By: Nelson S.B. No. 8

(In the Senate - Filed February 16, 2011; February 17, 2011, read first time and referred to Committee on Health and Human Services; April 4, 2011, reported adversely, with favorable Committee Substitute by the following vote: Yeas 9, Nays 0; April 4, 2011, sent to printer.)

COMMITTEE SUBSTITUTE FOR S.B. No. 8 By: Nelson

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

(c) 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 under Chapter 848, Insurance Code, as added by Article 3 of this Act, and that collaborative's negotiations of contracts with payors. 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) 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. 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. Title 12, Health and Safety Code, is amended by adding Chapter 1002 to read as follows:

CHAPTER 1002. TEXAS INSTITUTE OF HEALTH CARE QUALITY AND EFFICIENCY

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1002.001. DEFINITIONS. In this chapter:

(1) "Board" means the board of directors of the Texas Institute of Health Care Quality and Efficiency established under

this chapter.

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

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

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

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

(6) "Health care facility" means:

(A) a hospital licensed under Chapter 241;

(B) an institution licensed under Chapter 242;

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

(D) a birthing center licensed under Chapter 244;

(E) an abortion facility licensed under Chapter 245;

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

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

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

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

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

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

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

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

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

(11) "Potentially preventable event" means a 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.

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

[Sections 1002.003-1002.050 reserved for expansion]

SUBCHAPTER B. ADMINISTRATION

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

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

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

(1) the commissioner of the department;

(2) the executive commissioner;

(3) the commissioner of insurance;

(4) the executive director of the Employees Retirement System of Texas;

(5) the executive director of the Teacher Retirement System of Texas;

(6) the state Medicaid director of the Health and Human Services Commission;

(7) the executive director of the Texas Medical Board; and

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

(c) The governor shall 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 the institute.

(d) A person may not serve 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) Appointed members of the board serve two-year terms ending January 31 of each odd-numbered year.

(b) Board members may serve consecutive terms.

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

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

Sec. 1002.055. EXPENSES. (a) 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) Information relating to the billing and payment of expenses under this section is subject to Chapter 552, Government Code.

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

(b) 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 shall abstain from deliberations and actions on the matter in which the conflict of interest arises and shall further abstain on any vote on the matter, and may not

otherwise participate in a decision on the matter.

(c) Each board member shall:

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

Sec. 1002.057. PROHIBITION ON CERTAIN CONTRACTS AND EMPLOYMENT. (a) The board may not compensate, employ, or contract 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) The board may not compensate, employ, or contract 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) The board may meet as often as necessary, but shall meet at least once each calendar quarter.

(b) The board shall 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 the institute.

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

(b) 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) Protected health information and individually identifiable health information collected, assembled, or maintained by the institute is confidential and is not subject to disclosure under Chapter 552, Government Code.

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

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

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

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

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

[Sections 1002.062-1002.100 reserved for expansion]

SUBCHAPTER C. POWERS AND DUTIES

Sec. 1002.101. GENERAL POWERS AND DUTIES. The institute shall 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) The institute shall 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) 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 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) The institute shall study the feasibility and desirability of establishing a centralized database for health care claims information across all payors.

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

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

SECTION 2.03. 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 the Texas Institute of Health Care Quality and Efficiency created by Chapter 1002, Health and Safety Code, as added by this Act.

SECTION 2.04. The governor shall appoint voting members of the board of directors of the Texas Institute of Health Care Quality and Efficiency 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) Not later than December 1, 2012, the Texas Institute of Health Care Quality and Efficiency shall 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 Subsection (a), Section 1002.201, Health and Safety Code, as added by this Act;

(2) the plans initially developed under Subsection (b), Section 1002.201, 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) Not later than December 1, 2012, the Texas Institute of Health Care Quality and Efficiency shall 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 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; and

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

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

(A) pharmaceutical services;

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

(C) hospitalization.

