Except as provided by this section, all [~~All~~] data collected and used by the department [~~and the council~~] under this chapter is subject to the confidentiality provisions and criminal penalties of:

(1) Section 311.037;

(2) Section 81.103; and

(3) Section 159.002, Occupations Code.

(g) Unless specifically authorized by this chapter, the department ~~[The council]~~ may not release data elements in a manner that will reveal the identity of a patient. The department ~~[council]~~ may not release data elements in a manner that will reveal the identity of a physician.

(i) Notwithstanding any other law and except as provided by this section, the ~~[council and the]~~ department may not provide information made confidential by this section to any other agency of this state.

(j) The executive commissioner ~~[council]~~ shall by rule~~,~~ ~~with the assistance of the advisory committee under Section 108.003(g)(5),~~ develop and implement a mechanism to comply with Subsections (c)(1) and (2).

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

(l) Confidential data collected under this chapter that is disclosed to a department or commission program remains subject to the confidentiality provisions of this chapter and other applicable law. The department shall identify the confidential data that is disclosed to a program under Subsection (k). The program shall maintain the confidentiality of the disclosed confidential data.

(m) The following provisions do not apply to the disclosure of data to a department or commission program:

- (1) Section 81.103;
- (2) Sections 108.010(g) and (h);

1 (3) Sections 108.011(e) and (f);

2 (4) Section 311.037; and

3 (5) Section 159.002, Occupations Code.

4 (n) Nothing in this section authorizes the disclosure of
5 physician identifying data.

6 SECTION 6.05. Section 108.0135, Health and Safety Code, is
7 amended to read as follows:

8 Sec. 108.0135. INSTITUTIONAL [~~SCIENTIFIC~~] REVIEW BOARD
9 [~~PANEL~~]. (a) The department [~~council~~] shall establish an
10 institutional [~~a scientific~~] review board [~~panel~~] to review and
11 approve requests for access to data not contained in [~~information~~
12 ~~other than~~] public use data. The members of the institutional
13 review board must [~~panel shall~~] have experience and expertise in
14 ethics, patient confidentiality, and health care data.

15 (b) To assist the institutional review board [~~panel~~] in
16 determining whether to approve a request for information, the
17 executive commissioner [~~council~~] shall adopt rules similar to the
18 federal Centers for Medicare and Medicaid Services' [~~Health Care~~
19 ~~Financing Administration's~~] guidelines on releasing data.

20 (c) A request for information other than public use data
21 must be made on the form prescribed [~~created~~] by the department
22 [~~council~~].

23 (d) Any approval to release information under this section
24 must require that the confidentiality provisions of this chapter be
25 maintained and that any subsequent use of the information conform
26 to the confidentiality provisions of this chapter.

27 SECTION 6.06. Effective September 1, 2014, Subdivision (5)

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1 and (18), Section 108.002, Section 108.0025, and Subsection (c),
2 Section 108.009, Health and Safety Code, are repealed.

3 ARTICLE 7. EFFECTIVE DATE

4 SECTION 7.01. Except as specifically provided by this Act,
5 this Act takes effect September 1, 2011.