BILL ANALYSIS

Senate Research Center
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S.B. 8
By: Nelson
Health & Human Services
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

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

S.B. 8 achieves this goal by increasing health care transparency; encouraging health care provider collaboration, effective health care delivery models, and coordination of health care services; and giving health care providers the flexibility to collaborate and innovate to improve health care quality and efficiency.

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

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 3.01 (Section 848.151, Insurance Code) of this bill.

Rulemaking authority is expressly granted to the commissioner of insurance and the board of directors of the Texas Institute of Health Care Quality and Efficiency in SECTION 3.06 of this bill.

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

Rulemaking authority previously granted to the executive commissioner is modified in SECTIONS 5.06 (Section 98.105, Health and Safety Code), 5.08 (Section 96.1065, Health and Safety Code), and 5.09 (Section 98.108, Health and Safety Code) of this bill.

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

SECTION BY SECTION ANALYSIS

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

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

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

ARTICLE 2. TEXAS INSTITUTE OF HEALTH CARE QUALITY AND EFFICIENCY

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

CHAPTER 1002. TEXAS INSTITUTE OF HEALTH CARE QUALITY AND EFFICIENCY

SUBCHAPTER A. GENERAL PROVISIONS

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

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

[Reserves Sections 1002.003-1002.050 for expansion.]

SUBCHAPTER B. ADMINISTRATION

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

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

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

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

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

(b) Authorizes board members to serve consecutive terms.

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

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

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

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

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

(c) Requires each board member to 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.

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

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

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

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

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

Sec. 1002.060. PRIVACY OF INFORMATION. (a) Provides that protected health information and individually identifiable health information collected, assembled, or maintained by TIHCQE is confidential and is not subject to disclosure under Chapter 552 (Public Information), Government Code.

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

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

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

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

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

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

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

[Reserves Sections 1002.062-1002.100 for expansion.]

SUBCHAPTER C. POWERS AND DUTIES

Sec. 1002.101. GENERAL POWERS AND DUTIES. Sets forth the required duties of TIHCQE.

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

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

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

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

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

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

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

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

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

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

[Reserves Sections 1002.103-1002.150 for expansion.]

SUBCHAPTER D. HEALTH CARE COLLABORATIVE GUIDELINES AND SUPPORT

Sec. 1002.151. INSTITUTE STUDIES AND RECOMMENDATIONS REGARDING PAYMENT AND DELIVERY SYSTEMS. (a) Requires TIHCQE to study alternative payment and delivery systems and determine which models are appropriate for certification as a health care collaborative under Chapter 848, Insurance Code.

(b) Requires TIHCQE to make recommendations for the eligibility requirements for initial and continuing certification as a health care collaborative, such as recommendations concerning how a collaborative will:

(1) improve health care provider collaboration and coordination of services;

(2) improve quality of care; and

(3) contain health care costs.

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

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

(2) the quality of care;

(3) health care provider collaboration and coordination;

(4) the protection of patients; and

(5) patient satisfaction.

[Reserves Sections 1002.152-1002.200 for expansion.]

SUBCHAPTER E. IMPROVED TRANSPARENCY

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

(b) Requires TIHCQE to develop a plan:

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

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

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

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

(b) Requires TIHCQE to consult with DSHS and the Texas Department of Insurance (TDI) to develop a plan to establish the centralized claims database described by Subsection (a).

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

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

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

(2) any unexpended and unobligated balance of money appropriated by the legislature to the Texas Health Care Policy Council established under Chapter 109, Health and Safety

Code, as it existed immediately before the effective date of this Act, is transferred to TIHCQE created by Chapter 1002, Health and Safety Code, as added by this Act.

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

SECTION 2.05. (a) Requires TIHCQE, not later than December 1, 2012, to submit a report regarding improved health care reporting to the governor, the lieutenant governor, the speaker of the house of representatives, and the chairs of the appropriate standing committees of the legislature outlining:

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

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

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

(4) the cost implications to state agencies to implement the assessment and plans described by Subdivisions (1) and (2) of this subsection.

(b) Requires TIHCQE, not later than December 1, 2012, to submit a report regarding 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 initial plan developed under Section 1002.202(b), Health and Safety Code, as added by this Act;

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

(4) the cost implications to state agencies to implement the plan described by Subdivision (2) of this subsection.

ARTICLE 3. HEALTH CARE COLLABORATIVES

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

CHAPTER 848. HEALTH CARE COLLABORATIVES

SUBCHAPTER A. GENERAL PROVISIONS

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

Sec. 848.002. USE OF INSURANCE-RELATED TERMS BY HEALTH CARE COLLABORATIVE. Prohibits a health care collaborative that is not an insurer or health maintenance organization from using in its name, contracts, or literature certain words or initials, or any other words or initials that meet certain criteria.