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

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

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

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

(8) "Physician" means:

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

(B) a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes) or the Texas Professional Association Law by an individual or group of individuals licensed to practice medicine in this state;

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

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

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

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

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

Sec. 848.002. EXCEPTION: DELEGATED ENTITIES. (a) 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, 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 or a health benefit plan, including a health care plan, as defined by Section 843.002, 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. 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.

[Sections 848.006-848.050 reserved for expansion]

SUBCHAPTER B. AUTHORITY TO ENGAGE IN BUSINESS

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

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

(b) The person who establishes a health care collaborative shall appoint an initial board of directors. Each member of the initial board serves a term of not more than 18 months. Subsequent members of the board shall 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. The board shall elect a chair from among its members.

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

(d) If the participants in a health care collaborative are both physicians and other health care providers, the board of directors must 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) The board of directors may include nonvoting ex officio members.

(f) An individual may not serve 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) In addition to the requirements of Subsection (f), the board of directors of a health care collaborative shall adopt a conflict of interest policy to be followed by members.

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

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

Sec. 848.053. COMPENSATION ADVISORY COMMITTEE. The board of directors of a health care collaborative shall establish a compensation 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. The committee must 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) An organization may not organize or operate a health care collaborative in this state unless the organization holds a certificate of authority issued under this chapter.

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

Sec. 848.055. EXCEPTIONS. (a) 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) 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) An organization may apply to the commissioner for and obtain a certificate of authority to organize and operate a health care collaborative.

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

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

Sec. 848.057. REQUIREMENTS FOR APPROVAL OF APPLICATION. The commissioner shall 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) The commissioner may not issue 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) If the commissioner denies an application for a

certificate of authority under Subsection (a), the commissioner shall notify the applicant that the plan is deficient and specify the deficiencies.

Sec. 848.059. REVIEW BY ATTORNEY GENERAL. (a) 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, the commissioner shall forward the application to the attorney general. The attorney general shall 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, the attorney general shall notify the commissioner of this determination.

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

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

(d) 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, 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 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) If a completed application for renewal is filed under this section:

(1) the commissioner shall 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 shall 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) 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, regardless of whether the physician is participating in the health care collaborative at the time the request for the records is made.

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

(f) 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 may not charge a fee to the physician under Subsection (e); and

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

Sec. 848.102. INSURANCE, REINSURANCE, INDEMNITY, AND REIMBURSEMENT. A health care collaborative may 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. 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) A health care collaborative may:

(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) 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 patients must include a process for the notice and appeal of a complaint.

(c) A health care collaborative may not take 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) Except as provided by Subsection (b), a health care collaborative that enters into a delegation agreement described by Section 1272.001 is subject to the requirements of Chapter 1272 in the same manner as a health maintenance organization.

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

(c) A health care collaborative may enter into a delegation agreement with an entity licensed under Chapter 841, 842, or 883 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;

(G) Chapter 4201;

(H) Section 1367.053; or

(I) Subchapter A, Chapter 1507; or

(2) another function specified by commissioner rule.

(d) A health care collaborative that enters into a delegation agreement under this section shall 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) A health care collaborative that enters into a delegation agreement under this section is subject to Chapters 404, 441, and 443 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. 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, Business & Commerce Code, or any other applicable provision of law.

Sec. 848.110. RIGHTS OF PHYSICIANS; LIMITATIONS ON PARTICIPATION. (a) Before a complaint against a physician under Section 848.107 is resolved, or before a physician's association with a health care collaborative is terminated, the physician is entitled 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) A health care collaborative may 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. Each applicant physician or group shall be provided with a copy of the development plan.

[Sections 848.111-848.150 reserved for expansion]

SUBCHAPTER D. REGULATION OF HEALTH CARE COLLABORATIVES

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

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

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

(c) A health care collaborative shall pay to the department:

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

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

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

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

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

(c) On request of the commissioner or attorney general, a health care collaborative shall 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) Documentation provided to the commissioner or attorney general under this section is confidential and is not subject to 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;

(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) During the period a certificate of authority of a health care collaborative is suspended, the health care collaborative may not:

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

(2) advertise or solicit in any way.

