By Senator Alexander

17-1418-04

A bill to be entitled

An act relating to health care; amending s. 395.10973, F.S.; directing the Agency for Health Care Administration to make data concerning patient charges and performance outcomes collected from health care facilities available to the public; requiring the data to be placed on the agency's website by a specified date; directing the agency to select 100 medical conditions and treatments in order to compare data from licensed facilities; providing criteria for comparison procedures; directing the agency to publicly disclose the amount that each licensed facility charges for its services; requiring the agency to evaluate the benefit of disclosing comparative measures; directing the agency to report its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by a specified date and annually thereafter; requiring the agency to implement an audit program to examine a health care facility's patient bills and payor claims for charges of $20,000 or more; providing an acceptable error rate; authorizing the agency to impose a fine on licensed facilities that exceed the error rate; amending s. 395.301, F.S.; requiring that, in cases of nonemergency services, a licensed facility give each patient an estimate, in writing, of the anticipated charges the facility typically bills to treat

the patient's condition; requiring that the estimate be given to the patient before treatment is rendered or before the patient is admitted to the facility; providing that, if a licensed facility increases the estimated cost by a specified amount, the patient or payor is not required to pay more than the original written estimate; providing an exception for costs arising from unanticipated complications; requiring a licensed facility to give a patient access to the records necessary to verify the accuracy of the patient's bill within a certain time after the licensed facility receives the request for the records; providing that a patient or a patient's payor may appeal any charge listed in a licensed facility's bill; providing procedures for an appeal; requiring each licensed facility to file its uniform schedule of charges each year with the agency by January 1; requiring each licensed facility to notify the agency and the public of any proposed change to its schedule of charges 30 days before implementing the change; amending s. 408.061, F.S.; directing each licensed facility to report certain data to the agency each quarter; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 395.10973, Florida Statutes, is amended to read:

395.10973 Powers and duties of the agency.--It is the function of the agency to:

(1) Adopt rules under ~~pursuant to~~ ss. 120.536(1) and 120.54 to implement ~~the provisions of~~ this part conferring duties upon it.

(2) Develop, impose, and enforce specific standards within the scope of the general qualifications established by this part which must be met by individuals in order to receive licenses as health care risk managers. These standards shall be designed to ensure that health care risk managers are individuals of good character and otherwise suitable and, by training or experience in the field of health care risk management, qualified in accordance with ~~the provisions of~~ this part to serve as health care risk managers, within statutory requirements.

(3) Develop a method for determining whether an individual meets the standards set forth in s. 395.10974.

(4) Issue licenses to qualified individuals meeting the standards set forth in s. 395.10974.

(5) Receive, investigate, and take appropriate action with respect to any charge or complaint filed with the agency to the effect that a certified health care risk manager has failed to comply with the requirements or standards adopted by rule by the agency or to comply with ~~the provisions of~~ this part.

(6) Establish procedures for providing periodic reports on persons certified or disciplined by the agency under this part.

(7) Develop a model risk management program for health care facilities which will satisfy the requirements of s. 395.0197.

(8) Enforce the special-occupancy provisions of the Florida Building Code which apply to hospitals, intermediate residential treatment facilities, and ambulatory surgical centers in conducting any inspection authorized by this chapter.

(9)(a) Make available data concerning patient charges and performance outcomes collected from health care facilities under s. 408.061(1) and (2) for not less than 100 inpatient and outpatient diagnostic and therapeutic conditions and procedures. The data must be made available on the agency's website by October 1, 2004. The agency shall make a hardcopy format available upon requests. The data shall be updated quarterly.

(b) The agency, after consulting with the Comprehensive Health Information Systems Advisory Council, shall adopt by rule the conditions and procedures that must be made publicly available. When determining which conditions and procedures will be selected, the advisory council and the agency shall consider the variation in costs and outcomes and the magnitude of variations and other relevant information in order that the list of conditions and procedures selected will assist health care consumers to differentiate between health care facilities when making decisions regarding health treatment.