Sec. 848.003. APPLICABILITY OF INSURANCE LAWS. Prohibits an organization from arranging for or providing health care services to enrollees on a prepaid or

indemnity basis through health insurance or a health benefit plan, including a health care plan, as defined by Section 843.002 (Definitions), unless the organization holds the appropriate certificate of authority issued under:

(1) Chapter 841 (Life, Health, or Accident Insurance Companies);

(2) Chapter 842 (Group Hospital Service Corporations);

(3) Chapter 843 (Health Maintenance Organizations); or

(4) Chapter 883 (Mutual Insurance Companies other than Mutual Life Insurance Companies).

[Reserves Sections 848.004-848.050 for expansion.]

SUBCHAPTER B. AUTHORITY TO ENGAGE IN BUSINESS

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

Sec. 848.052. CERTIFICATE OF AUTHORITY REQUIRED. (a) Prohibits an organization from organizing or operating a health care collaborative in this state unless the organization holds a certificate of authority issued under this chapter.

(b) Prohibits an organization from using the term "health care collaborative" in its name, contracts, or literature unless the organization holds a certificate of authority issued under this chapter.

Sec. 848.053. EXCEPTIONS. (a) Provides that an organization is not required to obtain a certificate of authority under this chapter if the organization holds an appropriate certificate of authority issued under another chapter of this code.

(b) An organization is not required to obtain a certificate of authority under this chapter to the extent that the organization provides health care services only under contract with:

(1) the Centers for Medicare and Medicaid Services as a health care collaborative under the Medicare shared savings program (42 U.S.C. Section 1395jjj); or

(2) HHSC under Chapter 531 (Health and Human Services Commission), Government Code.

Sec. 848.054. CERTIFICATE APPLICATION. (a) Authorizes an organization to apply to the commissioner of insurance (commissioner) for and obtain a certificate of authority to organize and operate a health care collaborative.

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

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

(2) be verified by the applicant or an officer or other authorized representative of the applicant.

(c) Provides that an application for a certificate of authority is confidential and is not subject to disclosure under Chapter 552, Government Code.

Sec. 848.055. REQUIREMENTS FOR APPROVAL OF APPLICATION. Requires the commissioner to issue a certificate of authority on payment of the application fee

prescribed by Section 848.152 if the commissioner is satisfied that that applicant meets or has met certain criteria.

Sec. 848.056. DENIAL OF CERTIFICATE OF AUTHORITY; LIMITATIONS ON MARKET POWER. (a) Prohibits the commissioner from issuing a certificate of authority if the commissioner determines that:

(1) the applicant's proposed plan of operation does not meet the requirements of Section 848.055;

(2) the applicant's proposed health care collaborative is 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; or

(3) the applicant's proposed health care collaborative is likely to possess market power sufficient to raise rates above competitive levels.

(b) Authorizes the commissioner to revoke a health care collaborative's certificate of authority as provided by Section 848.201 if the commissioner determines that a change in the health care collaborative's market, or a change in the size or composition of the health care collaborative, has occurred that is likely to result in reduced competition, as described by Subsection (a)(2), or market power sufficient to raise rates above competitive levels, as described by Subsection (a)(3).

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

[Reserves Sections 848.057-848.100 for expansion.]

SUBCHAPTER C. GENERAL POWERS AND DUTIES OF HEALTH CARE COLLABORATIVE

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

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

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

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

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

(b) Authorizes a health care collaborative, notwithstanding Section 164.052(a)(13) (relating to impersonating a physician) or (17) (relating to aiding or abetting the non-licensed practice of medicine) or 165.156 (Misrepresentation Regarding Entitlement to Practice Medicine), Occupations Code, to contract for, receive, allocate, and distribute payments for health care services provided by a physician or health care provider participating within the organization.

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

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

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

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

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

(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.

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

Sec. 848.107. COMPLAINT SYSTEM. Requires a health care collaborative to implement and maintain a complaint system that provides reasonable procedures to resolve an oral or written complaint initiated by a complainant concerning health care services provided by participating physicians or health care providers. Requires that the complaint system include a process for the notice and appeal of a complaint.

Sec. 848.108. FINANCIAL RESERVE REQUIREMENTS. Requires a health care collaborative to maintain reserves in an amount determined by commissioner rule to be adequate for the liabilities and risks assumed by the health care collaborative, as computed in accordance with accepted standards, practices, and procedures relating to the liabilities and risks for which the reserves are maintained, including known and unknown components and anticipated expenses of providing health care services.

Sec. 848.109. VALIDITY OF OPERATIONS AND TRADE PRACTICES OF HEALTH CARE COLLABORATIVES. Provides that the operations and trade practices of a health care collaborative that are consistent with the provisions of this chapter, the

rules adopted under this chapter, and applicable federal antitrust laws are presumed to be consistent with Chapter 15 (Monopolies, Trust and Conspiracies in Restraint of Trade), Business & Commerce Code, or any other applicable provision of law.

