SUBJECT: Data collection and dissemination by the Health Care Information Council

COMMITTEE: Public Health — committee substitute recommended

VOTE: 5 ayes — Berlanga, Hirschi, Coleman, Glaze, Maxey

0 nays

3 absent — Davila, Delisi, Janek

WITNESSES: For — Joe DaSilva, Texas Hospital Association; Lisa McGiffert, Consumers Union

Against — None

On — Ann Henry, Texas Department of Health; Jim Loyd; Anne Heiligenstein, Texas Conference of Catholic Health Care Facilities

BACKGROUND: Last session the Legislature created the Health Care Information Council to develop a statewide data collection system to collect health care charges, utilization data, provider quality data and outcome data. The council contracts with the Texas Department of Health to collect data.

Health maintenance organizations (HMOs), hospitals and other health care facilities are required to submit data to the council. Individual physicians and physician organizations are exempt from data submission requirements. Rural providers are authorized, but not required, to submit data. Data access and release is restricted by confidentiality requirements.

DIGEST: CSHB 1616 would amend the Health and Safety Code regarding the Health Care Information Council to:

- modify council composition to include a representative from the Office of Public Insurance Council as an ex-officio member,
- redefine “rural provider” and exempt certain other hospitals from data submission requirements,
- require approved nonprofit medical corporations to submit data,

- specify the composition and use of technical advisory committees,
- require the council to publish notice of its meetings in the Texas Register,
- create “public use data” and “provider quality data” categories, require the council to collect patient racial and ethnic background data in addition to current data collection requirements,
- require a memorandum of understanding agreement between the council and TDH regarding TDH duties to the council,
- require the attorney general to furnish advice and legal assistance to the council,
- exempt certain hospitals from data submission requirements,
- remove requirements that the council develop the system in accordance with Department of Information Resources standards, and
- enact a Class A misdemeanor criminal penalty, punishable up to one year in jail and a $4,000 fine, for persons who with criminal negligence release data in violation of the chapter.

The bill would take effect September 1, 1997.

Rural and other providers. Rural providers subject to reporting requirements would continue to include providers in counties with populations not more than 35,000, but would also include providers in counties with populations greater than 35,000 if the provider does not have more than 100 licensed hospital beds and is not in an urbanized area. A rural provider could not be a state-owned hospital or a hospital that is managed or directly or indirectly owned by an entity that owns or manages one or more other hospitals.

Hospitals would not be required to submit data if they are exempt from state franchise, sales, ad valorem or other state or local taxes and do not seek or receive reimbursement for providing health care services to patients from any source, including the person legally obligated to support the patient, a third-party payor or Medicaid, Medicare and any other state, federal or local indigent health care program.

Data use. Provider quality data would refer to data that indicates the extent to which a provider renders care that, within the capabilities of modern

medicine, obtains for patients medically acceptable health outcomes and prognoses, after adjustments for severity are factored in. The council would have to make available in the council office, via the Internet and attached to the release, the written comments of any provider regarding the release of any specific provider quality data. Rural provider data would be exempt from provider quality data releases.

Public use data would be defined as patient level data relating to individual hospitalizations that have not been summarized or analyzed, that identifies patients and physicians only by use of uniform patient and physician identifiers, and that is severity and risk adjusted and verified for accuracy. Public use data would not include provider quality data or confidential data, and the release of public use data could not include data relating to rural providers.

The council would have to use public use data to prepare and issue reports that provide selected medical or surgical procedures and that provide data in a manner that identifies and compares data among individual providers, including physicians. The council would have to adopt rules allowing a provider to submit concise written comments regarding any specific public use data to be released, and the comments would have to be made available in the council office, via the Internet and attached to any public release.

Tapes containing public use data and provider quality reports would have to include consumer education material, including an explanation of the benefits and limitations of the information provided.

The council could not release data elements in a manner that would reveal the identity of a physician or patient and could not provide confidential information to any other state agency.

Committees. Adding to the current list of required technical advisory committees, the bill would require the council to appoint a technical advisory committee composed of individuals who have expertise in hospital information systems, information management and quality management.

The council would have to consult with appropriate technical advisory committees before finally adopting rules, except for emergency rules, which

would have to be submitted for the committees review by the first committee meeting after the emergency rule was adopted.

SUPPORTERS SAY:

CSHB 1616 would take care of problems uncovered in the first two years of operation of the Health Care Information Council and promote a smoother and more effective data collection and public information system.

Many of the proposed changes would address problems in council administration, and would more clearly define the roles of TDH, the council and the attorney general's office, the use of technical advisory committees and the council's duty to conform to appropriate state agency governing laws, such as the Texas Register Act and the open records laws.

The bill would narrow the definition of rural provider to better reflect the geographic distribution of population and providers in Texas. It would exclude rural hospitals that are part of a multi-hospital or multi-facility system, which allows them to have access to sophisticated system resources.

Submission of racial and ethnic patient data would help the state and epidemiological researchers track health care trends and risk factors and the prevalence of other influences in health care and illnesses. The bill would also clarify that unique physician and patient identifiers would be released, but the confidentiality of actual names would be protected, and any violation of confidentiality requirements would subject to the highest criminal misdemeanor penalty class.

OPPONENTS SAY:

The definition of rural provider should be further narrowed; not all rural hospital members of a hospital system have access to sufficient resources to meet the council's data submission requirements.

NOTES:

The committee substitute added provisions that would include in the definition of rural provider hospitals with fewer than 100 beds in rural counties having populations greater than 35,000; a representative from the Office of Public Insurance Council on the council; a new technical advisory committee composed of health care information systems specialists; and allow providers to write concise written comments regarding the release of public use data.

SB 802 by Zaffirini, includes similar provisions, passed the Senate on March 26 and was reported favorably, as substituted, from the House Public Health Committee on April 30.