(c) For each medical condition and procedure chosen, the agency shall report patient charges and performance outcomes, adjusted for case mix and severity if applicable, for each licensed facility. The agency shall report patient charges that are stated on the hospital's most recently filed charge master, as defined by s. 395.301(11). For each licensed facility, the agency shall compare:

1. Volume of cases;
2. Patient charges;
3. Length of stay;
4. Readmission rates;
5. Complication rates;
6. Mortality rates;
7. Infection rates; and
8. Use of computerized drug-order systems.

(d) The agency shall make available to the public educational information relating to the 100 conditions and procedures selected under this subsection, including, but not limited to, an explanation of the medical condition or procedure, potential side effects, alternative treatments, costs, and the additional resources that may assist consumers in making informed decisions. The information may be made available by providing a link on the website to credible national resources, such as, but not limited to, the National Library of Medicine.

(10) Make available on its Internet website a copy of each licensed facility's charge master for all services. The charge-master information must include any change in the facility's gross revenue due to a price increase or decrease in its charge master, as filed under s. 395.301(11), during the previous 12 months.

(11) Publicly disclose the information derived from subsections (9) and (10) to allow for the comparison of patient charges and performance outcomes between licensed facilities in the state. When doing so, the agency must use methods that are understandable to laypersons and accessible to consumers using an interactive query system. The agency must clearly state the age of the data and provide an

explanation for the methodology used to adjust the data in order to account for the applicable degree of risk. The agency must provide guidance to consumers in this state on how to use this information to make informed health care decisions.

(12)(a) Study and implement by October 1, 2005, the most effective methods to publicly disclose comparative patient charges and performance outcomes. The methods used to deliver this information to consumers must enhance informed decisionmaking choices among consumers and health care purchasers.

(b) The agency shall evaluate the benefit of disclosing additional comparative measures. Comparative measures to be considered must include, but need not be limited to, comparative measures that are adopted by the National Quality Forum, the Joint Commission on Accreditation of Healthcare Organizations, or similar national entities that establish standards to measure the performance of health care providers.

(13) Report its findings and recommendations under subsection (12) to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1, 2005, and annually thereafter. The agency shall make this annual report available to the public on its Internet website.

(14) Develop and implement by October 1, 2004, a program to audit each health care facility's patient bills and payor claims for charges by a provider of $20,000 or more. Each licensed health care facility shall be audited at least once every 3 years. The audit must establish a facility's ratio of errors in billing and payor claims. An error ratio under 5 percent is permissible. The error ratio shall be determined by dividing the number of payor claims and bills

containing errors from a statistically valid sample of claims and payor bills for the audit period by the total number of claims and bills in the sample. The agency may be assessed a fine if the error ratio is 5 percent or higher. The fine may be assessed in the amount of $500 per error. However, the total fine may not exceed $100,000 for the audit period examined. The agency shall require a facility to refund the overpaid amount to any patient or payor who was overcharged within 30 days after completion of the audit.

The agency shall adopt rules to administer this section by January 1, 2005.

Section 2. Section 395.301, Florida Statutes, is amended to read:

395.301 Itemized patient bill; form and content prescribed by the agency.--

(1)(a) In cases of nonemergency services, a licensed facility shall give each patient a good faith estimate, in writing, of the reasonably anticipated charges the facility typically bills to treat the patient's condition. The estimate must be given to the patient before treatment is rendered or before the patient is admitted to the facility. The facility shall also disclose other common, less costly methods to treat the patient's medical condition, including, but not limited to, outpatient services or drug therapies.

(b) If unanticipated complications arise, the licensed facility may charge the patient, or a third-party payor acting on behalf of the patient, for the additional treatment, services, or supplies resulting from the unanticipated complications, if these charges are itemized on the patient's billing statement.