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

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

(2) may not conduct further business except as

essential to the orderly conclusion of its affairs; and

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

(c) Notwithstanding Subsection (b), the commissioner may, by written order, 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. 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, the attorney general at the request of the commissioner may bring an action in a Travis County district court to enjoin the violation and obtain other relief the court considers appropriate.

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

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

(i) a registered nurse;

(ii) a dentist;

(iii) a podiatrist;

(iv) a pharmacist;

(v) a chiropractor;

(vi) an optometrist; [~~or~~]

(vii) a health care institution; or

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

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

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

(b) An insurer's preferred provider benefit plan may:

(1) offer access to other preferred providers; or

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

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

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

Sec. 1301.0626. ALTERNATIVE PAYMENT METHODOLOGIES IN HEALTH CARE COLLABORATIVES. A preferred provider contract between an insurer and a health care collaborative may use a payment methodology other than a fee-for-service or discounted fee basis. 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. 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. Section 11101 et seq.); or

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

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

ARTICLE 4. PATIENT IDENTIFICATION

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

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

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

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

(b) The department shall 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. The executive commissioner of the Health and Human Services Commission shall appoint an ad hoc committee of hospital representatives to assist the department in developing the statewide system.

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

(d) The department may 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) The department shall modify the statewide standardized patient risk identification system in accordance with evidence-based medicine as necessary.

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

ARTICLE 5. REPORTING OF HEALTH CARE-ASSOCIATED INFECTIONS

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

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

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

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

(1) avoid duplicate submission of records;

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

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

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

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

(1) cardiac procedures, excluding thoracic cardiac procedures;

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

(3) spinal surgery with instrumentation.

(d-1) The executive commissioner by rule may 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 the department. A health care facility must 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. A health care facility shall authorize the department 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. Section 98.1045, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, is amended by adding Subsection (c) to read as follows:

(c) The executive commissioner by rule may 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 the department. A health care facility shall authorize the department to have access to facility-specific data contained in a report made in accordance with a designation made under this subsection.

SECTION 5.05. 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 Sections 98.1046 and 98.1047 to read as follows:

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

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

(c) The department may not disclose 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) The department shall study which adverse health conditions commonly occur in long-term care facilities and, of those health conditions, which are potentially preventable.

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

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

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

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

(a) The department shall compile and make available to the 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

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

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

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

Regular Session, 2007, is amended to read as follows:

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

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

(c) The executive commissioner may 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. Section 98.110, Health and Safety Code, as added by Chapter 359 (S.B. 288), Acts of the 80th Legislature, Regular Session, 2007, is amended to read as follows:

Sec. 98.110. DISCLOSURE AMONG CERTAIN AGENCIES. (a) Notwithstanding any other law, the department may disclose information reported by health care facilities under Section 98.103[~~, 98.104,~~] or 98.1045 to other programs within the department, to the Health and Human Services Commission, [~~and~~] to other health and human services agencies, as defined by Section 531.001, 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. The privilege and confidentiality provisions contained in this chapter apply to such disclosures.

(b) 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, that agency may use the information submitted for purposes allowed by federal law.

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

ARTICLE 6. INFORMATION MAINTAINED BY DEPARTMENT OF STATE HEALTH SERVICES

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

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

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

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

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);

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

(4) Section 311.037; and

(5) Section 159.002, Occupations Code.

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

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

Sec. 108.0135. INSTITUTIONAL [~~SCIENTIFIC~~] REVIEW BOARD [~~PANEL~~]. (a) The department [~~council~~] shall establish an

institutional [~~a scientific~~] review board [~~panel~~] to review and approve requests for access to data not contained in [~~information other than~~] public use data. The members of the institutional review board must [~~panel shall~~] have experience and expertise in ethics, patient confidentiality, and health care data.

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

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

(d) Any approval to release information under this section must 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. Effective September 1, 2014, Subdivision (5) and (18), Section 108.002, Section 108.0025, and Subsection (c), Section 108.009, Health and Safety Code, are repealed.

ARTICLE 7. EFFECTIVE DATE

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

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