[Reserves Sections 848.110-848.150 for expansion.]

SUBCHAPTER D. REGULATION OF HEALTH CARE COLLABORATIVES

Sec. 848.151. RULES. Authorizes the commissioner in consultation with TIHCQE to adopt reasonable rules as necessary and proper to:

(1) improve the quality and efficiency of health care delivery by a health care collaborative;

(2) facilitate the creation of innovative health care collaborative payment systems; and

(3) implement the requirements of this chapter.

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

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

(c) Requires a health care collaborative to pay to the commissioner:

(1) an application fee in an amount not to exceed $750 for filing and review of its original application for a certificate of authority; and

(2) an annual fee in an amount not to exceed $750 for renewal of the certificate of authority.

(d) Requires a health care collaborative to pay to the commissioner a fee in an amount assessed by the commissioner and paid in accordance with rules adopted by the commissioner for the expenses of an examination under Section 848.154 that:

(1) are incurred by the commissioner or under the commissioner's authority; and

(2) are directly attributable to that examination, including the actual salaries and expenses of the examiners directly attributable to that examination, as determined under rules adopted by the commissioner.

Sec. 848.153. ANNUAL REPORT. (a) Requires a health care collaborative, not later than March 1 of each year, to file with the commissioner a report covering the preceding calendar year.

(b) Requires that the report meet certain criteria.

(c) Provides that an annual report filed with the commissioner under this section is confidential and is not subject to disclosure under Chapter 552, Government Code.

Sec. 848.154. EXAMINATIONS. (a) Authorizes the commissioner to examine the financial affairs and operations of any health care collaborative or applicant for a certificate of authority under this chapter.

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

(c) Requires a health care collaborative, on request of the commissioner, to provide to the commissioner:

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

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

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

[Reserves Sections 848.155-848.200 for expansion.]

SUBCHAPTER E. ENFORCEMENT

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

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

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

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

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

(b) Authorizes the commissioner to take an enforcement action listed in Subsection (a) against a health care collaborative if the commissioner makes certain findings relating to the health care collaborative.

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

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

(2) advertising or soliciting in any way.

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

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

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

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

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

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

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

SECTION 3.03. Amends Subchapter O, Chapter 285, Health and Safety Code, by adding Section 285.303, as follows:

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

(b) Requires the governing body of the hospital district to appoint the board of the health care collaborative formed under this section.

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

SECTION 3.04. Amends Section 102.005, Occupations Code, to provide that Section 102.001 does not apply, in addition to certain other individuals and entities, to a health care collaborative certified under Chapter 848, Insurance Code.

SECTION 3.05. Amends Section 151.002(a)(5), Occupations Code, to redefine "health care entity."

SECTION 3.06. Requires the commissioner and the board of directors of TIHCQE, not later than April 1, 2012, to adopt rules as necessary to implement this article.

ARTICLE 4. PATIENT IDENTIFICATION

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

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

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

(c) Requires DSHS to require each hospital to implement and enforce the statewide standardized patient risk identification system developed under

Subsection (b) unless DSHS authorizes an exemption for the reason stated in Subsection (d).

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

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

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

ARTICLE 5. REPORTING OF HEALTH CARE-ASSOCIATED INFECTIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Authorizes DSHS to:

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

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

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

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

Sec. 98.108. FREQUENCY OF REPORTING. Requires the executive commissioner by rule, in consultation with the advisory panel, to establish the frequency of reporting by health care facilities required under Sections 98.103 and 98.1045 (Reporting of Preventable Adverse Diseases), rather than under Sections 98.103, 98.104, and 98.1045. Prohibits facilities from being required to report more frequently than monthly, rather than quarterly.

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

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

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

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

ARTICLE 6. INFORMATION MAINTAINED BY DEPARTMENT OF STATE HEALTH SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

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

(j) Requires the executive commissioner by rule to develop and implement a mechanism to comply with Subsections (c)(1) (relating to data that could be reasonable be expected to real the identity of the patient) and (2) (relating to data that could reasonably be expected to reveal the identity of the physician), rather than requiring HCIC 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) Authorizes DSHS to disclose data collected under this chapter that is not included in public use data to any DSHS or HHSC program if the disclosure is reviewed and approved by the institutional review board (IRB) under Section 108.0135.

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

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

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

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

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

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

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

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

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

Sec. 108.0135. New heading: INSTITUTIONAL REVIEW BOARD. (a) Requires DSHS, rather than HCIC, to establish an IRB to review and approve requires for access to data not contained in public use data, rather than in information other than public use data. Replaces references to a scientific review panel with an IRB. Makes conforming changes.

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

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

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

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

ARTICLE 7. EFFECTIVE DATE

SECTION 7.01. Effective date: September 1, 2011.