(2)(a) A licensed facility may not, as a condition of admission or providing services, require a patient to sign any form that requires or binds the patient, or the patient's third-party payor, to make an unspecified or unlimited financial payment to the facility or to waive the patient's right to appeal the charges billed.

(b) A licensed facility may require a commitment for payment from a patient or the patient's third-party payor only if the licensed facility provides a good faith estimate, in writing, of the reasonably anticipated charges the facility typically bills to treat the patient's condition. The licensed facility shall notify the patient or payor of any revision to the estimate in a timely manner. If the facility makes a revision to the estimate which exceeds the lesser of 20 percent of the original estimate or $1,000, the patient or payor is not required to pay any amount over the original written estimate. This limitation does not apply to additional treatment, services, or supplies resulting from unanticipated complications.

(3)~~(1)~~ A licensed facility not operated by the state shall notify each patient during admission and at discharge of his or her right to receive an itemized bill upon request. Within 7 days following discharge or release from a licensed facility not operated by the state, or within 7 days after the earliest date at which the loss or expense from the service may be determined, the licensed facility providing the service shall, upon request, submit to the patient, or to the patient's survivor or legal guardian as may be appropriate, an itemized statement detailing in language comprehensible to an ordinary layperson the specific nature of charges or expenses incurred by the patient, which in the initial billing shall

contain a statement of specific services received and expenses incurred for the ~~such~~ items of service, enumerating in detail the constituent components of the services received within each department of the licensed facility and including unit price data on rates charged by the licensed facility, as prescribed by the agency.

(4)~~(2)~~ Each ~~such~~ statement:

(a) May not include charges of hospital-based physicians if billed separately.

(b) May not include any generalized category of expenses such as "other" or "miscellaneous" or similar categories.

(c) Shall list drugs by brand or generic name and not refer to drug code numbers when referring to drugs of any sort.

(d) Shall specifically identify therapy treatment as to the date, type, and length of treatment when therapy treatment is a part of the statement. Any person receiving a statement under ~~pursuant to~~ this section shall be fully and accurately informed as to each charge and service provided by the institution preparing the statement.

(e) Shall conspicuously display notice of the patient's or a third-party payor's right to appeal any of the charges in the bill. The patient must also be notified whether interest will be applied to any billing charge not covered by a third-party payor and, if so, the rate of interest which will be charged.

(5)~~(3)~~ On each ~~such~~ itemized statement there shall appear the words "A FOR-PROFIT (or NOT-FOR-PROFIT or PUBLIC) HOSPITAL (or AMBULATORY SURGICAL CENTER) LICENSED BY THE STATE OF FLORIDA" or substantially similar words sufficient to

identify clearly and plainly the ownership status of the licensed facility. Each itemized statement must prominently display the phone number of the medical facility's patient liaison who is responsible for expediting the resolution of any billing dispute between the patient, or his or her representative, and the billing department.

(6)~~(4)~~ An itemized bill shall be provided once to the patient's physician at the physician's request, at no charge.

(7)~~(5)~~ In any billing for services subsequent to the initial billing for ~~such~~ services, the patient, or the patient's survivor or legal guardian, may elect, at his or her option, to receive a copy of the detailed statement of specific services received and expenses incurred for each ~~such~~ item of service as provided in subsection (1).

(8)~~(6)~~ No physician, dentist, podiatric physician, or licensed facility may add to the price charged by any third party except for a service or handling charge representing a cost actually incurred as an item of expense; however, the physician, dentist, podiatric physician, or licensed facility is entitled to fair compensation for all professional services rendered. The amount of the service or handling charge, if any, shall be set forth clearly in the bill to the patient.

(9) A licensed facility must make available to a patient, or a payor acting on behalf of the patient, the records necessary to verify the accuracy of the patient's bill or payor's claim relating to the patient's bill. The records must be provided within 3 business days after the licensed facility receives the request for the records. The records shall be made available at the licensed facility's offices. The records must be available to the patient or patient's payor before and after payment of the bill or claim. A

licensed facility may not charge the patient or the patient's payor for making the records available, except that the facility may charge its usual charge for providing copies of records as specified in s. 395.3025.

(10) A patient or a patient's payor may appeal any charge listed in a licensed facility's bill. A licensed facility shall establish an impartial method for reviewing billing appeals. The licensed facility must provide its written decision to the patient or the patient's payor making the appeal and to the agency within 30 days after the licensed facility receives the appeal. The decision must include a clear explanation of the grounds for the decision. A facility shall maintain a complete and accurate log of all appeals and shall report to the agency the number of appeals, the total amount of the charges subject to appeal, and a summary of the dispositions of the appeals by January 1 of each year.

(11) A licensed facility shall file each year with the agency by January 1 a copy of its charge master. A facility must include an estimate of the percentage increase in its gross revenue due to any price increase or decrease in its charge master during the previous 12 months. As used in this section, the term "charge master" means a uniform schedule of charges represented by the facility as its gross billed charge for a given service or item, regardless of payer type.

(12) A licensed facility shall report to the agency and provide public notice on its Internet website or by other electronic means, and in its reception areas open to the public, any proposed change to its charge master 30 days before implementing the change. The notice must separately identify the amount and percent by which a charge is being reduced or increased. The licensed facility must include in

the notice an explanation developed by the agency as to how the public may use the information in selecting a health care facility.

Section 3. Paragraph (a) of subsection (1) of section 408.061, Florida Statutes, is amended to read:

408.061 Data collection; uniform systems of financial reporting; information relating to physician charges; confidential information; immunity.--

(1) The agency may require the submission by health care facilities, health care providers, and health insurers of data necessary to carry out the agency's duties. Specifications for data to be collected under this section shall be developed by the agency with the assistance of technical advisory panels including representatives of affected entities, consumers, purchasers, and such other interested parties as may be determined by the agency.

(a) Data shall ~~to~~ be submitted by health care facilities quarterly for each preceding calendar quarter no later than February 1, May 1, August 1, and November 1 of each year beginning on August 1, 2004. The data shall ~~may~~ include, but are not limited to: case-mix data, patient admission or discharge data with patient and provider-specific identifiers included, actual charge data by diagnostic groups, financial data, accounting data, operating expenses, expenses incurred for rendering services to patients who cannot or do not pay, interest charges, depreciation expenses based on the expected useful life of the property and equipment involved, and demographic data. Data may be obtained from documents such as, but not limited to: leases, contracts, debt instruments, itemized patient bills, medical record abstracts, and related diagnostic information.

Section 4. This act shall take effect upon becoming a law.

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SENATE SUMMARY

Directs the Agency for Health Care Administration to make data concerning patient charges and performance outcomes available to the public. Requires the data to be placed on the agency's website. Directs the agency to select 100 medical conditions and treatments to compare data from licensed facilities. Directs the agency to disclose what each licensed facility charges for its services. Directs the agency to report its findings and recommendations to the Governor and Legislature. Requires the agency to implement an audit program to examine health care facility patient bills and payor claims for charges of $20,000 or more. Provides an acceptable error rate. Authorizes the agency to impose a fine on licensed facilities that exceed the error rate. Requires that, in cases of nonemergency services, a licensed facility give each patient a good faith estimate, in writing, of the reasonably anticipated charges. Requires that the estimate be given to the patient before treatment is rendered or before the patient is admitted to the facility. Provides an exception for costs arising from unanticipated complications. Requires a licensed facility to give a patient access to the records necessary to verify the accuracy of the patient's bill. Provides that a patient or a patient's payor may appeal any charge. Requires each licensed facility to file its uniform schedule of charges with the agency. Requires each licensed facility to notify the agency and the public of any proposed change to its schedule. (See bill for details.)